TEHIP News

Vol.1 No.1 January-June 1999

On evidence - based planning

Testing a Process

A newsletter of the IDRC/MOH Tanzania Essential Health Interventions Project

Evidence - based planning

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Cover Photo
Rearing children and working to feed the family compounds the burden of disease for women in most of the developing countries.

TEHIP News is published by the Tanzania Essential Health Interventions Project, a joint initiative of Tanzania's Ministry of Health and Canada's International Development Research Centre (IDRC). Contents do not necessarily reflect the views of partners working together in the development and implementation of the project.

TEHIP Partners

The Tanzania Essential Health Interventions Project (TEHIP) partners work together on a Steering Committee to provide overall policy guidance in the development and implementation of the project

The Government of Tanzania is responsible for the in-country management of the project, including project design, the development of integrated packages, project planning at the district level, and service delivery. It provides overall policy advice in relation to the Health Reform Process within the overall context of Local Government Reform both underway in the country. Central Tanzania Ministries and the District Health Management Teams of the participating districts are involved in the project.

The International Development Research Centre (IDRC) is the overall project manager. It funds the initiative (with resources from other partners and IDRC), manages the financial administration, and is responsible for the research and evaluation components of the project.

The World Health Organization (WHO) provides policy advice and technical expertise with respect to the project design and implementation of specific health intervention packages coordinated through its TEHIP Support Unit located in its Country Office in Dar es Salaam.

The World Bank's Human Development Department (WB) provides technical expertise in the areas of project design, implementation and evaluation in relation to WDR '93.

UNICEF contributes its experience in policy development and technical assistance in the delivery of national health programs in developing countries, at both the district and community levels.

The Canadian International Development Agency (CIDA) contributes overall policy guidance, practical advice and support to the project's development and implementation. The Agency provided essential financial support to initiate EHIP/TEHIP.

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EDITORIAL

Responding to challenges of improving health delivery systems

Dr. Eva Rathgeber, Executive Director of the Essential Health Interventions Project

When the 1993 World Development Report (WDR'93) proposed that a package of essential public and clinical services be designed based on the burden of disease and the selection of cost-effective interventions, little did we know that a partnership would be forged in Tanzania to test some of the proposals. Tanzania became the first partnership country in the attempt to examine the feasibility of a process of planning and setting priorities at a district level in low income countries.

Under the auspices of the Tanzania Essential Health Interventions Project (TEHIP), research teams, managers, planners, health workers and communities are participating in an investigation in two districts to find out how an integrated strategy for health care reform can be established and sustained. The purpose of the project is to empower the District Health Management Teams to allocate their resources effectively. We are working on the premise that more rational and efficient decisions on health resource allocation can be made on the basis of information obtained at the district level. This approach is different from the traditional practice where plans are centrally worked out and merely delivered to the district for implementation.

Since we embarked in earnest into testing of the *investing in health* endeavors, the Project staff, partners, and participating communities have braced up to tackle the challenges of implementing an innovative project with urgency and vigor aiming at achieving tangible gains. Although we are still at the early stages of the project implementation, a wealth of information and experiences have been generated. These can be shared with other developing countries striving to improve their health delivery systems.

Activities in the field have given momentum to the positive trend in the health sector reforms. At this juncture, I am delighted to note that we have already made impressive progress. Such success has been realized particularly because of the commitment of all stakeholders and unequivocal support from the Tanzanian government.

Activities in the field have given momentum to the positive trend in the Health Sector Reforms

With the launch of this newsletter, we have created a forum to keep you updated on the progress taking place in both research and development aspects of the project.

We hope that the information and experiences to be exchanged through this newsletter, which will appear at regular intervals on our website and in print, would contribute positively to the world debate in restructuring and decentralization of decision making. The interaction would, undoubtedly, lead to development of superior concepts, tools and methods that would create a situation in which everyone gains -- nations, stakeholders, present and future populations.

Eva Rathgeber
Regional Director, IDRC

OVERVIEW

New knowledge to improve health status in districts

The Tanzania Essential Health Interventions Project (TEHIP) is a health research and development initiative that has grown out of a series of international consultations and activities. It is a collaborative effort between Tanzania's Ministry of Health and Canada's International Development Research Centre (IDRC). The initiative is a response to the 1993 World Development Report (WDR), *Investing in Health* which recommended that an integrated package of minimum essential public and clinical health interventions could significantly reduce overall disease burden in low-income countries.

The project goal is to test the feasibility and measure the impact of an evidence based approach to health planning at the district level. It took off within the framework of proposals outlined in *Investing in Health*. A package of essential public health and clinical services was designed based on burden of disease and the selection of cost effective interventions. TEHIP, however, came up with two additional criteria for selection of interventions: the inclusion of community preferences; and analysis of health system capacity.

What does TEHIP test?

A process of planning which takes more account of *evidence* from:

- Burden of Disease
- Cost-effectiveness of available interventions
- Community preferences
- Capacity of the health system to deliver interventions

Various research and development outputs are expected by the end of the four year period of the projects implementation (1997-2001). On the development side, it is expected that District Health

PROJECT MILESTONES

1993

- World Development Report concludes that an integrated package of minimum essential public and clinical health interventions could significantly reduce overall disease burden in low income countries.
- Ottawa Conference recommends that a project be funded to examine the feasibility and impact of introducing an integrated package of interventions at the district level

1994

- Conceptual Design Meetings

1995

- In country planning starts in Tanzania
- TEHIP workplan for the first year of the project developed

1996

- Demographic surveillance system developed
- Core protocol guidelines developed
- National District Health Planning Guidelines (NDHPG) Training Manual pre-tested
- Completion of District Health Plans for Morogoro (R) and Rufiji districts
- Pilot Implementation of Cost Tracking system in Rufiji and Morogoro (R) districts
- Master Trainers Workshop On Integrated Management of Childhood Illnesses conducted.
- TEHIP Facility Assessment and District Equipment and staff profile
- Workshop on Reproductive Health Package.
- TEHIP officially launched.

