⑤ モロゴロでのワークショップ報告

# REPORT OF THE FIRST WORKSHOP

# ON DISTRICT HEALTH SERVICES IN MOROGORO REGION

HELD AT TANESCO CENTER, MOROGORO

2-3 December 1999

MINISTRY OF HEALTH

AND

JICA TANZANIA OFFICE

DECEMBER 1999

# 1.BACKGROUND

The Ministry of Health, in collaboration with JICA and Morogoro region, has been formulating the project type technical cooperation request to be submitted to JICA for her assistance. The main objective of the project is to strengthen regional and district management skills so that they can perform full-fetched implementator of health services in the districts. In the framework of national level decentralization and associated health sector reform, the roles and responsibilities of the regions as well as districts will experience tremendous change and challenges ahead. The central Ministry is no longer the key implementator of district health services, but remain as policy maker and provider of guidance. However, the transition requires time and gradual capacity building of staff concerned at regional and district levels. Since February 1999, the Ministry and JICA had exchanged views over this issue and identified Morogoro region as a target site for intervention. Since then, discussion included various stakeholders in Morogoro and those who have projects in Morogoro region. In August 1999, the proposal was drafted and official request to the Government of Japan was submitted accordingly.

With the favorable consideration of the project in mind, JICA headquarters dispatched Preliminary Study Mission Team to Tanzania for 30 November to 7 December 1999, headed by the Managing Director of Medical Cooperation Division of JICA.

Taking this opportunity, the Workshop was held in Morogoro in order to jointly formulate and design the project through informal brainstorming sessions. The Workshop was held during 2 and 3 of December in TANESCO Training Center, inviting participants from all districts, stakeholders from the region and other key players from JICA Tanzania Office and MOH.

## 2. TERMS OF REFERENCE OF THE WORKSHOP

(1) OBJECTIVE: To share issues and concerns among stakeholders focusing on the health sector reform and new responsibility, in order to identify areas and modalities of high priority support in the new project.

(2) OUTPUT: Key areas of assistance sought to be identified and incorporated to the revised proposal/activity plan.

(3) List of participants (invited)

MOH/HQ (2 person) Head of PHC Secretariat, Health Cooperation Planning Advisor

RAS, RAO, Regional Planner, Regional Education Officer, Regional Water Engineer

RMO and other members of RHMT

Approximately 3 persons from Regional Hospital (i.e. Medical Officer in charge of Hospital)

From each of 5 district: DED + DMO + HMIS focal point DHMT member + 1 other DHMT member (DMO to decide) = 4 persons from each district

Zonal training Center (Dr. Kisimbo, Ms. Magome)

Japanese Mission Team members (3 persons)

JICA Tanzania Office (1 person)

Facilitation by Professor Hiza

(4) Timetable

| Workshop Session I December 2, 14:00 - 17:00 at TANESCO Training Center in Morogoro **Please be punctual - it will begin at 14:00.** |
|---|
| (1) Opening by RAS<br>(2) Introduction of Participants<br>(3) Background of the project, and what has so far been done on the project formulation, purpose of this workshop<br>(4) Speech by the head of Mission Team<br>(5) Background and framework of Health Sector Reform by the facilitator<br>(6) Exchange of ideas |

| Reception by the Mission Team December 2, 19:00 - Acropole Hotel |
|---|
| All Workshop Participants are invited |

| Workshop Session II December 3, 8:00 - 11:00 at TANESCO Training Center in Morogoro |
|---|
| (1) Further exchange of ideas<br>(2) Wrap up and closing |

(5) Financing

The Workshop is funded by JICA with support of MOH and MRALG (Ministry of Regional Authority and Local Government).

## 3. PROCEEDINGS OF THE WORKSHOP

(FROM THE SUMMARY WRITTEN BY PROF. HIZA)

The Government of Japan through its International Cooperation Agency JICA conducted a workshop in Morogoro Region involving the Regional Health Management Team, District Health Management Teams from constituent Districts of Kilosa, Kilombero, Ulanga, Morogoro Rural and Morogoro Urban. Other participants were the RAS, a representative of the Ministry of Health and representatives from the Zonal Training Centre based in Morogoro municipality Mission Team from JICA Headquarters, The Assistant Resident Representative, JICA Tanzania Office, the Health Cooperation Planning Advisor of JICA to MOH and the Head of PHC Secretariat of MOH were also in attendance.

After the initial opening ceremonies and formalities the Objectives of the workshop were explained namely Information Exchange regarding the Proposal for Technical Cooperation with JICA for the Strengthening of District Health Services in Morogoro Region.

