National Expansion of TEHIP Tools Zonal Roll Out

End of Programme Evaluation

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Acronyms

AIDS	-	Auto Immune Disease Syndrome
BOD	-	Burden of Disease
CCHP	-	Comprehensive Council Health Plan
CPD	-	Continuing Professional Development
CE	-	Continuing Education
CHMT	-	Council Health Management Team
CMO	-	Chief Medical Officer
CR	-	Community-based Rehabilitation
DHR	-	Department of Human Resources
DHS	-	Demographic Health Survey
DPS	-	Department of Preventive Services
DPP	-	Department of Policy Planning
DSS	-	Demographic Surveillance System
EPI	-	Expanded Program for Immunization
HIV	-	Human Immunodeficiency Virus
HMIS	-	Health Management Information System
HRD	-	Human Resources Development
HRS	-	Human Resource for Health
HSRS	-	Health Sector Reform Secretariat
HTI	-	Health Training Institute
IDRC	-	International Development Research Centre
IFMIS	-	Integrated Financial Management Information System
IHRDC	-	Ifakara Health Research and Development Centre
IMC	-	Integrated Management Cascade
IMCI	-	Integrated Management of Childhood Illness
ITN	-	Insecticide Treated Net
M&E	-	Monitoring and Evaluation
MDG	-	Millennium Development Goal
MKUKUTA	-	Tanzania Poverty Reduction Strategy
MOH	-	Ministry of Health
MoFEA	-	Ministry of Finance and Economic Affairs
MTEF	-	Medium Term Expenditure Framework
NACTE	-	National Council for Technical Education
NETTS	-	National Expansion of TEHIP Tools and Strategies
NGO	-	Non-Governmental Organization
OPRAS	-	Open Performance Review and Appraisal System
OVI	-	Objectively Verifiable Indicators
PHC	-	Primary Health Care
PlanRep2	-	Planning and Reporting Software version 2
PMTCT	-	Prevention of Mother to Child Transmission
PST	-	Pre Service Training
QA	-	Quality Assurance
RHMT	-	Regional Health Management Team
SAVVY	-	Sampling Vital Registration and Verbal Autopsy
SHM	-	Strengthening Health Management
SMI	-	Safe Motherhood Initiative
STI	-	Sexually Transmitted Infection
SWAp	-	Sector Wide Approach
TASAF	-	Tanzania Social Action Fund
TB DOTS	-	Tuberculosis Directly Observed Treatment Short Course
TEHIP	-	Tanzania Essential Health Interventions Project
TNA	-	Training Needs Assessment
TOT	-	Training of Trainers
VCT	-	Voluntary Counselling and Testing
WB	-	World Bank

WHO	-	World Health Organization
ZHRC	-	Zonal Health Resources Centre
ZORO	-	Zonal Roll Out
ZTC	-	Zonal Training Centre

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Executive Summary

Introduction

This report provides the final evaluation of the programme for National Expansion of TEHIP Tools and Strategies – Zonal Roll Out (NETTS-ZORO) for the period 2006 – 2009. The objective of the evaluation was to examine the extent to which the strengthening of Zonal Health Resources Centres (ZHRCs) and rollout of TEHIP tools, strategies and interventions has taken place in actual field conditions and to suggest a way forward.
Between 1997 and 2004 the Tanzania Essential Health Intervention Project (TEHIP) successfully developed and tested a range of tools and supportive strategies to directly strengthen the planning, prioritisation and implementation of essential health interventions within progressively strengthened district health systems. These tools were Burden of Disease Profile, District Health Accounts, Strengthening Health Management, Integrated Management Cascade, Community-based Rehabilitation of Health Facilities, and Integrated Management of Childhood Illnesses.

Programme set-up

The goal of the NETTS ZORO programme was to establish a decentralised institutional training system to scale up tools, strategies and interventions. Strengthening the ZHRCs should capacitate district health staff to plan, prioritise, integrate and deliver the essential health interventions.
The programme had six objectives: strengthen ZHRC capacity for scale up TEHIP tools and strategies; scale-up district health system tools and support strategies; scale-up essential health interventions commencing with IMCI; develop capacity of ZHRC in innovation and learning for the purpose of linking training and practice; provide programme technical and managerial support to achieve national scale up targets; monitor and evaluate the programme.
The NETTS-ZORO programme was seen as a reforms programme; therefore a management team, consisting of three consultants and support staff, was located in the Health Sector Reform Secretariat (HSRS) in the Directorate of Policy and Planning (DPP). A steering committee, chaired by the Permanent Secretary of the Ministry of Health and Social Welfare (MOHSW), provided oversight over the programme.
The World Bank and the Medium-term Expenditure Framework (MTEF) or basket financing provided funds, of US$ 12.4 million in total.

Implementation

The programme started in 2006, with initially preparations for the training. The tools were reviewed, updated, training manuals were produced, and where needed translated in Kiswahili. Thereafter trainers of trainers were selected, capacitated and a start was made for strengthening ZHRCs, to take up the role of coordination and logistical support in the training programme. New personnel were recruited (both administrative and professional staff) and staff was sent for upgrading in different areas, to improve the teaching competencies of ZHRCs. The infrastructure of the ZHRCs was improved. The ZHRCs built up a network of trainers in the zones (from health training institutions, regional and district hospitals, Council Health Management teams, etc.) who could facilitate actual training.
In 2007 actual training of different tools started according to phases, spreading over the country. In total around 75% of the training programme planned could be completed before the end of the programme in June 2009. Major constraint in the training was the slow disbursement of funds. It took often months to mobilise funds for training activities, making it impossible to work according to plan. Finally, only 83% of World Bank funds and 53% of MTEF funds could be used because of delays experienced.
The programme team managed to build up relations with other institutions and donors, who support ZHRCs, which gave the possibility to enhance the programme of strengthening weaker ZHRCs and to guarantee continuity of the programme.

Contextual Factors

Because of dynamic changes in the health sector, the environment of the NETTS-ZORO programme deviated more and more from the conditions under which the TEHIP project was implemented. The decentralisation by devolution process continued giving an ever-growing role the Local Government Agencies with new planning mechanisms and new funding mechanisms. The district basket funding increased, giving more opportunities to councils to improve their health services. New policies were introduced in the ministry, strengthening primary health care. At the same time the human resources crisis in Tanzania deepened, with more shortages of staff especially in remote areas.
The MOHSW tool steps to strengthen health training institutions in the country; the ZHRCs were recognised in policies and strategic documents, but their formal legal structure was never put in place.

Findings of the Evaluation

Relevance

Strengthening ZHRCs and rolling out TEHIP tools was very relevant in view of the policy of decentralisation of health service delivery and human resources development, as well as enhancing quality of service delivery. Spreading IMCI countrywide was rightfully seen as crucial for improvement of child health. Improving district health care management has the potential to use available (and increasing) resources in a better manner.

Effectiveness

Efforts to increase human resources, equipment etc. for the ZHRCs were effective in creating conditions for these centres to facilitate the comprehensive training programme of rolling out tools. The rollout of TEHIP tools was effective to a certain extent only. The training in management tools was less effective, first of all because in most districts the training programme is unfinished. Secondly, follow-up after training was not yet completed, and not linked to the regular CHMT or RHMT supervision. Thirdly, some tools were not in line with developments of the last years.

Efficiency

While the Zonal Centres are under the responsibility of the Department of Human Resources (DHR), the NETTS-ZORO was in the Directorate of Policy and Planning. The DHR did not take full ownership of the programme, and collaboration by many vertical programmes was very insufficient. Parallel operations of capacity building in human resources continued.

The erratic procedures of financing the programme activities frustrated planned operations, and turned the programme in another haphazardly and ad-hoc type of project.

Impact

The programme could not reach a stage of making significant impact, as its real period of operations lasted only about two years, and a large agenda of unfinished business remains. However, ZHRCs are now in a better position to face the challenges of a decentralised system of human resources development.

Sustainability

At this moment in time, legalisation of ZHRCs is the first requirement for sustaining them, together with regular government funding through the MTEF. Districts should ensure that training is allocated financial resources within the CCHP.

For sustaining the training of TEHIP tools of for achieving long-lasting effects of training, further embedding in a regular training and supervision system is required.

Recommendations

1. There is need to legalise the ZHRCs and spell out clearly the mandate of the Zones as being part of the Ministry of Health structure, and define their roles within the MOHSW structure.

2. The support for strengthening ZHRCs should continue. This continuation should be focused on integrating activities into the regular MOHSW systems. An adequately resourced unit for strengthening the human resources development activities in ZHRCs should be created within the Directorate of Human Resource Development. The current Steering Committee should continue to oversee the process.

3. The training programme of rolling out TEHIP tools should continue, but necessary adjustments should be made:
   - Update the Plan-Rep 2 tool from time to time to accommodate new insights
   - Revise the Integrated Management Cascade tool and the Community Based Rehabilitation tool
   - Ensure follow-up visits as essential part of training programmes
   - Link follow-up after training to regular supportive supervision by RHMT and CHMT
   - Train RHMTs adequately so that they are able to supervise the districts
   - Put in place system impact monitoring of tools

4. For effective integration of the TEHIP tools in the system there is need to incorporate these tools into the curriculum of pre-service training.

5. Strengthen and smoothen the decentralised administrative procedures with emphasis to promoting quick and efficient disbursement and procurement practices.

6. Increasingly MTEF funding should guarantee payment for the core functions of the ZHRCs, while regions, districts and vertical programmes contribute to the training cost.

1 Introduction

1.1 Evaluation

This report provides the final evaluation of the programme for National Expansion of TEHIP Tools and Strategies – Zonal Roll Out (NETTS-ZORO) for the period 2006 – 2009. One national and one international consultant carried out the evaluation from 18 May to 5th June 2009. The objective of the evaluation was to examine the extent to which the strengthening of Zonal Health Resources Centres[1] (ZHRCs) and rollout of TEHIP tools, strategies and interventions has taken place in actual field conditions and to suggest a way forward. (See annex 1 for the Terms of Reference.)
The consultants performed a desk study, interviewed stakeholders in the Ministry of Health and Social Welfare (MOHSW), from ZHRCs, from Health Training Institutions (HTIs), from Regional Health Management Teams (RHMTs), from Council Health Management Teams (CHMTs) and from Development Partners (DPs). The evaluation team performed field visits in three Zonal Health Resources Centres and Regions and Districts nearby. (See annex 2 and 3 for itinerary and people met.) The draft evaluation report was circulated for comments, before finalising it, and the findings of the mission are shared with stakeholders during the last steering committee meeting on 26 June 2009.