1997

- Implementation of TEHIP activities begins
- Training opportunities for DHMTs and Associated staff provided.
- Cost Tracking Systems Implementation.
- Essential Health Interventions Improved and Supported.

1998

- Research agreements drawn up and signed.
- Research facilitation provided
- Research projects implemented.

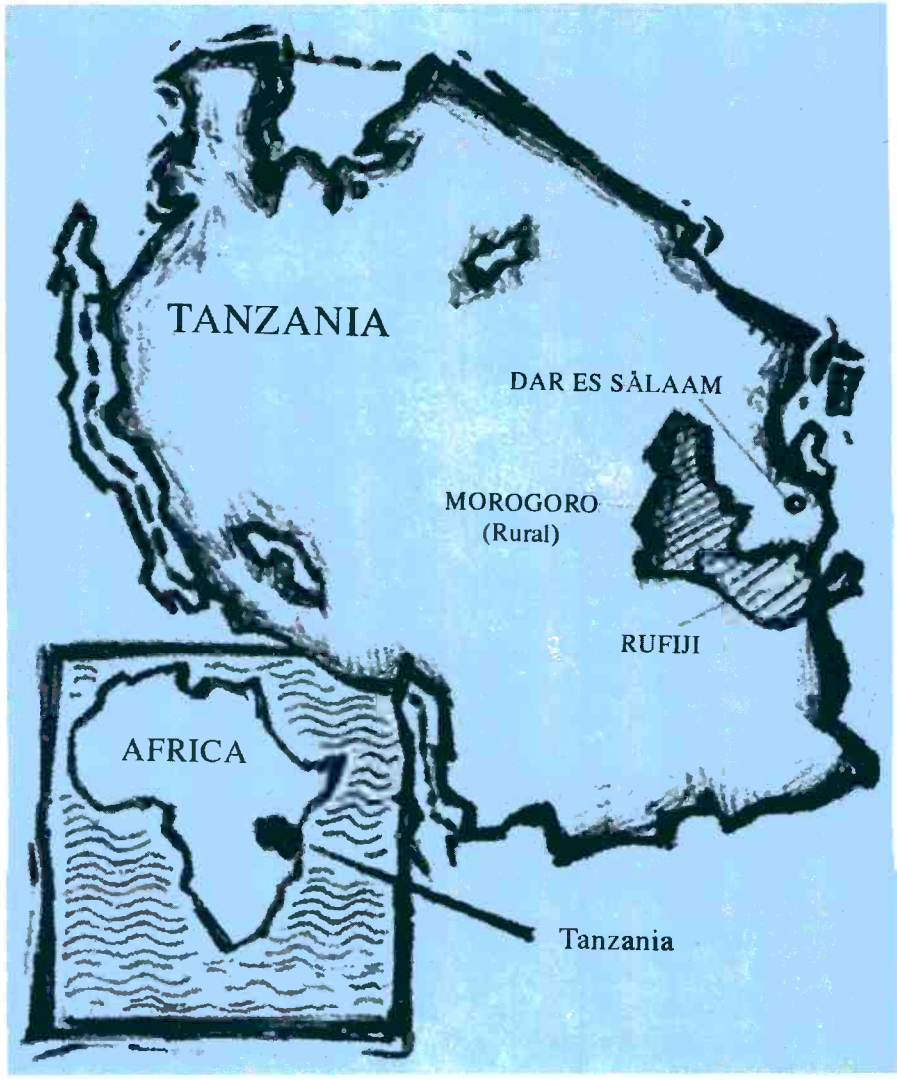
Management Teams would have demonstrated the ability to plan and manage district level health resources. Delivery and use of the selected health interventions would also have improved and expanded. Three important questions are expected to be answered in the research aspect:

- In the context of decentralization, how and to what extent, can DHMTs establish priorities and plan the allocation of resources according to local estimates of burden of disease and knowledge of cost effectiveness of relevant interventions?
- How and to what extent are these District Health Plans translated into the delivery and use of the essential health interventions.
- How, to what extent and at what cost does this have an impact on the burden of disease?

To answer the above, activities were framed into three major components which included: Health Systems, Health Behaviours and Health Impacts.

The bulk of TEHIP funding in supporting the interventions is directed toward the delivery of essential health services at the district level by the DHMTs based on the principles of sustainability and achievement of equity. TEHIP, however, is not striving to find a formula for a minimum package of interventions, planning and resource allocation that can be universally applied. It is about testing certain principles of process which , if found workable, could have application in other countries for efficient health care.

TEHIP links with Health Sector Reform issues in Tanzania in areas such as community participation, resource allocation and integration, costing of essential health interventions, human resource mobilization and development, and management of PHC. The project is also of relevance in matters concerning local and central government roles in the health sector, household health system relationship, burden of disease analysis, sustainability and equity. Essentially, TEHIP is designed to assist in the process of decentralizing health planning to the district level.



In Morogoro (Rural) and Rufiji districts TEHIP is examining the feasibility of institutionalizing more evidence-based approach to planning

REFORMS

TEHIP's intrinsic value to Health Sector Reforms

Issues examined by the TEHIP are of great relevance to the Health Sector Reforms being implemented in Tanzania. **Dr. Ahmed Hingora,** Head of the Primary Health Care Secretariat in the Ministry of Health gives an update of the implementation of the reforms and appraises the links between TEHIP and HSR in an interview with **William Lobulu**.

Q: After two years of the implementation of the first Health Sector Reform Plan of Action, what is your assessment?

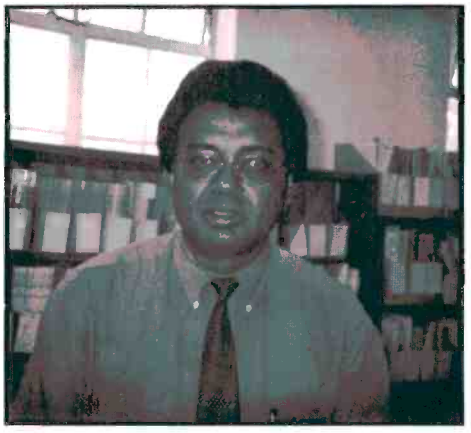
A: If you want to assess what has been done so far in the implementation of the Health Sector Reforms, I would say that we are still in the middle of the preparatory process. You can't embark on reforms and confine the initiatives within specific time limits.

Q: What achievements have been realized so far?

A: We can count a number of achievements. Let's start with the Medical Stores Department (MSD). It has been re-organized and is now operating more on a commercial basis. MSD has been strengthened structurally and we've developed a viable procurement and distribution system. Zonal medical stores are being strengthened to provide services to districts around them. Some programmes are being integrated as far as ordering, storage and distribution of drugs is concerned.

We have also established an Integrated Transport System. Vehicles are no longer confined to individual programmes. Vehicles have been put in pools created according to distribution and supervision demands of each district.

Integrated supervision guidelines have been developed.



Dr. Ahmed Hingora. Head of the PHC Secretariat in the Ministry of Health

Unlike the past whereby each programme did its own supervision, now we have teams which cover all aspects of service delivery regardless of the programme. The guidelines will soon be distributed and based on those guidelines, each district will develop its own system. In the past each programme had a mechanism for its own supervision.

Q: What else has been achieved?

A: Treatment protocols have been worked out. What we call standard treatment guidelines. These guide health workers, particularly peripheral ones, to manage common cases.

Management Training Guidelines are also in place. These are specifically aimed at the Regional and District Health Management Teams.

When these modules become operational each member of the regional and district teams will be conversant on how to manage District Health Services. The training modules cover the areas of planning, resource management, developing partnerships and district health systems.

Q: Are there any significant strides in cost sharing?

Initiatives are going on to develop alternative health financing mechanisms. Not cost recovery but basically cost sharing. Patients pay a token and get some service in return. There are still problems in financial control as regards revenue and expenditure. There's need for more control as increased revenue would lead to improved services. On the other hand we have developed a pre-payment scheme, some kind of insurance for people in the rural area. We call it Community Health Fund.

It was first tested in Igunga District and now it has been extended to six more districts. The scheme is very simple. During the harvest period, the communities themselves decide to contribute some money to take care of their health. The Fund is supervised by a board. To date Igunga district has a total of TShs. 115 million in the Fund. Those who do not want to contribute to the Fund are given the option of paying per service TShs. 1,000 which also goes to the Fund. Meanwhile we are developing a National Health Insurance Scheme for Formal Sector Workers. Those working with the Central Government first. If things work according to plans we should be able to launch the scheme in July 1999.

Q: Any progress in establishing District Health Boards?

Modalities are being worked out to develop them. The exercise has started in Kagera, Tanga and Dar es Salaam. Based on experiences from those areas we shall develop guidelines for the rest of the country.

The Boards will have representatives from the community and they will be accountable not to the MOH but to the Local Councils.

In a nutshell the reforms require a lot of preparations and much has been

Health Reform Questions

How Can Health Reform Enhance:

- Community Participation
- Household - Health Sector Relationship
- Resource Allocation and Integration
- Financing
- Private Sector
- Alternative Referral System
- Human Resource Management and Development
- Management of PHC
- DHMT/PHC Committees
- Local & Central Government Roles
- Costing of Essential Health Interventions
- Use of Burden of Disease information
- Use of Cost effectiveness information
- Sustainability
- Access, Equity and Quality of Essential Health Services?

going on quietly. We are preparing for the major thrust. Instead of starting with all districts at a go we are taking off with a few in phases. The first phase begins in July 1996 with 35 districts.

Q: What are the major challenges that have to be overcome for successful implementation of HSR?

A: We have been struggling to get close cooperation with the Local Government. We can't develop strategies in isolation of the Local Government. We have to be in agreement with other sectors and harmonize activities and this takes time.

Another big challenge ahead of us is developing the capacities of RHMTs, DHMTs, and DH Boards to handle their decentralized functions. Previously policies and decisions originated from Dar es Salaam. Now they are to be trained to plan and implement. To me that is a major challenge. There are also challenges of under-resources, management of human resources and lack of legal backing to support the changes. The list of challenges is long.

We should also reckon with the challenge of integrating the numerous vertical programmes and address them as a package.

An Integrated Health Management Information System has been put in place and lot of data has been gathered. The challenge ahead of us is how to develop capacity to use this information in health management.

Q: How is the Tanzania Essential Health Interventions Project (TEHIP) contributing to the Health Sector Reforms?

A: They are assisting us in many ways. First, their initiatives in health planning are critical. They are working in two districts and they have introduced a system of cost tracking to find out how to prioritize the allocation of resources. We have keen interest to learn from their activities. Each of the two districts under the project would hopefully be able to plan and allocate resources based on disease burden and from the two districts we shall be able to see how the system works.

They are also assisting us in capacity building of the DHMTs. Meanwhile, they are training and giving them working tools . TEHIP are creating a situation that would enable districts to work and make decisions of their own. Consciously or unconsciously they are developing a mechanism that would integrate the health sector into the Local Government plans. At the moment there's concern that we are developing plans, comprehensive ones, but in a way these plans are still vertical.

TEHIP is also assisting us in researching various aspects of health that would be useful in policy development. They are actually finding ways of strengthening operations at the district level to see how we can operationalize Reforms in the Tanzanian context.

Q: What role is the government playing in the implementation of the project.