1.2 Background

Between 1997 and 2004 the Tanzania Essential Health Intervention Project (TEHIP) developed and tested a range of tools and supportive strategies to directly strengthen the planning, prioritisation and implementation of essential health interventions within progressively strengthened district health systems. As a result of this pilot a significant reduction of the burden of disease was realised, especially for children. The Ministry of Health (MOH) successfully rolled out the tools, strategies in two regions (Coast and Morogoro Regions) in the years 2003 – 2006, with financial and technical support from World Health Organisation (WHO). It was decided that further expansion should be done in a structured manner using the Zonal Health Resources Centre system, if these centres could be strengthened and resourced to this intent.

In March 2005 a consultants' team suggested a comprehensive revision of the training system making the Zonal Health Resources Centres the hub of Pre-Service Training (PST) and Continuing Professional Development (CPD), but this proposal could not be implemented fully. The NETTS-ZORO project concentrates on the "quick wins" in the proposal.

Box 1. The TEHIP Tools

Burden of Disease Profile
The Burden of Disease Profile (BODP) is derived from data produced by the sentinel Demographic or Mortality Surveillance System and presents graphically (using specifically developed software) how essential health interventions contribute to reduction of morbidity and mortality. The information is updated annually and helps the CHMTs to prioritise and allocate resources for essential health interventions that should be delivered in order to reduce the overall mortality, including:
- IMCI (Integrated Management of Childhood Illnesses) for children under five

[1] The name of the Zonal Health Resources Centre (ZHRC) used to be Zonal Training Centre (ZTC). The name was changed in 2008, because these centres aim to provide a broader range of services in human resources management and human resources development than training alone, e.g. library services, human resources database, assistance in recruitment. However, the name ZTC is still frequently used. In this report the name ZHRC is consistently used, even in quotations from older documents, which refer to ZTC.

- Malaria Case Management
- IPT (Intermittent Preventive Treatment) for malaria control in pregnancy
- ITNs (Insecticide Treated Nets) for malaria prevention
- STI/HIV Control (Sexually Transmitted Infection Syndromic Management), including condom promotion, strengthening Blood Transfusion Services, School Health Education and Youth; Care and Treatment; Anti Retroviral Therapy, etc.
- SMI (Safe Motherhood Initiative) including ante and postnatal care, IPT, delivery care, family planning, etc.
- EDP (Essential Drugs Program) kits or Indent;
- EPI Plus (Expanded Program on Immunisation with Vitamin A Supplementation);
- TB DOTs (Tuberculosis Directly Observed Therapy)
- Injury Care (Rule of Rescue, etc)

District Health Accounts

The District Health Accounts Tool is a tool that is derived from a combination of two tools, the District Health Budget Analysis Tool and District Burden of Disease Profile. This tool provides a graphical 'picture' of the proportion of budget allocated per intervention versus the intervention addressable burden, which is the proportion of the burden of disease addressed by that intervention. This 'picture' allows the CHMT to visually see the extent to which budget allocation matches the burden of disease.

Integrated Management Cascade
The Integrated Management Cascade (IMC) helps the CHMT to delegate regular supportive supervision to health centres. Through this cascade system, all dispensaries are linked to their geographically closest health centre. The Cascade serves a broad range of activities: improved drug management, focused laboratory services, improved supervision and training of health workers, improved patient advice and referral, improved management of disease epidemics, improved health information collection and improved personnel management.

Strengthening Health Management
This is a modular course originally designed by WHO and it incorporates a series of approaches to strengthen health management. It comprises three training modules each composed of a workshop, implementation period and supervisory follow-up. This training can be complemented by a menu of additional CHMT training requirements in such areas as computerisation, financial management, office management, maintenance concepts etc.

Community Driven Rehabilitation of Health Facilities
Through Community Driven Rehabilitation (CR) CHMTs and other district personnel are taught to engage communities and to promote a sense of ownership and engagement towards rehabilitation and then regular maintenance of their health facilities. The local communities plan and contribute labour and materials. Community driven rehabilitation serves as an entry point to greater village involvement in district health care management.

Integrated Management of Childhood Illnesses
The Integrated Management of Childhood Diseases (IMCI) package addresses the most important sources of the disease burden in young children and its application can make a major impact on their health status. Countrywide implementation could have significant impact on infant and child mortality. Proper implementation of IMCI/Malaria depends on support systems (drug availability, referral care system and supportive supervision etc. which are addressed by other TEHIP tools).

In 2005 a concept note was produced, which outlined the plans for a three-year programme for strengthening the Zonal Health Resources Centres in functions of teaching methodologies and institutional management, while implementing countrywide training in TEHIP tools and strategies. The programme started in January 2006 with an inception phase, and the first activities were implemented in May 2006.

2 NETTS-ZORO programme design

2.1 Objectives

The goal of the NETTS ZORO programme was to establish a decentralised institutional training system to scale up MOH tools, strategies and interventions for strengthening District Health System performance in support of national poverty reduction and health goals. Strengthening the Zonal Health Resources Centres should capacitate district health staff to plan, prioritise, integrate and deliver the essential health interventions.
The programme has six objectives, which intended to:

- Strengthen ZHRC capacity for scale up TEHIP tools and strategies
- Scale-up district health system tools and support strategies
- Scale-up essential health interventions commencing with IMCI
- Develop capacity of ZHRC in innovation and learning for the purpose of linking training and practice
- Provide programme technical and managerial support to achieve national scale up targets
- Monitor and evaluate the programme

The following table shows the objectives and expected outputs of the three years' programme.

Table 1. Objectives and expected outputs of the NETTS-ZORO programme

Objective	***Expected Outputs***
To strengthen Zonal Health Resources Centres Capacities for tools and interventions scale up	- Necessary infrastructure for scaling up tools and essential interventions established, improving communication, transport facilities and teaching devices - Zonal Health Resources Centres capacity in training established and improved with critical mass of competent trainers - Follow up and supportive supervision mechanism for training established
To scale up health system tools and strategies	- District personnel trained in the use of the MOH tools - Application of MOH tools in planning, resource allocation, tracking expenditure and public health impact established - MOH tools updated using community based surveillance system.
To scale-up essential health interventions starting with IMCI and Malaria ITN	- Facility IMCI coverage improved - Coverage of community IMCI including malaria case management and ITNs promotions improved. - IMCI training, follow-up and supervision capacity at Zonal level, district and community levels strengthened - Adherence to IMCI and Malaria Case Management guideline improved
To develop capacity of ZHRC in innovation and learning for the purpose of linking training and practice, and to initiate the mechanism of decentralised and coordinated PST and CE	- ZHRC policies and regulations within the HRH policy guidelines harmonised - Business/strategic plan for each zone developed incorporating results from complete situation analysis of all HTIs in each Zone and identification of the HTIs in each zone - Capacity of the MOH Human Resources Department to prepare and implement the updated HR policy strengthened - Human Resources improvement through setting up decentralised and coordinated PST and CE activity initiated

Objective	*Expected Outputs*
To coordinate and administer the programme	- Management and coordination mechanism of programme at central level established - Harmonisation with the other strategies of HSR and modular arrangements for the purpose of institutionalisation - Technical support provided - Continuous improvement of tools, modules and supportive strategies provided - Resources for strengthening the zones mobilised and streamlined into the MTEF annually
To monitor and evaluate the programme	- Defined minimum set of key indicators selected - Key indicators used for monitoring and evaluation of the programme - Impact monitoring system developing over life of project to cover the country

2.2 Management of the programme

The NETTS-ZORO programme was seen as a reforms programme. As such the management team was located in the Health Sector Reform Secretariat (HSRS) in the Directorate of Policy and Planning (DPP). The Head of the HSRS was also head of the programme and the link person with the other ongoing reform strategies. Through the HSRS and the Directorate of Policy and Planning relations were maintained with relevant directorates within MOHSW (e.g. Human Resource, Preventive Health and Hospital Services, Administration and Personnel) and PMORALG (Prime Minister's Office for Regional Administration and Local Government).
One education expert was hired for the programme and two consultants from the former TEHIP Management team, who were responsible for implementing the technical component of the programme, ensuring coordination and updates of tools, facilitating scaling up of interventions, capacity building of zones, programme monitoring and evaluation. A Steering Committee of the programme was created, chaired by the Permanent Secretary of MOHSW, with members from ministry (Chief Medical Officer, and Departmental Directors), Development Partners (WHO, UNICEF, WB, GTZ, CIDA, JICA), ZHRC coordinators and other nominated individuals.

2.3 Programme Funding

The World Bank Health Sector Development Programme-II (HSDP) reallocated US$ 6 million of the projects (non-basket) component in 2005 towards funding of the NETTS-ZORO programme. The second phase of the HSDP programme was extended to June 2009. In 2006 the Canadian International Development Agency (CIDA) increased its funding to the Health Basket Fund (HBF) with CAN$ 7 million, under the agreement with the MOHSW that this money would be allocated to the NETTS-ZORO programme.
Two financial systems were maintained: the MOHSW financial regulations for World Bank project funds, and the government regulations for HBF funds.

3 Programme Implementation

3.1 General

In the year 2006 the number of ZHRCs was expanded from six to eight. The centres are located in Arusha, Mwanza, Kigoma, Dodoma, Morogoro, Iringa, Mbeya and Mtwara. ZHRCs are attached to existing health training institutions (HTIs), mostly institutions for pre-service training (PST, formal training for students who never worked in the health sector before) or in-service training (IST, formal training upgrading health workers). The principal of the HTI acts as Zonal Coordinator, and the staff of the institute also work as the core staff for the ZHRC. The resources, e.g. class rooms, library, means of transport, and also financial resources are shared between the ZHRC and the HTI.