A: The Government is providing policy guidelines to ensure that what is being done is within the government policy framework. We invite TEHIP to attend various fora so that we are able to monitor developments of the project and exchange ideas with the project staff. In the process we are looking at their achievements especially quality improvement because in the Reforms, one of the crucial issues is quality assurance especially in view of the fact that services are no longer free. The project evaluation would most likely be able to provide us with tangible contributions that would lead to improvement of services and care.

Our working relationship with the project implementors is very close and they do keep us informed of developments. The Permanent Secretary is the chairperson of the Project Steering Committee which provides overall project direction and policy decisions.

Q: Donor funded projects often ground to a halt when donors funding stops. What do you envisage after the project phase?

A: In that aspect we are also very happy with TEHIP. They are trying to ensure that all operations at the district level, whether funded by the government or TEHIP, are owned by the local communities. Nothing is done in isolation of the local leadership, TEHIP is not operating as a vertical programme Whatever is provided by TEHIP is put under local ownership. The process has been internalized so when the project comes to an end, the system would still be operational. If the process being tested by the project is found viable it would be integrated into the district planning system. TEHIP is not working in competition against the existing system but operating within it.

REFORMS
Mapping the Way Forward

Tanzania has adopted a reform package in response to health service delivery problems and in line with changing economic policies. Since 1991 some elements of the Health Sector Reforms have been implemented country-wide using different approaches.

In October 1998 a workshop was held in the coastal town of Bagamoyo to take stock of experiences from various partners testing different components of the health sector Reforms at district level , draw some lessons and incorporate them into the 1999 - 2001 Health Sector Program of Work.

The workshop which was organised by the Ministry of Health and funded by the British Department of International Development was attended by project coordinators, planners and functionaries from national to district level.

The Workshop identified key issues that should be addressed for smooth implementation of the reforms. Participants prioritized issues so as to determine what is practical for immediate implementation:

Capacity building

To improve management skills of the District Health Management Teams and implementors of the Health Sector Reforms.

Advocacy

Should be organized as a joint venture of the Reforms in the health sector, Civil Service and Local Government.

Partnership

Partnership should be forged at the district level among NGOs/CBOs , bi-lateral donors and across districts in planning, monitoring and evaluation of district health plans.

Co-ordination

There should be coordination of the reforms in the Health Sector, Civil Service and Local Government among others , to ensure closer collaboration and implementation

Strengthening the PHC Secretariat

The PHC Secretariat should be strengthened to be able to carry out documentation, dissemination and coordination of experiences and use them as a basis for replication.

Legal Framework

There should be a legal framework to support the reform process in order to facilitate the acceptability of health financing and management systems.

Sustainability

Sustainability of the Health Sector Reforms should be in terms of operations and financing. DHMTs are a very important component and they should be empowered through capacity building.

National Health Management Forum

Such fora should be established for broad based advocacy and sharing of experiences. Also to review progress and define the way forward.

Closing the workshop, the Permanent Secretary in the Ministry of Health, Mrs. M.J.Mwaffisi, reckoned that it was a big challenge to consolidate the lessons learnt into the three year Health Sector Programme of Work to be implemented by the Ministry between July 1999 and June 2002 but reiterated the MoH commitment to the reforms.

Elements of Health Sector Reforms

- Ideological Change
  Health services no longer free for all
- Managerial Change
  Improving performance of the civil service
  Improving role and function of Ministry of Health
- Organizational Change
  Decentralization/Local ownership
- Financial Change
  Broadening health financing options; cost sharing
- Public-Private Mix
  Introducing managed competition
- Health research

CAPACITY BUILDING

No easy formula for devising strategies

Capacity building for DHMTs is more than going back to school. In order to further the efficiency of district health planning, it has been necessary to upgrade the management and the administrative skills of the DHMT. Through The SHARMS Tool, DHMTs have been facilitated to work together and share responsibilities using a delegated team approach to problem-solving.

Whilst the process of decentralization of district health planning, budgeting and implementation of health service delivery to the district level is the vital ingredient of Health Sector Reform, weak management and administration capacity of the district health teams is one of the major obstacles to be overcome.

TEHIP, through its development activities, aims to document the current weaknesses and thus design capacity-building interventions to overcome them. The concept of sustainability continues to guide the activities. It is important that all capacity building interventions that are identified and pilot-tested in the TEHIP districts, are ultimately packaged into user-friendly "tools" which can be "rolled out" to all districts in the country. The idea of TEHIP is **not** to stage manage the two best districts in the country but to utilize these test districts to identify areas of weakness and to formulate a cost effective "tool box" which can strengthen the ability of any DHMT to perform their decentralized duties effectively.

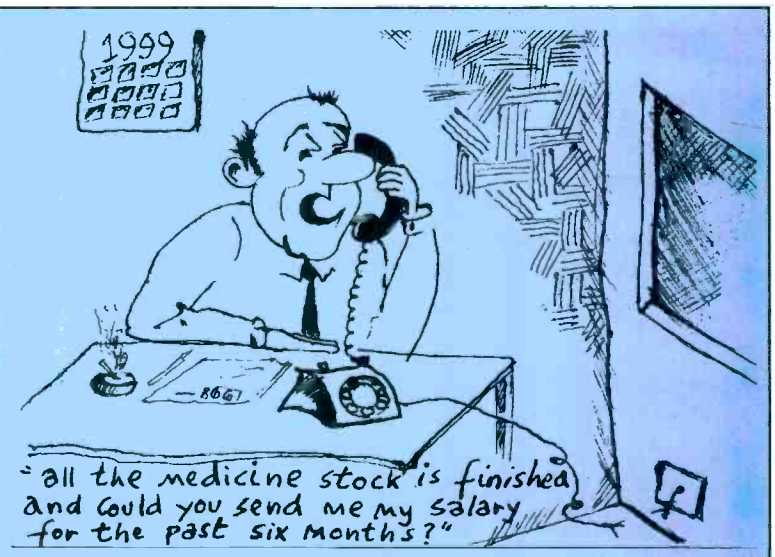
Over the first year of development activities, early capacity-building attempts focussed on the obvious areas of weakness. These covered issues such as driver training, provision of and training in computer techniques, and the promotion of district accountants into the DHMTS.