3.2 Strengthening Zonal Health Resources Centres

In recent years new staff were posted to the HTIs and attached to ZHRCs. The programme provided 16 scholarships for training and upgrading of staff from ZHRCs/HTIs, mostly Master degree courses. Some of these staff members are still out for upgrading training, and have not yet started contributing to the centres. Most centres employed new tutors, health secretaries and accountants, reinforcing the administration. Despite the employment of new staff, most ZHRCs/HTIs still require more staff, especially staff with advanced training in education methodology.
The ZHRCs maintain databases of capable trainers in all types of training from outside the HTI (the RHMT, Regional Hospital, or CHMTs), called accredited trainers. Most of them were capacitated in the initial phase of the programme, or by vertical programmes. These trainers conduct most of the training sessions. The ZHRC's role is mainly of overseeing, coordination, logistics, quality assurance of training and financial management of training funds.
The programme assisted the ZHRCs with the purchase of essential equipment for training activities, like computers, projectors, photocopiers and vehicles. The programme realised Internet connection for most of the centres. The NETTS-ZORO team developed proposals for collaboration with the International Network for Availability of Scientific Publications and with International Network for Online Resources and Materials for Internet access to publications and materials, but funding for these proposals could not be obtained although there is some hope with World Bank funding for the coming year.

3.3 Scale up health system tools and strategies

In the initial phase of the programme the available TEHIP tools were updated, and where necessary translated into Kiswahili. The NETTS-ZORO team recruited experts to work as trainers of trainers, and oriented them in the TEHIP materials. Initially the national trainers worked hand in hand with trainers from the zones (staff from the HTIs, Regions or Districts), which enabled those trainers to get acquainted with the material and gain experiences with the teaching. Thereafter the zonal trainers performed the training autonomously.

DHA Tool
The original DHA tool was integrated into the PlanRep2 tool, which PMORALG/MoFEA applies countrywide for planning and reporting on District and Municipal Councils plans and their implementation. The University Computing Centre was contracted to develop a specific software module for district health planning and reporting. In all districts in the country the ZHRCs trained one RHMT and four CHMT members in using the tool and performed follow-up visits. In the past three years the PlanRep2 software has been updated several times which included the annual updates of the DHA tool.

IMC
Members of CHMTs in all districts in Tanzania mainland were trained in using the Integrated Management Cascade tool. Guidelines for follow-up after training have been developed and pilot tested. Funds for this activity have been released and the follow-up is expected to be done before the end of the project.

SHM
The Strengthening Health Management tool consists of three modules, developed by WHO, each with a training component of one week and a practical part, to be performed in the duty station. All CHMTs have gone through module one including follow-up. Training for module two has started and all CHMTs will have been trained by end June 2009. It is envisaged that follow-up for module two and training for module three will be done in the fiscal year 2009/10 using MTEF funds through the Department of Policy and Planning.

CR
Community-labour based rehabilitation, which should be an entry to greater community involvement in health, has been introduced in part of the districts. In most zones the facilitators have not yet performed the planned follow-up visits.

3.4 Scale-up essential health interventions

IMCI
Training in Integrated Management of Childhood Illnesses was chosen as a tracer essential health intervention for the rollout process, because of its potential impact on child morbidity and mortality. Zonal trainers were identified and capacitated, in collaboration with the Reproductive and Child Health Unit in the MOHSW. Health workers from all districts were trained with financial support from the NETTS-ZORO programme, while other programmes, such as RCH provided funding as well. In some cases, CHMTs have approached ZHRCs to assist in training health staff, using funds from the Council health budget. The trainers performed follow-up visits after most of the training courses, and handed over supervision to the CHMTs, of which many have competent trainers in their district.

3.5 Capacity of ZHRC in innovation and learning

The programme aimed at clarifying the roles and responsibilities of the ZHRCs and creating an own identity of these centres. The programme formulated a structure for the ZHRCs, and the mandate of the centres. (See annex 4.)

Box 2. Proposed Structure and Mandate of the ZHRCs

The ZHRC should consist of four departments (Continuing Education Coordinator, Pre- and In-service Training Coordinator, Health Information Resource Coordinator and Quality Assurance Coordinator), under leadership of a Zonal Director.
The role of the ZHRCs should be supervision and support to HTIs, planning and facilitation of CPD in districts and regions, providing information and consultancy to districts, regions and HTIs, and facilitating research.
There should be a steering committee with all principals of the HTIs in the zone, which plans strategies, helps in selection of candidates and prepares exams of students. The Board, appointed by the DHR, should advise on plans and activities and mobilise resources for the institutes.
Relations between ZHRCs and districts, regions and other stakeholders should be regulated, ensuring good collaboration and mutual support.

The draft structure and mandate of ZHRCs was presented during the second NETTS-ZORO steering committee meeting on 24th January 2008, where it was suggested that the Director of Human Resources should present it to the Ministerial Management Team for endorsement. The director never did this, because – in his views – legal advice was required on the status of Boards, suggested in the draft document.

The programme engaged consultants to assist ZHRCs in formulation of strategic plans and business plans. The strategic plans for a five-year' period cover all training activities (PST, IST, CPD) in the zone and summarise the actions of all HTIs in the zone to improve human resources development. The plans highlight the collaboration between the institutions in the zone and the role of the ZHRC as coordinating centre. The business plans concentrate only on the ZHRCs and the HTI, to which they are attached, and outline the plans for improving the institutions in the coming five years. The Zonal strategic plans and ZHRCs' business plans were officially launched in February 2009.

3.6 Coordination and administration of the programme

In 2006 in the HSRS a programme secretariat was formed, with the three consultants, administrative staff and drivers, mostly from the former TEHIP project. The accounting staff of the HSRS provided assistance to the financial management of the programme. The NETTS-ZORO team produced work plans and sensitised stakeholders on the programme. During the first phase the team made an inventory of available resources and initiated the procurement of equipment and vehicles. To begin with, there were a number of preparatory steps that had to be made; that is why it was only in 2007 that actual training of district staff started.
Initially the NETTS-ZORO team presented annual reports over 2006 and 2007. From October 2007 onward the team produced more detailed quarterly reports, which included details on training output and expenditure information per activity. A Steering Committee was appointed to oversee the programme. The first meeting was in September 2007, the second in January 2008, the third in November 2008, and the last one is planned for June 2009. The steering committee approved reports and plans/budgets, and discussed issues of interest for programme management.

Table 2: NETTS - ZORO Expenditure July 2005 - April 2009

A) World Bank plus Counterpart Fund		
Financial Year	**Budget - USD**	**Actual Expenditure - USD**
July 2005 - June 2006	2,382,000.00	2,256,031.93
July 2006 - June 2007	1,610,000.00	1,392,122.89
July 2007 - June 2008	1,850,000.00	1,513,029.58
July 2008 - April 2009	1,320,000.00	808,222.67
	7,162,000.00	**5,969,407.07**
B) Basket Fund (Medium term expenditure framework)		
Financial Year	**Budget - Tshs**	**Actual Expenditure - Tshs**
July 2005 - June 2006	320,000,000.00	319,171,300.00
July 2006 - June 2007	2,731,000,000.00	1,550,527,379.00
July 2007 - June 2008	1,854,170,000.00	776,296,754.00
July 2008 - April 2009	2,062,826,240.00	1,055,753,982.99
Total in Tshs	**6,967,996,240.00**	**3,701,749,415.99**
Total in USD*	**(USD 5,359,997.11)**	**(USD 2847499.5)**

** Current conversion rate of USD 1 = Tshs 1300 used*

Funds from the World Bank were readily available from May 2006 onwards, as the HSDP was already located in the HSRS. The funding through the basket fund took many months to reach the programme, after CIDA had released the funds to the Ministry of Finance in March 2006. Initially, the financial procedures for World Bank funds were relatively simple, e.g. because Permanent Secretary provided blanket approval of expenditure based on action plans and budgets. Later this was changed to separate approval procedures per activity. The government procedure for mobilising resources was more demanding and required at least 12 steps. The minimal period of mobilising funds was one month, but more often two to three months were required before the release of funds was effectuated. With further tightening of

procedures in recent months (pro-forma invoices for any expenditure anywhere in the country), longer lead times for mobilising resources are common. Government procurement procedures applied, with long lead times. The procurement of vehicles for ZHRCs took nearly three years. In the period July 2005 – April 2009 83% of World Bank funds were spent and 53% of the MTEF funds, with just three months project implementation time remaining.
In the course of the programme unplanned expenditure was necessary, funded by other donors. The Danida Health Sector Programme Support (HSPS) provided financial support for specific activities, e.g. the development of the PlanRep2 tool. The NETTS-ZORO team tried to mobilise other resources, e.g. from Comic Relief in the United Kingdom, which agreed to provide scholarships and funds for monitoring and evaluation of the programme. The team worked closely with USAID, I-TECH and Centres for Disease Control (CDC) to coordinate their support to ZHRCs.

3.7 Monitoring and Evaluation of the Programme

The annual and quarterly reporting was discussed above. Since October 2007 reports show implementation per planned activity, and provide financial details. In 2008 a Mid-Term Review of the programme was carried out, but the report was not published before the end-of-project review took place.
The EMPOWER project, funded by Comic Relief in the UK, planned to assist in the development of an impact monitoring system, assessing district performance after training. However, due to late start of the project in September 2007, it could not be realised in time to make a useful contribution to the NETTS-ZORO project. The EMPOWER project funded the mid-term review and part of the end-of-project evaluation.

4 Contextual factors

In recent years the working environment in districts changed, often in positive ways, sometimes in negative ways, affecting implementation of health service delivery. New health and local government policies were introduced, which had an impact on the work in the districts. The Tanzanian health sector provides a very dynamic environment, which may differ from the original setting in which the TEHIP tools were developed. Some of those contextual factors are discussed below.

4.1 Decentralisation by Devolution

Since 1994 Tanzania has embarked on a Local Government Reforms Programme (LGRP). The aim of the reforms is to establish decentralisation by devolution (D-by-D), whereby Local Government Authorities take charge of health service delivery (among other tasks). The CHMTs produce Comprehensive Council Health Plans (CCHP), using the PlanRep2 tool as part of the District Council planning. The District Council approves the CCHP before submission to higher authorities. These plans pass through the Regional Administration and are assessed by a national team of MOHSW and PMORALG officials, before presentation to the Ministry of Finance and Economic Development. Zones do not play a role in the process, and the national assessors do not use the PlanRep2 tool. In order to address this shortcoming the University Computing Centre has developed a software for Regional and national levels to link to and assess PlanRep2 tool. PMO-RALG is continuously adding elements and refining tools, which will support CHMT management.
A new LGRP phase for the period July 2008 – June 2013 has started, which aims at eliminating the institutional, legal, organisational and operational bottlenecks to realisation of D-by-D policy at all levels of government, and improve collaboration with line ministries. There will be further fiscal decentralisation, and further decentralisation of human resources management. Line ministries will delegate more operational tasks to LGAs.
The PMO-RALG implements the Local Government Development Grant (LGDG). This system provides discretionary development funds for rehabilitation and expansion of infrastructure to local authorities. The LGDG has now created a mechanism for funding construction and rehabilitation of health facilities.

4.2 District funding

The central philosophy of the TEHIP programme was giving responsibility to staff at district and facility level to manage health programmes, providing them with the capacity and with the tools to do so. One of the facilitating interventions in the TEHIP programme was the provision of funds for district health interventions. All over Tanzania mainland district funding through block grants and basket funding increased since 2006; district basket funding went up from US$ 0.50 in 2006 to US $ 1.25 per capita in 2009. Extra funding enabled districts to invest more in capacity building of staff, and make necessary purchases, e.g. medicines for IMCI. With more funds in the districts, a situation was created which was more similar to the TEHIP project districts. This offered better opportunities to make good use of the rollout of the TEHIP tools.

4.3 MOHSW policies and strategies

Few years ago, the roles and functions of ZHRCs were not clear, but they are now mentioned in several documents, and strengthening capacities of the health work force gets more and more attention. According to the Health Policy 2007 the government will provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable. The health services will focus on those most at risk and will satisfy the needs of the citizens in order to increase the lifespan of all Tanzanians. The government is committed to increase the number and quality of staff in health services. The

ZHRCs are mentioned part of the health system. The Health Sector Strategic Plan 2009 – 2015 states that Zonal Health Resources Centres will be strengthened to support training institutions in setting up quality assurance in education, and to assist regions and districts in continuing education. Vertical programmes will improve collaboration, and will incorporate their training activities in CCHPs and MTEF plans. They will work through ZHRCs in activities of continuing professional development. Follow-up and coaching will become integral part of on-the-job training.
The Human Resources for Health Strategic Plan 2008 – 2013 indicates how the MOHSW will strengthen the ZHRCs. (See box below.)
In year 2007 the MOHSW developed the Primary Health Care Service Development Programme (PHCSDP). This programme is better known by the Kiswahili name of Mpango wa Maendeleo ya Afya ya Msingi 2007-2017 (MMAM). The objective of the MMAM programme is to accelerate the provision of primary health care services for all by 2012, while the remaining five years of the programme will focus on consolidation of achievements.

The main areas will be strengthening the health systems, rehabilitation, human resource development, the referral system, increase health sector financing and improve the provision of medicines, equipment and supplies. This programme is implemented by the Ministry of Health and Social Welfare in collaboration with other sectors by the existing Government administrative set-up including PMO-RALG, RSs, LGAs and Village Committees.

Box 3. The ZHRCs in the Human Resources for Health Strategic Plan 2008 – 2013

Analysis
"Most of the training is held outside the health facilities and it creates a serious problem of absenteeism at work places. The MOHSW has established eight Zonal Health Resources Centres (ZHRCs) to facilitate the updating of health workforce skills and structured monitoring of the various training institutions under their respective catchments' areas. Strengthening of the capacity of ZHRCs is being pursued by the MOHSW. However, ZHRCs face a problem of limited capacity in terms of skilled staff, financing, and inadequate development of the infrastructure." (Page 12)

Work plan
"Improve Zonal Health Resources Centres to support regions, districts and training institutions in delivering quality health care and training and to ensure effective linkage between training and services by 2013

Facilitate effective coordination between MOHSW, ZHRCs and all other stakeholders region and districts through redefining roles of each player
- Ensure ZHRCs are adequately staffed
- Mobilise funds to facilitate coordination role of MOHSW, ZHRCs, Regions and districts
- Establish governing committees in all ZHRCs and health training institutes
- Develop a supervision guideline for supervising the ZHRCs"

(Page 35)

Draft Health Services Act
The new draft Health Services Act (2009) envisages the formation of a Tanzania Health Training Board within the Directorate of Human Resources in the MOHSW, which will be responsible for training, continuing education and zonal coordination. HTIs will be more autonomous and have Governing Boards. The ZHRCs are regulated in the law, giving responsibility to the Minister of Health to establish those centres and regulate their governance and management.

4.4 Human Resources

The human resources crisis in public health facilities in Tanzania is serious: only 29,063 health workers of the 82,277 required are in place, amounting up to 65% shortage (HRH strategic plan 2006). In private facilities the shortage is even worse. At the same time the recruitment of staff is difficult. The shortage in the peripheral health facilities is relatively

highest. The MOHSW gets only limited permissions for hiring staff; not all staff graduating can be hired. At the same time the attrition is estimated at 0.5% per annum. Exact data on actual staffing are not available, but some claim that the staffing situation in the health sector as a whole is still deteriorating. The evaluation team noted that there were strong complaints of high turnover of staff everywhere, not least because of aging of the workforce, due to many years of restricted recruitment.

Table 3. Shortage of staff in health facilities

	Facilities	Required	In place	Shortage	Percentage shortage
Public facilities	3,565	82,277	29,063	53,214	65%
Private facilities	1,959	43,647	6,139	37,508	86%
	5,524	125,924	35,202	90,722	72%

Source: HRH strategic plan 2006

The training programme of rolling out TEHIP tools took place in against the background of shortages and high turnover.

4.5 Support to ZHRCs

I-TECH

The International Training and Education Centre on HIV (I-TECH) supports all ZHRCs. Besides technical training in the area of HIV/AIDS, the organisation provides capacity building in the area of teaching methodologies (for more than 300 tutors) and developing distance education programmes. The organisation helps to develop ZHRCs' coordination mechanisms in the zones with stakeholders' meetings, annual work plans, financial management and leaderships training programmes. The organisation provides technical assistance to some smaller centres and help in building up libraries and information centres.

In addition to supporting the ZHRCs, I-TECH also helps pre-service training institutions to improve their curricula and teaching programmes.

Other organisations

The German Development Organisation GTZ concentrates its assistance to Southern and South West ZHRCs, where it assists in strengthening the technical and organisational competencies of these two institutions. USAID supports Kigoma, Arusha and Iringa centred zones, focusing on reproductive health. CEDHA Arusha and PHC Institute Iringa have each a series of collaborations and partnerships, based on their capacities as training institutes (and not specifically targeting ZHRC functions..

4.6 Capacity building for Regions and Districts

The vertical programmes in the MOHSW have each capacity building programmes, related to specific diseases (HIV, TB, Malaria) or health conditions (reproductive health, neonatal and child health) funded by the Global Fund and other donors. Each programme organises the capacity building in its own way, applying its own methodologies, using its own trainers, and its own timing. Besides MOHSW programmes there are various NGOs that support at regional or district level health providers, which plan training activities, parallel to the CCHPs. In general the vertical programmes and NGOs do not make use of the ZHRCs, or at best utilise the conference facility.

The RHMT capacity building project (funded by JICA) assessed opportunities for collaboration with ZHRCs to work together in RHMT capacity building, but concluded that the trainers affiliated to the zones did not have the required capacities. Therefore the project now collaborates with Mzumbe University. The project has invited ZHRCs to join as participants in the training, which would create opportunities for future collaboration.

5 Finding of the evaluation

5.1 General

ZHRCs clearly feature in the Human Resources for Health Strategic Plan 2008–2013, in the Health Policy (2007) and the Health Sector Strategic Plan 2009–2015 as intermediate between the MOHSW-DHR and HTIs, as well as link between MOHSW and Regions and Councils in matters of human resources management and human resources development. All officials interviewed are convinced that the concept of Zonal Health Resources Centres is viable. The NETTS-ZORO programme, without any doubt, fits in the MOHSW policies. The NETTS-ZORO programme therefore is a relevant programme for the health sector.

Box 4. Strategic Vision of Zonal Training

The 2005 consultancy report on integrated PST and CDP proposed a strategic vision of a training system with a polytechnic structure at zonal level, whereby the ZHRC would function as the hub for coordination, management and quality assurance for all HTIs in the area. In the longer run the centres therefore should be organisationally detached from the HTI where it is housed right now, and have their own dedicated staff, especially the Zonal Coordinators, concentrating fully on zonal functions, rather than operating in double functions.

CEDHA Arusha and PHC Iringa traditionally are strong institutes, and therefore they are capable of delivering ZHRC activities and attract new partners. The other ZHRCs, often attached to smaller HTIs, are still developing and more dependent on support from the MOHSW or partners, who want to invest in the institution, like GTZ in Mtwara and USAID in Kigoma. The I-TECH support complements the NETTS-ZORO programme.

In principle, ZHRCs do not aim at performing all training with their core staff, but capacitate trainers from various backgrounds, including RHMTs and CHMTs, regional and district hospital, HTIs, etc. The competent trainers are registered in a ZHRC database for future facilitation of training. The core business of the ZHRC is coordination, organisational and financial management of training activities. Vertical programmes, regions districts hardly understand this concept; they look at in-house capacity of HTI staff, where the ZHRC is located, not at the capacity of ZHRCs to mobilise trainers and organise courses. Vertical programmes or other programmes for that matter, seldom use ZHRCs, or only the infrastructure as conference centre. Uncoordinated and ad-hoc planned on-the-job training, initiated from different directorates in MOHSW-HQ, continues as before the programme of strengthening ZHRCs started. Often the same health workers are invited for a range of courses, while others – especially hospital staff – are left behind. There may be dozens of training courses in the country running at the same time, without anybody having an overview. ZHRCs do not receive copies of training materials and often are unaware of the contents of training courses. High levels of inefficiency in capacity building of health staff continue to exist.