Since there is no easy formula or menu of capacity building strategies, the plans for the development interventions could not be set out in pre-defined domains, but evolved progressively through discussion and interaction with the DHMT and other key Local Government staff. In addition, inputs of the Health Systems Research Team assisted in tracking the impact of the introduced interventions as well as outlining other areas of identified weaknesses and needs.

As TEHIP entered the second year of activities, it became possible to identify specific tools for piloting and refining. In addition to promoting an evidence-base for DHMTs to draw on, the **Burden of Disease Tool** will utilize results of the population-based household demographic surveillance system. This is currently being conducted in both Morogoro (R) and Rufijii in collaboration with the DFID Adult Morbidity and Mortality Project (AMMP). It remains to be seen whether this research strategy can be moved towards a cost effective sentinel-site system for the entire country.

In order to further the efficiency of district health planning, it has been necessary to upgrade the management and administrative skills of the DHMT. Through the **SHARMS Tool** (Strengthening Administration and Resource Management), DHMTs have been facilitated to work together and share responsibilities using a delegated team approach to problem-solving. This has been augmented by practical training on District Health Planning and the joint responsibility of the DHMT to quarterly Technical and Financial report writing. It is envisaged that these quarterly report designs will be acceptable for all health funding partners in the district and thus cut down on unnecessary report writing for individual funders as was the case with previous vertical programmes. Training opportunities for DHMTS and

Evidence - based planning



A handy tool for frontliners

The Health Facility Cascade Tool is designed to address further autonomy, decision-making, advocacy and involvement within the district health facilities and promoting arrangements of all Frontline Health Workers (FLHW) towards the activities of the district health plan and Health Sector Reform (HSR) implementation.

Its need arises from observation that despite the implementation of HSR and the creation of District Health Management Teams (DHMTs), communication and engagement of FLHW in HSR has been minimal.

In order to address this priority need, communication between DHMTs and FLHWs must be dramatically improved. Through the Health Facility Cascade Tool, it is proposed that all dispensaries are assigned to a coordinating health centre. In order to promote involvement, plans are underway to equip each health centre with a radio. Both Health centres and DHMTs would receive radios but for the latter groups, provision will also be made for radio/e-mail.

Once communications with Health Centres are in place, DHMTs will be able to promote a number of delegated activities to the Health Centres and full pilot work up should result in specification of a range of activities which can be achieved at the sub DHMT level. These could include the following examples although others will no doubt be identified during the pilot phase:

*regular and efficient payment of salaries through the HC's on behalf of the dispensaries

* delegation of some integrated supervision activities e.g.

√ delivery of drugs

√ assistance with facility-level analysis of HMIS and collection plus

√ Supply of HMIS/CTS data books

√ checking over and assistance with INDENT order forms for subsequent delivery to DHMTs

√ provision of local training, capacity building workshops etc., for dispensary staff

√ update of equipment inventory, processing of equipment orders and repairs for delivery to DHMTs

√ arranging local transfer of FLHWs in response to staff illness/leave, etc.

associated staff were provided in collaboration with the Iringa Primary Health Care (PHC) Institute.

Other major initiatives in capacity building which are being introduced and tested are the **Budget Matrix Tool and Health Facility Support Cascade Tool.** With respect to the **Budget Matrix Tool**, all funding sources (Government, NGO, multilateral, bilateral, etc.) into the district health plan (DHP) are compiled and summarized and related to specific essential health interventions and/or delivery support. This allows the DHMT to increasingly present realistic and integrated budget requests to Central and Local Government and these can be confirmed before the commencement of DHP activities. This need to re-confirm and possibly re-prioritize the submitted DHP in the light of actual funding commitments (as opposed to requests) from the basis of a **Two Stage Planning Strategy** which TEHIP districts now undertake (see attachment).

Despite or perhaps as a result of the focus of attention which TEHIP has put on strengthening the capacity of the DHMT, the links between the DHMT and the health facilities is still weak. In order to address this, the DHMTs have proposed a step back in time in order to revitalize the historical role of Health Centres, as coordinating centres for approximately five satellite dispensaries. At the moment, plans are drawn up to place radios in each of the health centres and to provide a small resource centre with textbooks in order to promote local in-house training and staff development.

The beneficial impact of communication between the DHMTs and the district health facilities could and should be enormous. A number of potential activities which this communication could potentially benefit are set out in the attachment describing the **Health Facility Support Cascade Tool.**

PLANNING

Complexities of setting priorities and planned spending

"To plan is to choose" is a familiar maxim to most planners, managers and politicians in Tanzania's districts. However, a review of most District Health Plans may indicate that what is chosen is often not what is actually "needed"

One of the first activities to be undertaken by the project was a review and analysis of the 1997/98 District Health Plans (essentially the TEHIP baseline year) to match them with the philosophy of the project-prioritization and allocation of resources based on the Burden of Disease. A retreat by the project team and a workshop involving members of the District Health Management Teams provided an opportunity to learn how to prioritize and apportion the limited resources to the interventions.

The Rufiji and Morogoro Rural District Health Plans followed the National District Health Planning Guidelines as outlined by the Primary Health Care Secretariat in the Ministry of Health. In terms of information sources, reference had been made to District Annual Health Reports and Population figures were based on latest available census calculations.

In Morogoro, there was evidence that data from the Adult Morbidity and Mortality Project (AMMP) had been utilized in addition to some community input from focus group discussions. In Rufiji, despite the potential access to several sources of statistics through the Essential Drug Programme and the Health Management Information System which was being introduced into the district, there was little evidence that such data had been utilized to any great extent for essential health planning.

Definition of needs

It was apparent that there had not been a clear definition of needs with respect to burden of disease, community inputs, facilities, staffing, among others.