Despite the good intentions of ZHRCs, there is no systematic way of channelling training materials and modules from vertical programmes to pre-service or in-service training courses, denying them the opportunity to update their curriculum. As a result, students graduating from a HTI may be in need of immediate additional training, to learn about PMTCT or other new programme. This, again, is not efficient.

The main issue that hampers further development, according to ZHRC coordinators and others, is that the ZHRCs have no official legal standing and/or written mandate from the MOHSW, and have no uniform structure. In this regard, in their current form they are not official entities and depend on goodwill of their counterparts, who can accept or refuse the ZHRC functions. It remains optional whether vertical programmes wish to use them or even inform these centres on their training activities. ZHRCs can advise but not supervise HTIs or help them to update their curriculum. The MOHSW-DRH can bypass the ZHRCs in its dealings with HTIs. The NETTS-ZORO programme has developed a proposal for mandate

and structure in 2007, which is still under scrutiny in the HR Directorate. Senior management in the MOHSW is still to decide how it will concretise the policy intentions mentioned in various strategic plans. Maybe the new health services act will offer a way out.

5.2 Strengthening Zonal Health Resources Centres

ZHRCs are still virtual institutes, and for staffing and resources dependent on the HTIs to which they are attached. The institutions have now more personnel than three years ago, but most are understaffed and poorly funded. The smaller ZHRCs were fully dependent on the NETTS-ZORO funding for the running costs. When the programme funding comes to an end in June 2009, there will be acute problems, e.g. payment for internet subscription, for those institutions, which do not have partners that fund running costs. Fortunately, starting the next fiscal year ZHRCs will receive a small government budget for running costs.
The ZHRCs certainly lack resources, but construction works are ongoing in some centres (e.g. Dodoma and Arusha), and plans are on the drawing board for others (e.g. Morogoro). Books, journals and teaching aids are still short in supply, although in some centres partners have provided some.
The strategic plans are joint plans of all HTIs in a zone, which is very positive for coherence and collaboration. However, those plans were not scrutinised for feasibility, and probably are not easily implementable, given the high budgets attached to them. The ZHRC business plans provide a good basis for action, but need further development of the resource mobilisation strategies. The plans were launched in March 2009, and are now turned into realistic and implementable annual plans with the help of I-TECH. In general, the smaller ZHRCs are not good at 'marketing' themselves and 'sell' their products to vertical programmes or CHMTs that should make use of their services. This skill certainly needs further strengthening.

5.3 Scale up health system tools and strategies

General
The NETSS-ZORO training programme – despite its efforts to reach many health workers – could not cover all health workers in all districts. Due to the erratic funding mechanism ZHRCs could not work according to a predefined plan, but only could start logistic arrangements for training when money was at their disposal. During the first two quarters of the fiscal year there was hardly any money, and therefore few training courses, while during the last two quarters there was a bulk of training activities to be finalised before the end of the fiscal year. Around 75% of the planned training activities was actually implemented (see annex 5 for details on the training).

Table 4: Percentage coverage of training programmes against defined targets

	Zones							
TOOLS/INTERVENTIONS	**Southern**	**South-Western Highlands**	**Southern Highlands**	**Western**	**Central**	**Eastern**	**Northern**	**Lake**
SHM MODULE 1	100%	100%	100%	100%	80%	100%	59%	100%
SHM MODULE II	33%	67%	31%	40%	50%	100%	34%	72%
SHM MODULE III	0%	0%	0%	0%	0%	0%	0%	0%
COMMUNITY REHABILITATION	100%	100%	100%	0%	80%	50%	66%	70%
PLAN REP	100%	90%	100%	100%	100%	100%	100%	100%
IMC	50%	100%	100%	0%	68%	31%	100%	100%
IMCI	83%	20%	39%	30%	35%	7%	41%	27%

Note: the target group for training in district management tools consisted of CHMTs, while the target group for IMCI comprised all health workers. The percentages of IMCI training presented here is low, because from each health facility only one or two staff members participated in IMCI training. Furthermore IMCI training funded from other sources is not included in this table.

Due to high turnover of staff and limited dissemination of knowledge and skills within CHMTs and RHMTs, the effects of training in the region or the districts quickly wear off. For maintaining knowledge and skills new officers have to be trained, and others have to undergo refresher training.
It was not possible to implement follow-up visits after all training programmes, partly because of lack of funds for this activity and partly because many training activities were performed only shortly before closing the project. The transition from follow-up after the training to regular supervision by CHMT or RHMT was not structured clearly. In some instances the RHMT members were not included in the training (or trained persons left the office), which resulted in situations whereby the supervisors were not able to advise the Council health staff adequately. Training is not a panacea for improvement of health workers' performance. It is not realistic to expect a series of training courses to make a sustainable impact. During the TEHIP project intensive supervision and support took place after training sessions; this was minimised in the NETSS-ZORO programme. The programme put its stakes of sustainability in making the ZHRC system working, and expected those centres to provide on-demand capacity building and coaching to districts. The beginning is there, but there is still a long way to go. The revitalisation of the RHMT should be key for introduction of the TEHIP management tools in CHMTs.

BODP and DHA – PlanRep2
The integration of the original DHA tools into the PlanRep2 tool integrated in Council planning is an example of flexible response to actual developments. All districts can use the tool and have three or four CHMT members who are conversant with the software package, although some find it difficult maintain the practical skills, and are not able to use the software options fully. The Comprehensive Council Health Planning (CCHP) system enforces utilisation of the system; plans are only approved with PlanRep2 files attached, and therefore it is sustained. Stakeholders evaluate the tool very positively. Hopefully the system can be maintained to update the tool based on new BOD figures, or other insights into health care interventions.

IMC
The integrated management cascade is not implemented in many districts, partly because follow-up after training has not yet been done, and partly because CHMTs hesitate to delegate supervision responsibilities to health centres, arguing that these centres have no means to perform supervision. Sometimes financial arguments play a role. Some districts expect the ZHRCs to train their health facility staff in supervision.
In the Coast and Morogoro Region rollout similar constraints were encountered with this tool, which has not been taken up by the NETTS-ZORO programme. Performing good supportive supervision, coaching and on-the-job capacity building is an art, which cannot be learned during a seminar. It requires a change in mentality and a paradigm shift. It may be necessary to reconsider this tool and develop another strategy to introduce this valuable concept.

SHM
None of the CHMTs completed the full set of three training modules in strengthening health management and home assignments. Many CHMTs are still in the first or second module. In some areas only few CHMT members attended the training, which makes implementation difficult, because the whole CHMT has to adapt its way of working. Delay of funding was the main reason for slow implementation of the training programme. It is not realistic to expect that impact of the training would be visible by now, because most districts have not completed the modules. However, most CHMTs interviewed were satisfied with what they had learned so far.
The same applies as for the IMC tool: problem solving participatory management cannot be learned in three training sessions of one week, but needs coaching and follow-up, for which the RHMTs should be equipped.

CR
The Community-based Rehabilitation of health facilities seems to be the most problematic tool for countrywide introduction. Basically, it is a community empowerment tool, with rehabilitation of health facilities as entry point. However, the tool does match with ongoing decentralisation of local government authorities, which include measures to empower Council Health Services Boards and Facility Health Committees through the Community Health Fund.

It does not link to the (now closed) Joint Rehabilitation Fund or the new Health Window in the Local Government Development Grant. There were debates during training sessions on the right government procedures for tendering or procurement, on the role of local craftsmen or communities in civil works. Often trainers or consultants have not been able to provide adequate answers to questions raised.
In the Morogoro and Coast Region roll out this tool did not work, but it was not updated in the NETTS-ZORO programme. Community involvement in construction and rehabilitation is very relevant in the context of the MMAM policy (to provide health services in every village). Empowerment is a key strategy for better health, and therefore the tool requires a complete overhaul, bringing on board all aspects of government decentralisation, community health initiatives (CHF), etc. But also experiences from Savings and Credit Cooperative Societies (SACCOS) and school rehabilitation programmes could enrich the tool.

5.4 Scale-up essential health interventions

IMCI
The IMCI case management training for health workers is fully operational in the country. It is assumed that in most districts health facility staff is conversant with IMCI and have medicines, although there is no hard evidence of actual coverage. The NETTS-ZORO programme helped to step up training, while other funds were used as well. Districts used their own resources for training, and many districts now have capable trainers. The MOHSW-RCH department provides training materials to ZHRCs and refers to them for facilitation, when districts request training from HQ. The follow-up after training was weak in most zones, because funds were not available for trainers to move out to health facilities. The quality of supervision in facilities is not always good and therefore the discipline of adhering to the IMCI standards may weaken, as we know from literature. This element needs strengthening, e.g. as part of the RHMT revitalisation programme.
Community-IMCI is directly managed from MOHSW head quarters, not involving ZHRCs as such, but sometimes working with individuals working in ZHRCs. Given the good experiences with IMCI case management, there is no reason why handing over this training programme to the zones should be delayed.