Absence of clearly defined "needs" has obviously impacted negatively on development of interventions to address these needs and this had adversely affected the possibility of prioritization and budget allocation. High burden priorities such as malaria were not addressed in the plan while much lower burden priorities were well addressed.

Based on the District Health Plan analysis, it was evident that there were deficiencies in the skills of the District Health Management Teams (DHMTs) across a range of issues

Determining interventions

The DHMTs submitted full district health plans for the 1997/98 period. Whilst the planning

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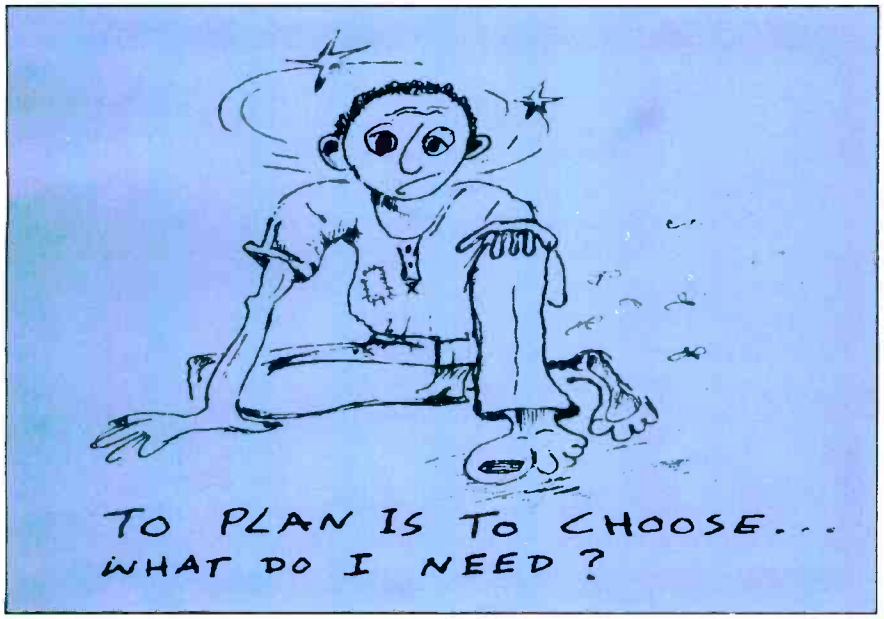

Evidence - based planning

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methodology was not based upon the collection and analysis of burden of disease or cost effectiveness, two intervention packages were identified in the plan. One of these, the Integrated Management of Childhood Illness Package (IMCI) which involved training, drug and equipment supply; the other package involved supplementing the already existing Essential Drugs Package (EDP).

Based on the District Health Plan analysis, it was evident that there were deficiencies in the skills of the District Health Management Teams (DHMT's) across a range of issues. Numerical analysis is a skill requirement for at least one DHMT member.

This will also be increasingly required if use is to be made of the Health Management Information System (HMIS) at the District level.

In order to assist DHMTs to prepare the 1998/99 District plans a pre-planning workshop was conducted to acquaint the DHMT members with skills and tools for developing effective District Health Plans based on an evidence-based approach. The exercise proved useful in working out plans.

TEHIP funding at the district

TEHIP is committed to support the District Health Plans in its pilot districts up to $2 per capita per annum. The DHMTs may request support against specific line items, at their discretion, either towards the cost of specific essential health interventions or essential delivery/ support items.

All funds are dispersed quarterly into a District Health Account operated through the signature of the District Medical Officer and District Executive Director. Within this ceiling of yearly funding, there are certain activities which have a maximum defined limit. These comprise DHMT support funds, health facility rehabilitation, basic medical equipment, transportation/vehicle allotment and capital support for the DHMT office.

All funds can be carried over from one year to the next and thus there is maximum flexibility. This permits sufficient time to plan for the more complex activities, for example, community-led facility rehabilitations, to be appropriately planned without risk of funds being lost through insufficient utilization. It is interesting to note that over the first year of TEHIP funding support of the District Health Plans, DHMTs were only able to utilize between 50-60% of the available funds. Such a situation endorses the need to build capacity because controlled and planned spending is as complex a process as integrated health planning and budgeting. It will be interesting to follow the trend in funding utilization over the life of the project as the DHMTs become more proficient as a management team.

Re-casting a wish list to a plan

In a situation where one is not sure of the flow of funds to implement plans a two Stage Planning Strategy may become critical in allocating resources.

Given that the system for health budget allocation to the districts from central government is unclear, it is impossible to project likely funding ahead of time. Additionally, potential funding inputs from other sources (e.g. Non Governmental Organizations) cannot be clarified simultaneously but are dependent upon the organizations' financial year.

The present system requires DHMTs to initiate their District Health Planning (DHP) around October so that they can be submitted to Local Government by the end of December. The actual budget figures from Central Government are released around June/ July of the following year.

Given the delays in receiving funding information into the DHP, it is proposed that there needs to be a second planning process around June/July. At this time, efforts should have been made to obtain figures from all proposed funders of the DHP. These actual budgets can then be used to re-prioritize and if necessary re-align the original draft DHP.

This second stage planning process is critical in that it sets actual health intervention priorities against a known budget level. It is the key stage that re-sets the DHP from a "wish list" into approved activities and timetable. It is only against this second readjusted plan that DHP implementation can be assessed at the end of the district health year.

It should also be appreciated that budget allocation figures from all DHP donors may differ significantly to actual funds disbursement. The second adjusted plan will thus be subject to close scrutiny and possible re-prioritization over the course of the district health year by the DHMT. The DHP is a guiding framework only and not a rigidly "cast" document. It will require continual review by the DHMT to adjust activities to actual funding availability over the course of the year. However, it will be appreciated that the second stage plan will be a much more useful tool then the original draft "wish list" plan submitted to Government for funding consideration.