5.5 Capacity of ZHRC in innovation and learning

The posting of new staff to the ZHRCs/HTIs has contributed to increase of capacity of the institutions. The Masters degree courses for 16 person help to improve the quality of the staff in the centres. The capacity building by the NETTS-ZORO programme, as well as by I-TECH, has definitely contributed to competencies in teaching methodology and management of training programmes. However, the academic quality is still insufficient in the smaller ZHRCs. Most ZHRCs are not linked to academic institutions in health, and therefore miss the exposure to the most recent developments in health care. Also the academic developments in education may only trickle down slowly. This requires further action, even if the academic institutions operate in the education sector. The zones have minimal libraries and make little use of internet to download scientific materials, teaching aids or other training materials, while there is a wealth of information out there, from all over the world.
The ZHRCs now are mainly dependent on courses developed elsewhere, and have limited capacity of developing new courses and training materials or adapting courses to new developments. For many courses it is good to use nationally standardised training materials, but in future ZHRCs are also supposed to deliver courses on demand.
ZHRCs collaborate well with the HTIs in the zone, but more on the basis of peer relations, than on the basis of leadership in academic quality.
All in all, ZHRCs are making progress as centres for improvement of pre-service, in-service and continuing education, but have not yet reached the envisaged capacity. As mentioned in the general paragraph of this chapter, structure and mandate of the centres have to be sanctioned by senior management in the ministry, providing clarity and strategic direction to all stakeholders in education in the health sector.

5.6 Coordination and administration the programme

Apparently strategic considerations motivated placing the NETTS-ZORO programme in the HSRS under the DPP, being a programme of reforms. However, the programme to a large extent operated in the area of human resources development, where DHR is the lead. One of the expected results of the programme was capacity building of the Directorate of Human Resources. There is little evidence that the programme indeed succeeded in this; it operated mainly in parallel. Although officials in the DHR endorse the ZHRC concept, they did not embrace the programme, and did not take ownership of its products. This raises serious questions with regard to sustainability after conclusion of the NETTS-ZORO programme. Will the directorate champion the continuation of strengthening ZHRCs? Will assistant directors in the DHR have time to devote themselves to this development work, while they are complaining of being overwhelmed with routine activities?
With regard to operational management, the slow release of funds, or delayed access of funds for the programme made it impossible to work according to plan. New measures of financial control in MOHSW-HQ make the running of a decentralised programme even more complicated. There was also slow retirement and accounting for funds provided to ZHRCs, which delayed again release of next tranches, but posting of accountants in the zones alleviated this problem. The procurement process was extremely slow. Vehicles for the ZHRCs only arrived towards the end of the project.
The NETTS-ZORO team undertook various efforts to link ZHRCs to other programmes and succeeded to in working with I-TECH, USAID, and GTZ. Collaboration with the RHMT revitalisation programme, the hospital reforms and many vertical programmes is still weak. At the end of the programme the question is open how to continue management of the training and supervision activities, or how to update the tools. The HSRS under DPP can continue funding training activities as before, but cannot mobilise the technical expertise for strengthening the ZHRCs or improving the teaching in TEHIP tools.

5.7 Monitoring and Evaluation of the Programme

The expected outputs were not all formulated in the “SMART” way, and were not always quantified. Key indicators were not formulated as planned and impact monitoring was not established in the programme. The programme counted on the EMPOWER project to establish impact monitoring, which did not materialise. Even if a monitoring system had been operational in time, it would have been difficult to measure impact after just two years of (unfinished) training.
The system of quarterly reporting was adequate for operational issues, and reports improved in the course of time, but did not assist in assessment of achievements vis-à-vis programme objectives.

5.8 Other activities

In 2008 the ZHRCs assisted the MOHSW in the recruitment of staff, when new employment permits were issued. It facilitated recruitment in peripheral areas, which are not easily reached from Dar es Salaam. Despite some procedural shortcomings, this recruitment was seen as a positive contribution, which could be repeated.
The Directorate of Administration and Personnel would like the ZHRCs to produce databases with health personnel in the zones, to assist the ministry in maintaining a better overview of available human resources and their training and career development needs.
Some ZHRCs actively recruited students for HTIs from remote districts, to ensure that more students would come from the rural areas, hoping that in future after graduation they might go back to back to those places.
The NETTS-ZORO team has been engaged in many health sector reforms activities; it has worked on the Health Sector Strategic Plan, the Payment-for-Performance programme, and assisted in development of Health Workforce Initiative. The consultants often performed smaller or larger tasks in the Health Sector Reforms Secretariat. In all these duties, they could bring in the many years of experience in the TEHIP project.

6 Conclusions and recommendations

6.1 Conclusions

Relevance
Strengthening ZHRCs and rolling out TEHIP tools was very relevant in view of the policy of decentralisation of health service delivery and human resources development, as well as enhancing quality of service delivery. Spreading IMCI countrywide was rightfully seen as crucial for improvement of child health. Improving district health care management has the potential to use available (and increasing) resources in a better manner.

Effectiveness
Efforts to increase human resources, equipment etc. for the ZHRCs were effective in creating conditions for these centres to facilitate the comprehensive training programme of rolling out tools. The strengthening of ZHRCs has laid the foundation for further building strong organisations for coordination and quality improvement of human resources development in the zones.
The rollout of TEHIP tools was effective to a certain extent only. IMCI training has resulted in a solid system IMCI case management in all districts, which can be maintained now by the CHMTs.
The training in management tools was less effective, first of all because in most districts the training programme is unfinished. Secondly, follow-up after training was insufficiently done, and not linked to the regular CHMT or RHMT supervision. Thirdly, some tools were not in line with developments of the last years, and not implementable. Of the TEHIP management tools only the PlanRep2 tool can be considered as fully effective at this moment in time.

Efficiency
While the Zonal Centres are under the responsibility of the Department of Human Resources, the NETTS-ZORO was in the Directorate of Policy and Planning. The DHR did not take full ownership of the programme, which seriously hampered efficient operations. Parallel operations of capacity building by many vertical programmes was very insufficient, certainly in a country severely constrained in human resources, where one national strategy of capacity building of the few staff available should be applied.
The erratic procedures of financing the programme activities frustrated planned operations, and turned the programme in another haphazardly and ad-hoc type of project.

Impact
The programme could not reach a stage of making significant impact, as its real period of operations lasted only about two years, and a large agenda of unfinished business remains. However, ZHRCs are now in a better position to face the challenges of a decentralised system of human resources development.

Sustainability
At this moment in time, legalisation of ZHRCs is the first requirement for sustaining them, together with regular government funding through the MTEF. Districts should ensure that training is allocated financial resources within the CCHP.
For sustaining the training of TEHIP tools of for achieving long-lasting effects of training, further embedding in a regular training and supervision system is required.

6.2 Recommendations:

1. There is need to legalise the ZHRCs and spell out clearly the mandate of the Zones as being part of the Ministry of Health structure, and define their roles within the MOHSW structure.

2. The support for strengthening ZHRCs should continue. This continuation should be focused on integrating activities into the regular MOHSW systems. An adequately resourced unit for strengthening the human resources development activities in ZHRCs should be created within the Directorate of Human Resource Development. The current Steering Committee should continue to oversee the process.

3. The training programme of rolling out TEHIP tools should continue, but necessary adjustments should be made:
   - Update the Plan-Rep 2 tool from time to time to accommodate new insights
   - Revise the Integrated Management Cascade tool and the Community Based Rehabilitation tool
   - Ensure follow-up visits as essential part of training programmes
   - Link follow-up after training to regular supportive supervision by RHMT and CHMT
   - Train RHMTs adequately so that they are able to supervise the districts
   - Put in place system impact monitoring of tools

4. For effective integration of the TEHIP tools in the system there is need to incorporate these tools into the curriculum of pre-service training.

5. Strengthen and smoothen the decentralised administrative procedures with emphasis to promoting quick and efficient disbursement and procurement practices.

6. Increasingly MTEF funding should guarantee payment for the core functions of the ZHRCs, while regions, districts and vertical programmes contribute to the training cost.

Annex 1 Terms of Reference (summarised)

Objective of the evaluation:
To objectively examine the extent to which the strengthening of ZHRCs and rollout of tools, strategies and interventions has taken place in actual field conditions and to suggest a way forward.

Purpose of the evaluation:
To produce a report that draws lessons learned from the NETTS/ZORO project and that suggests the requirements of the next steps for strengthening ZHRCs now called Zonal Health Resource Centres (ZHRCs). The report should present a model for potential for linking pre-service training and continuing professional development, addressing the prevailing human resource for health crisis and unfolding future opportunities.

Scope of work:

- Evaluate the implementation of activities comparing what was planned (original design) versus what actually was implemented
- Assess the scaling up of the tools including their coverage, success and challenges
- Make an inventory of possible opportunities with respect to ongoing initiatives on HRH and their implications of ZHRC development
- Provide feedback to stakeholders and facilitate the process of joint formulation of conclusions and recommendations

Methodology

- Develop a draft budget and work plan for the evaluation
- Review the project documents, and the implementation reports
- Conduct interviews of selected stakeholders, development partners, MOHSW officials, project officials, zones, etc
- Conduct sampled visit to zones, training institutions and districts.
- Produce a debriefing note and facilitate debriefing meeting for formulation of conclusions and recommendations
- Produce a final evaluation report, including graphs, tables, illustrating the coverage, spelling out recommendations and future developments

Timeframe:
Between the last week of April and June 15, 2009.