Cost tracking captures true costs

Several types of costs must be considered when estimating the total resources needed to carry out an intervention. Some of these costs are difficult to calculate with accuracy. However, TEHIP will be measuring costs of interventions, diseases and of running health facilities so as to get information to be used in planning health services delivery.

In order to test cost effectiveness, cost information is a necessary tool. The cost tracking system was designed, developed and is being implemented to produce cost information which will be used by DHMTs in Morogoro Rural and Rufiji districts, and other users, for planning and decision making.

The Cost tracking system captures and processes statistical and cost data, variable and fixed costs. Capturing of statistical data is done by the health workers at health facilities while cost data is gathered by the cost accountants.

Implementation of the cost tracking system started in October, 1997 by the selection and training of accountants who are responsible for managing and supervising implementation of the system in their respective districts. Two accountants from each district were trained in computer use and cost tracking system. Two data entry clerks, one from each district, were also recruited and trained in the cost tracking system

District Health Management Team (DHMT) and other District officials were later sensitized and introduced to the Health Sector Reforms, TEHIP supportive activities, the cost tracking system and how the system fits in the overall framework of Health Sector Reform. They were also informed as to how it would help them in planning the delivery of health services in a cost effective way. The training of front line health workers, who are implementors of cost tracking system in their respective health facilities, was also conducted. A total of 151 frontline health workers from the two districts had been trained as of September 1998.

The pain and joy of measuring burden of disease

Measuring burden of disease is an overwhelming task but its outcome has far reaching consequences. It is a useful tool in the planning process and assessing the impact of interventions.

The issue of burden of disease and cost-effectiveness measurements is integral to the development of the district health plan.. Burden of disease was defined by Musgrove (1994) as *the total amount of healthy life years lost, to all causes, whether from premature mortality or from some degree of disability over some period of time. These disabilities can be physical or mental. A given disease, deficiency, or trauma may produce more than one kind of health damage, and a given disability may arise from more than one cause. The burden of disease can in principle be attributed to distinct risk factors, each of which may contribute to the likelihood to severity of one or more diseases or conditions.*

At any moment, the burden of disease in a population is a reflection of both the amount of health care already being provided and the effects of all other actions that protect or damage health. For *Investing in Health*, an attempt was made to estimate the burden of disease against a common measure, both globally and by region, and to estimate the cost-effectiveness of interventions against the various conditions that contribute to the burden.

For most developing countries, accurate statistics including prevalance and incidence figures, are not available.

The GBD survey conducted for *Investing in Health* attempted to move beyond traditional surveys that focused only on mortality to include conditions that lead to disability (such as residual paralysis or depression), and to quantify their effects on individuals and the health system. On the basis of the *International Classification of Diseases*, diseases were classified into 109 categories that covered most possible causes of death and disability.

Burden of disease measurements serve two purposes within the framework of EHIP/TEHIP.

* as a tool to assist districts in their planning process, and
* as a research tool to assess the impact of the intervention(s).

Evidence - based planning

Facelift engages community voice

Facility rehabilitation is being used as an entry point to engage the "community voice" in the whole process of health planning and implementation in the district.

In order to meet minimum standards in health facilities for the effective and secure delivery of essential health interventions, TEHIP Districts set aside a modest amount of funds to complement efforts of the district authorities and communities to improve their health centres and dispensaries.

The participation of local communities through contribution of labour and materials in carrying out the improvements and maintenance was emphasized as a precondition.

The main objectives are to promote ownership to the local communities of the local health facilities; impart appropriate skills to both the local community and leadership on labour based construction and maintenance; and develop and put in place a sustainable mechanism for operation and maintenance.

With guidance from a local consultancy team, vested with experiences in community labour based methodologies, TEHIP carried out a demonstration exercise to three dispensaries in each of the two districts using the community labour based methods.

In Morogoro (R) district three dispensaries have been refurbished. These are Mikese, Hembeti and Mtombozi. In Rufiji, dispensaries in Mkongo, Nyambunda and Hanga are in final stages of completion.

Part of a health facility that has been repaired by the community with modest financial support from the DHMT. A sustainable mechanism for operation and maintanance is being put in place.

The district authorities in Morogoro decided to hand over the dispensaries to the communities so that they could continue maintaining them and carry out minor repairs on a sustainable and cost effective basis.

The handover ceremonies took place on November 25th and 26th, 1998. Ownership certificates were presented to the chairman of the respective village governments in ceremonies attended by, among others , the Constituency Member of Parliament , Mr. Semindo Pawa; Chairman of Morogoro District Council , Mr. Charles Malyaga; the District Executive Director , Mr. John Gille; District Administrative Secretary , Mr. G. Linga. TEHIP was represented by Drs. Graham Reid and H. Kasale.

The Guest of Honour , the Regional Nursing Officer, Mrs. Anna Gutapaka underscored the importance of continuous maintenance of the rehabilitated health facilities. She urged the communities to engage themselves in other development activities for example, water supply, schools and agricultural activities using the same approach.

The villagers expressed their enthusiasm and promised to continue making similar moves in refurbishing the staff quarters.

The exercise has clarified the way forward in rehabilitating other health facilities in the districts.

Social marketing triggers demand for nets

Malaria is among the most frequently reported cause of death and disease in Tanzania. About 16 million cases are reported per year and accounts for more than 20% of all child deaths.

Both Rufiji and Morogoro (R) districts have identified the use of mosquito nets treated with insecticide (ITN) as among the most viable interventions against Malaria.

Promotion of ITNs is underway as a collobarative effort of various programmes. Population Services International (PSI), responsible for social marketing and communication for AIDS control activities, in collaboration with the National Malaria Control Programme (NMCP) in Ministry of Health, are carrying out a DFID funded project called 'SMITN' which stands for "Social Marketing of Insecticide Treated Nets".

The purpose of the project is to develop and demonstrate strategies for the promotion and sale of branded nets and insecticide for net treatment using a social marketing approach.

In order to reduce mortality rates caused by malaria an ITN programme has been launched in the TEHIP programme areas making use of PSI experiences. In Rufiji District, phase one covers 22 villages in three divisions namely Kikale, Mkongo and Mbwera.The first consignment of 3000 nets has been sold and the next consignment has been ordered . TEHIP research will document trends in household behaviours in relation to malaria, malaria prevention, mosquitos and ITNs including expenditure behaviours.

In Morogoro District the first phase covers 41 villages in three divisions - Mlali, Mikese and Ngerengere. On June 21, 1998 PSI launched ITN amid an enthusiastic crowd at Mlali village with full participation of the DHMT.

As community surveys and training of animators continue demand for ITNs are increasing. Morogoro (R) has ordered 5,250 more nets 16,000 insecticide tabs and promotional materials.

According to the ITN Coordinator for Morogoro District, L.N. Mbombwe "Our big task is to improve the programme by doing thorough supervision, monitoring and evaluation in order to make the project sustainable."

Addressing leading causes of death

The two Districts participating in TEHIP have chosen Integrated Management of Childhood Illnesses(IMCI) as one of the major strategies for cost-effective under five mortality and morbidity reduction.

Morogoro Rural District has a population of 525,000 inhabitants living in 215 villages. The probability of dying by age five is 188 per 1000, and the five leading causes of child mortality are acute febrile illness (including malaria), diarrhea, pneumonia, malnutrition and AIDS.

Rufiji District has a population of 172,000 inhabitants living in 91 villages. Under-five mortality, estimated at 191 per thousand in the 1992 DHS, is the first health priority of the district. The leading causes of attendance at health facilities are malaria (27%), URTI (9.6%), diarrhoea (8.3%), anemia (7.4%) and intestinal worms (5%). Prevalence of anemia in under- fives is 40%. All the major leading causes of death in the two districts are well addressed by the IMCI approach.

Tanzania is presently in the early stages of implementing IMCI in seven districts Morogoro being one of them. The training component is well underway.

Two week- course schedules with 14 to 17 participants each were used during training of peripheral health workers. In view of non clinicians managing more than 30% of health facilities in Rufiji, two special three-week- course schedules for health workers with learning difficulties were used.

With WHO and TEHIP support, health worker training is taking place at a rapid pace in both districts.

In Morogoro, 93% of health facilities (HF) have been covered with at least one trained health worker , and 81% in Rufiji. Training activities are continuing and full training coverage is expected in both districts by July 1999.

TEHIP support to IMCI implementation in the country in general has been in areas of provision and sharing of training materials during training sessions. Participants coming from other districts not involved in the project have been invited to attend training sessions organized by Rufiji and Morogoro districts.

Experiences from IMCI implementation in the two districts have been found useful to other districts starting to implement IMCI in the country. The experiences in training, referral problems, provision of drugs and follow-up of trained workers have also been shared at international level in meetings organized by WHO AFRO for English speaking countries. The same experiences are being used to provide an opportunity for the implementation of the WHO sponsored Multi Country IMCI evaluation.

RESEARCH
Unique opportunity to test a process

The project seeks to answer several questions facing Health Sector Reform in Tanzania

Apart from contributing to the Health Sector Reform initiatives, TEHIP is providing a unique opportunity for the Tanzanian research community which conducts all TEHIP research.

In Morogoro (Rural) and Rufiji Districts TEHIP is examining the feasibility of institutionalizing a more evidence-based approach to planning using burden of disease and cost-effectiveness measurements as tools for setting priorities and allocating health resources.

It is expected that these considerations, combined with an appreciation of community preferences and the capacity of the District health services, will lead to the identification and improved delivery of packages of essential health interventions, and ultimately to significant reductions in the burden of disease.

. The project seeks to answer several questions facing health sector reform in Tanzania and other countries with similar economic and social constraints. Activities are within a framework of four research areas:

**Health Systems Research* on District Health Planning, Prioritization, and Resource Allocation Processes

**Health Behaviours Research* on Household Health Seeking Behaviours in Relation to Essential Health Interventions

**Health Impact Research* on Demographic and Health Effects of Process Changes;

**Research and Development of Practical Tools* for Routine District Health System Analysis and Planning.

Each research component addresses research questions which demand the skills of a number of disciplines. Such skills and disciplines are often attached to different host institutions in the academic, governmental, non governmental, and private sectors. It was necessary that inter-disciplinary, inter-institutional research consortia be assembled to address adequately and coherently the research questions within and across the Components.

To ensure that the TEHIP Research Objectives are met, each research institution or network awarded a TEHIP Research Program Grant is assessed on an ongoing basis during their tenure of the grant.

Field research started in December 1997 and among tasks that have been fulfilled so far in the various research components are:

- Recruitment and training of all field research staff.
- Equipping and establishment of field research stations.
- Situational Analysis of the Annual District Health Planning Process and feedback to DHMTs.
- Documentation of all planning process.
- Situational analysis and feedback of Initial Utilization Patterns and Trends of the selected essential health interventions (Integrated Management of Childhood Illnesses IMCI and Insecticide Treated Nets ITNs) .
- Baseline enumeration on health impact (Demographic Surveillance Systems) has started in Rufiji.
- Mortality surveillance in Morogoro alreday running since 1992 and new system established for Rufiji is now operational.

Progress is evident in all areas of research and some tools are already available to the DHMTs . Such tools include: the Budget Matrix Tool , a spread sheet which summarizes the District Health Plan showing the selected Essential Health Interventions, their budgets and various sources of funding and the Service Support Items, their budgets and sources of funding and The Burden of Disease Tool, a histogram showing the share of burden addressable by DHMT selected interventions.

TEHIP research is funded through a network of research programs, and not as a collection of research projects. The TEHIP project facilitates Tanzanian research institutions to be able to approach larger programs of research over several years.

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