Expected Outputs:

1. Draft budget and work plan developed
2. Debriefing notes for stakeholders' meeting
3. Final report

Annex 2 Itinerary

Date	Activity
18 May	Travel Amsterdam-Dar es Salaam Jaap Koot
19 May	Meeting NETTS team Meeting DPP, JICA
20 May	Meeting Health Reforms Secretariat Meeting DAP, TB programme, RCH programme Meeting EMPOWER project, IHI
21 May	Travel to Dodoma, meeting zonal coordinators, meeting RHMT Dodoma, meeting CHMT members
22 May	Meeting ZHRC, meeting DHR, Travel to Morogoro, meeting ZHRC in Morogoro, meeting CHMT members, meeting RHMT, Travel to Dar es Salaam
23 May	Summarising interviews and preparation field trip
24 May	Report writing
25 May	Travel to Arusha, meeting CEDHA staff, meeting RHMT, meeting CHMT
26 May	Meeting CEDHA staff, meeting CHMT, Travel Arusha - Dar
27 May	Meeting CIDA, USAID, World bank, Meeting Head HSRS,
28 May	Meeting I-TECH, WHO, EMPOWER
29 May	Debriefing meeting NETTS-ZORO team Debriefing CMO Evening departure Jaap Koot

Annex 3 Persons met

SN	Name	Title	Pace of work
1	Dr. Haruna Kasale	Lead Consultant ZORO NETTS -	MoHSW
2	Dr. Conrad Mbuya	Consultant - ZORO NETTS	MoHSW
3	Ms . Regina Kikuli	Director of Policy and Planning	MoHSW
4	Ms. T. A. Chando	Director of Administration and Personnel (DAP)	MoHSW
5	Dr. Said M. Egwaga	Program Manager TB& Leprosy	MoHSW
	Dr. Bjarne O. Jensen	Senior Health Advisor HSPS	MoHSW
6	Dr. Neema Rusibamayila	Manager IMCI	MoHSW
7	Mr. Isaack D. Kaneno	HS – Dodoma Regional Hospital	Dodoma
8	Mr. P.I Lenga	DLT- Dodoma	Dodoma
9	Ms. Valeria Mtimba	DNO – Dodoma Municipality	Dodoma
10	Ms. Inviolata G. Laswai	Health Secreatary -	Dodoma
11	Ms Joyce L. Gellege	Ag RRCHCO	Dodoma
12	Ms. Jane M. Naleo	Hospital Matron - Dodoma	Dodoma
13	Mr. Alex Bunyara	Continuing Education Co	Dodoma
14	Dr. Zainab Chaula	Ag RMO – Dodoma Region	Dodoma
15	Ms. Harrieth Kidayi	DRCH Co	Dodoma Council
16	Ms Eugenia Kidyala	ZRCH	Central Zone
17	Dr. Sadock Ntunaguzi	Principal &WZCO	Kigoma
18	Dr. Romani Momburi	Deputy Director PHC Institute	Iringa
19	Ms. Rabisante Sama	Ag Principal & ZCO Central Z	Mirembe
20	Ms Ruphina Mwamdanga	Health Secretary – Central Zone	Mirembe
21	Mr. Daniel Muhochi	For Principal & NZCO - CEDHA	Arusha
22	Ms Veronica Mpazi	Principal and ZCO - EZ	Morogoro
23	Dr. Mwinchande Bakari	Principal and ZCO – Lake Zone	Mwanza
24	Dr. Cosmas C.Chacha	Ag. Principal & Zco SHZ	Mbaya
25	Ms. Neema Ringo	Health Secretary EZHRC	Morogoro
26	Mr. Lameck Msetule	Tutor EZHRC	Morogoro
27	Mr. Yohani Sully	Health Officer – Resource Person	Mvomero - Morogoro
28	Sr. A. Masoy	AMO – Tutor - EZHRC	Morogoro
29	Mr. Phillemon Orungi	Accountant - EZHRC	Morogoro
30	Mr. Lucius Mbombwe	District Health Officer – Morogoro District Council	Morogoro
31	Dr. Marco Nkya	Ag RMO – Morogoro	Morogoro
32	Erika Fukushi	Ag Chief Advisor – Regional Referral	MoHSW
33	Naomi Okada	Chief Advisor M&E - Regional Referral	MoHSW
34	Mayumi Sugihara	Human Resource Development – Regional Referral	MoHSW
35	Judith Msuya	AIDS CO	Arusha Municipal
36	Mary Malya	MTUHA Co	Arusha Municipal
37	Regina Dalabe	Ass RCH	Arusha Municipal

SN	Name	Title	Pace of work
38	Dr. Aziz Msuya	DMO	Meru D Council
39	Dr. Said Mgude	Principal	CEDHA
40	Mr. James Mwesiga	Coordinator NZTC	CEDHA
41	Ms Catherine Jansen	Coordinator NZTC	CEDHA
42	Dr. Sidney Ndeki	Consultant – NETTS - ZORO	MoHSW
43	Ms. Peggy Thorpe	Senior Health HIV/AIDS Advisor	Canadian Embassy
44	Mr. Rober Cunane	Mission Director	American embassy
45	Dr.Faustin Njau	Head HSRSP	MoHSW
46	Dr.Emmanuel Malangalila	Consultant – World Bank	WB – Country Office
47	Dr. Flavian Magari	Country Director – I-TECH	DSM
48	Martin Kalowela	ZTC Program Manager	DSM
49	Ibrahim George Voniatis	Former Accountant - HSRPS	DSM
50	Daniel Mhando	Accoutant – NETTS /ZORO	MoHSW
51	Dr. Gosbert Muta	Head – Continueing Education	MoHSW
52	Dr. E. Nangawe	WHO – Officer	WHO Country Office
53	Ms. Anna Nswila	Head , Strengthening District Health Services	MoHSW
54.	Dr. Deo Mtasiwa	Chief Medical Officer	MoHSW

Annex 4 ZHRC structure (proposed to Steering Committee)

ESTABLISHING A STRUCTURE FOR ZONAL HEALTH TRAINING INSTITUTIONS

Introduction

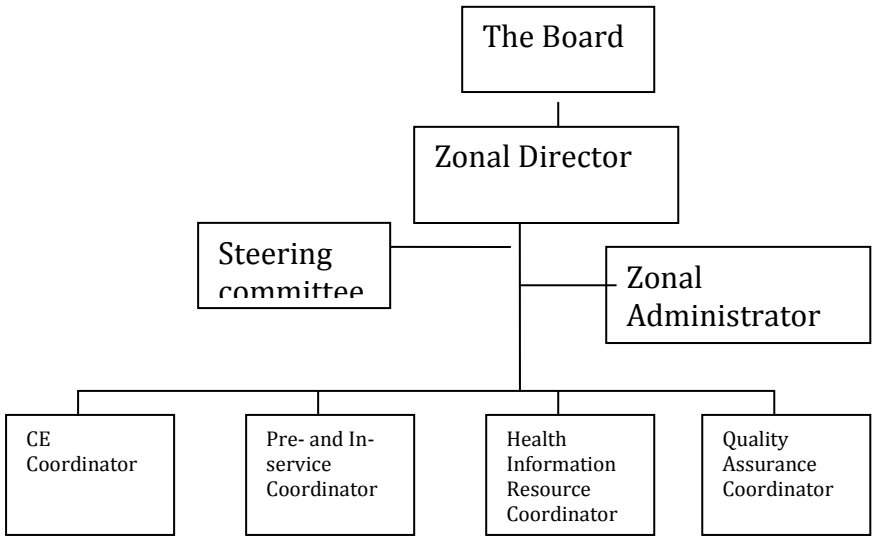
The Ministry of Health and Social Welfare is undergoing reforms to improve the effectiveness and efficiency of health systems delivery. Being part of this change the training systems is also required to change. In order to accommodate these changes, the Director of Human Resources Development requested to seek and include opinions from ZHTIs. In addition when collecting ideas from ZHTIs, a background was set from Consultants report on strengthening of Continuing Education and Pre-service Training for the health sector in the country.

This report is a summary of what the eight zonal centres suggested in regard the establishment of the ZHTI structure The meetings were guided by the following discussion items:

- The structure of the zones
- Roles in the ZHTI
- Committees and The Board
- Relationships of ZHTI with stakeholders
- Procedures
- Way forward

The structure of the ZHTI

There were several suggestions from different groups during the discussions. However ideas revolved around the following structure of the ZHTI.



ROLES OF THE ZHTI AND ITS RELATED COMMITTEE AND BOARD

The suggested roles of the ZHTI were to:

1. Supervise academic aspects of health training institutions and to ensure implementation of curriculum to the required standards
2. Plan and implement continuing education training according to the training needs of the HTI, districts and regions.
3. Provide training in the districts, region and colleges according to the demand of the schools, district and regions.
4. Acquire up to date information in various packages on human resources for training in the zones.
5. Establish resources centres in the HTI, districts and regional hospitals and other health facilities.
6. Facilitate in the provision of high quality services and in proper use of information technology.
7. To involve colleges in the hospital management teams (HMTs), Council Health Management teams (CHMTs), Regional secretariat/ Regional health Management teams in auditing and supervision of health services.
8. Facilitate HTIs in the zone to conduct research for evidence based reforms and policy implementation.
9. To provide consultancy services to the region, district and HTIs in order to improve training and quality health services.

Apart from the general Zonal roles it was also suggested that individuals with positions in the structure should have spelt –out roles as followings:

Zonal Director:
- Oversee the zonal activities
- Report to the MoH&SW
- Be a link between the ZHTI and MoH&SW
- Appoint all functional coordinators in the ZHTI
- Solicit resources for the ZHTI
- Link with other ZHTI's
- Select students for HTI in the zone in collaboration with MOH&Sw
- Suggest names for the board to the MOH&SW

Zonal administrator
- Prepare the overall budget
- Support the ZHTI director in all administrative matters

Programme coordinators
- Plan, budget and implement programme activities
- Coordinate programme activities
- Provide feedback to Zonal Director
- Ensure quality implementation of the programme

Steering committee
This committee which consists of all Principles of schools in the Zone shall:

- Hold regular meetings to discuss the implementation of the various activities
- Provide feedback to the ZHTI on important activities the zone
- Prepare strategic plan
- Assist the MOH&SW on the selection of students in the zonal health training institutes
- Assist the MOH&SW in setting qualifying examinations

The Board
It was generally agreed that there should be a ZHTI Board. The Board members should not exceed twelve members and their composition should include important individuals in the Zonal such as Regional Administrative Secretaries, Sheikhs or Bishops, Educators from Training institutions and Universities, Donor and partners operating in the zone etc. These names should be suggested by the Director of the Zone and then they should be endorsed by the Director of Human Resources. The Director of the ZHTI should be the secretary to the Board.

The role of the Board should be to:

- Advice on plans and implementation of ZHTI activities
- Solve/settle disputes in the ZHTI
- Advice the zone on financial matters and approve budget for ZHTI
- Support on availability of human and non human resource for ZHTI development.
- Advice on implementation of training policies
- Monitoring and Evaluation of ZHTI activities
- The Board is appointed by, and accountable to the Director of Human Recourses

RELATIONSHIPS

To have effective networking between ZHTI, districts and institutions, it was suggested that there should be a clear relationship in the following areas:

Relationships within the ZHTI

The allocation of the coordinators within the zone should be distributed among the HTIs depending on the already existing resources such as human, structural and physical resources so as to utilize effectively the HTIs and to delegate the ZHTIs responsibilities.

Relationship with Faith Based Organisations (FBO)

- Bishops to be appointed as Board members for ZHTI
- Reports should be shared between ZHTI and FBO schools

- FBOs staff should be included in school supervision
- There should be equity in training chances between FBOs school and government schools
- Tutors on secondment should have equal rights.
- FBO employees should be recognized and have equal rights with tutors in the Govt.
- Expertise should be shared.

Relationship with University Affiliated Schools:

- Universities to be ZHTI resource centres
- MOH &SW to award relevant certificates through ZHTI
- University to conduct research and training in collaboration with ZHTI
- There should be Memorandum of understanding between the ZHTI and Universities.

Relationship with Districts and Regions:

- ZHTIs to work as resource centre for the districts and regions.
- Schools to be included in CHMT membership and in supervision
- ZHTI to be involved in health campaigns e.g. NID, malaria, TB etc
- ZHTI to conduct tracer studies in districts and regions where the graduates are working.
- Support each other in field training and transport
- Districts should provide practicum sites for students to practice
- The district should provide part-time trainers for Training institute
- Expertise in the districts should be available for training in institutions
- Institution should provide training to the districts

PROCEDURES

It was suggested that the ZHTI directors should be directly accountable to the Director of Human Resource. Also the MOHSW should directly support ZHTIs particularly in areas of capacity building, infrastructure and monitoring and evaluation. However it also agreed that there should be guidelines which should be followed so as to facilitate smooth operation between the zones and MoH&SW. In addition the following were suggested**:**

- There should be regular annual zonal meetings to discuss zonal issues.
- Principals of the HTIs should be members in CHMTs, HMTs and where relevant in the RHMTs.
- Management courses should be provided to both Principals and HTIs management teams
- Tutors should be updated in teaching methodology through short and long courses.
- Various committees should be formulated to monitor the quality of implementations. In particular it was noted that:
- Training should be in line with the national health policy
- Training from programmes should be coordinated back in the ZHTI

- ZHTI should maintain quality training

FUNDING

Funding for ZHTI should be solicited from the following sources:

- Budget from the Ministry of Health and Social Welfare
- Developmental Partners and donor agents
- ZHTI to write proposals and conduct consultancy services for soliciting of funds
- ZHTI projects e.g. hostel, venue, internal café
- Training fees collected from long and short courses

WAY FORWARD

The following activities were suggested:

1. the MOH & SW to inform the Prime Ministers Office, Regional Administration and Local Government about the concept of ZHTI.
2. There should be an official documentation that Training Institutions should be involved in District Committee
3. Districts should involve the ZHTIs during their planning sessions
4. There should be a forum involving Regions, Districts and HTIs and ZHTIs
5. Sensitization should be done on availability of zonal health training services
6. ZHTI should link and learn from neighbouring zones
7. MOH&SW to prepare a finalized version of the structure and indicate clearly how to operationalize zonal activities.
8. Zonal members should develop a sense of ownership; by conducting zonal meetings and participate actively to the zonal activities.

Annex 5 training activities in ZHRCs

COMPREHENSIVE REPORT ON SCALING UP/STRENGTHENING ZONES 2006-2009

SOUTHERN ZONE

TOOLS/INTERVENTIONS	2006/07			2007/08			2008/09			NO. OF FACILITATORS PER TOOL	REMARKS
	No. OF COUNCILS COVERED	No. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF CUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAIEND		PROPORTION OF HEALTH WORKERS TRAINED
SHM MODULE 1 TRAINING	12									7	100%
SHM MODULE 1 FOLOOW UP				7		5				7	59%
SHM MODULE II				4		8				7	33%
SHM MODULE II FOLLOW UP											0%
IMCI	9			1					2	7	83.34%
IMCI FOLLOW UP											0%
COMMUNITY REHABILITATION				6			6			4	100.00%
COMMUNITY REH.FOLLOW UP											0%
PLAN REP TRAINING	12									6	100%
PLAN REP FOLLOW UP								12		6	100%
IMC	6								6		50%
MASTER IN PUBLIC HEALTH	1			1							

WESTERN ZONE

TOOLS/INTERVENTIONS	2006/07			2007/08			2008/09			NO. OF FACILITATORS PER TOOL	REMARKS
	No. OF COUNCILS COVERED	No. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF CUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAIEND		PROPORTION OF HEALTH WORKERS TRAINED
SHMI I	10	0	0	10	10	0	0	0	0	6	100%
SHMI II	0	0	0	0	0	0	4	0	6	3	40%
COMMUNITY REHAB	4	0	6	0	0	0	0	0	0	6	40%
PLANREP	10	0	0	0	0	0	0	10	0	5	100%
IMCI	3	0	7	0	0	0	0	0	0	6	30%
HEALTH MAPPER	0	0	0	0	0	0	0	0	0	0	0
COMMUNITY VOICE	0	0	0	0	0	0	0	0	0	0	0

SOUTH WEST HIGHLANDS (Mbeya and Rukwa)

TOOLS/INTERVENTIONS	2006/07			2007/08			2008/09			NO. OF FACILITATORS PER TOOL	REMARKS
	No. OF COUNCILS COVERED	No. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED		PROPORTION OF HEALTH WORKERS TRAINED
(SHM) Module I	0	0	13	12	11	2	2	2	0	7	**100%**
(SHM) Module II	0	0	13	4	0	9	5	0	4	7	**66.9%**
(SHM) Module III	0	0	13	0	0	13	0	0	13	5	**0%**
(IMCI)	**3** councils	0	10	1	0	10	2	0	10	18	**20%**
PlanRep2 Training	0	0	13	12	12	1	1	0	0	4	**90.8%**
Community Rehabilitation	0	0	13	10	0	3	3	0	0	4	**108.60%**
Integrated Management Cascade (IMC)	0	0	13	13	0	0	0	4	0	8	**100%**

SOUTHERN HIGHLAND ZONE

TOOLS/INTERVENTIONS	2006/07			2007/08			2008/09			NO. OF FACILITATORS PER TOOL	REMARKS
	No. OF COUNCILS COVERED	No. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF CUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAIEND		PROPORTION OF HEALTH WORKERS TRAINED
Planrep	nil	nil	nil	13	13	0	nil	nnil	nil	6	100%
SHM 1	13	nil	nil	nil	4	nil	nil	nil	nil	5	100%
IMC	4	0	9	7	0	2	2	1	0	4	100%
IMCI	nil	nil	nil	4	nil	9	1	nil	8	24	39%
Com. Rehab	nil	nil	nil	nil	nil	nil	13	nil	nil	4	100%
SHM 2	nil	nil	nil	4	nil	9	nil	nil	nil	5	31%

CENTRAL ZONE (Singida&Dodoma)

TOOLS/INTERVENTIONS	2006/07			2007/08			2008/09			NO. OF FACILITATORS PER TOOL	REMARKS
	No. OF COUNCILS COVERED	No. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED		PROPORTION OF HEALTH WORKERS TRAINED (%)
SHM Module 1 Training	14		1						0	7	80
SHM Module 1 follow up	0	0	0	0	9	1	9	0	0	7	90
SHM Module 11	0	0	0		5	5	5	0	0	7	50
IMCI Training	0	0	0	6	0	4	6	0	0	6	34.8
IMCI follow up	0	0	0	0	0	0	0	0	0		
Plan Rep -1	0	0	0	10	10	0	0	0	0	6	100
Plan Rep follow up (Backstop) 2009				10	10	0	10	10	0		80
Community Rehabilitation	0	0	0	10	0	0	10	0	0		80
IMC	0	0	0	2	0	8	8	0	2		68

EASTERN ZONE

TOOLS/INTERVENTIONS	2006/07			2007/08			2008/09			NO. OF FACILITATORS PER TOOL	REMARKS
	No. OF COUNCILS COVERED	No. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF CUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAIEND		PROPORTION OF HEALTH WORKERS TRAINED
IMC	5	NONE	11	0	0	11	0	0	11	5	31%
IMCI	0	0	16	1	0	15	0	0	15	15	7%
COMMUNITY REHAB	0	0	16	6	0	10	2	0	8	10	50%
PLANREP	4	0	12	12	0	0	0	16	0	8	100%
SHM 1 & 2	16	0	0	0	16	0	0	0	0	25	100%
SHM 3	0	0	16	0	0	16	0	0	16	25	0%
HEALTH MAPPER	0	0	16	0	0	16	0	0	16	25	0%
COMMUNITY VOICE	0	0	16	0	0	16	0	0	16	25	0%

NORTHERN CEDHA

TOOLS/INTERVENTIONS	2006/07			2007/08			2008/09			NO. OF FACILITATORS PER TOOL	REMARKS
	No. OF COUNCILS COVERED	No. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF CUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAIEND		PROPORTION OF HEALTH WORKERS TRAINED
SHM NMODULE I	14	-	15	-	-		3			8	58.6
SHM MODULE II				6		-	4			8	34.4
SHM FOLLOW UP I					14					8	48.3
IMCI	10			1			1			7	41.4
CBRT					12		7			5	65.5
IMC											100
PlanRep	24			5							100

ZONAL HEALTH RESOURCE CENTRE - LAKE ZONE

TOOLS/INTERVENTIONS	2006/07			2007/08			2008/09			NO. OF FACILITATORS PER TOOL	REMARKS
	No. OF COUNCILS COVERED	No. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF CUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAINED	NO. OF COUNCILS COVERED	NO. OF COUNCILS FOLLOWED UP	NO. OF COUNCILS UNTRAIEND		PROPORTION OF HEALTH WORKERS TRAINED
SHM I Training				29				8		7	100%
SHM II Training							21		8	12	72%
IMCI Training				4			4		21	10	27%
PlanRep2 Training	10			19	29					8	100%
Community Rehabilitation Training				13			8		8	5	70%
IMC Training				29							100%
Backstopping							14		15		48%
Sourcing from schools and this							8		14		