JICA had in August 1999 commissioned a study on Situation Analysis of Health Services in Morogoro Region which listed among its concerns the lack of Information on Health Sector Reform. JICA therefore contracted Professor Philip Hiza to facilitate the Workshop with a view to provide this information. The information was categorised into the following broad areas:

Evolution of Health Reform

The Government of Tanzania resolved in 1985 to introduce Reforms in all Sectors with particular emphasis on Agriculture, Transport and Industries. The

Health Sector at that time received little attention as it was deemed not contributing much to the Economy an idea which was later rescinded in 1993 as exemplified by the World Health Report which directed emphasis on Investing in Health.

Health Sector

- The first signs of change were the Liberalisation of the Pharmaceutical Sector in terms of Liberalising Procurement and Strengthening of the Pharmacy Board as a Regulatory Authority beginning in 1985.
- Next was the repeal of the Private Practice Regulation Act of 1977 and Amendment of the same in 1991, thereby recognising the role of Private Practice contribution to the overall health service.
- The stepwise introduction of User fees at health facilities beginning with tertiary level in 1993 and subsequently to secondary and primary levels in 1994.This represented a major departure from the doctrine of delivering free medical services.
- The MOH was invited to Washington by the World Bank in 1993 to discuss the significance of the change in the Banks Policy in advocating Investing in Health. Resulting from this meeting was the MOH's Strategy Document highlighting area that were ripe for Reform
- The MOH then commissioned a Team to deliberate on the Reforms in the context of the strategy and after deliberating for a year came out with the HEALTH SECTOR REFORM PROPOSALS, which after lengthy discussions was adopted by the Government. The document emphasised the changing role of the MOH from being the sole provider of health services to the following functions:
  Facilitation of health services
  Policy Formulation.
  Legislation.
  Regulation.
  Quality Control.
- Financing Options
  1. Recognizing the role of Private Practice is a major milestone in enabling those that can afford to pay directly for the service
  2. Introducing USER FEES
  3. Piloting on Community Health Fund (CHF) as a means of

encouraging community contribution to funding for their own health.

4. The passing of the National Health Insurance Bill ushered in the Legal basis for introducing the National Health Insurance Fund.
5. Government indicated its commitment to increase Public Expenditure on Health.

- **Decentralisation**

  The Government resolved to decentralise health services to the Districts as a means of transferring autonomy to the Local Authorities.

- **Health Sector Review in 1998.**

  This Review recommended the formulation of a Programme of Work which would lie out the budget in line with the Governments Rolling Plan and Forward Budgeting and likely to attract donor funding in a Sector wide Approach.

ELEMENTS OF REFORM IMPLEMENTATION

- **Programme of Work (POW) 1999-2002**

This Programme was designed to conform to the Governments fiscal reform of Rolling Plan and Forward Budgeting. The Comprehensive Document has been distributed to all DHMTs as Executing Agents of Reform.

- **Plan of Operations (POA) July 1999- June 2000**

This Plan represents the number of Activities that can be carried out by the Health Sector Implementing Agents in the course of the year. It presents a budget, which includes both Government and Donor financial commitments and has also been distributed, to all Districts in their capacity as Executing Agents.

Both the Programme and the Plan are based on 8 Implementation Strategies

1. District Health Services with the aim of improving ACCESS, QUALITY AND EFFICIENCY.
2. Secondary and Tertiary Hospital Services
3. Role of the Central Ministry of Health
4 Human Resource Development
5 Central Support Systems inclusive of :
   Drug Supplies
   Medical Supplies and Equipment
   Transport System

HMIS

Estate Management

6 FINANCING

Strengthening Planning and Budgeting

NHIF

Cost Sharing Mechanisms.

CHF

Joint Financing System between Government and Donors7

7 Public / Private Mix

Promotion and Facilitation of Private Practice.

8 Donor coordination

Joint Funding of POA by GoT and Donors through Basket and Vertical Funding Mechanisms.

Coordination between MOH and MRALG Reforms.

- Morogoro Region Health Situation Analysis (carried out by the local consultant under JICA funding)

  A health situation analysis done in August this year identified the following CONCERNS

  1. Lack of Information on Health Reform
  2. RHMTs Role not well defined.
  3. Health Systems continue to Deteriorate
  4. There exists an urgent need for Recruitment
  5. Composition, mandate and selection criteria for DHBs not well defined.
  6. Roles of MOH and MRALG not well defined
  7. Capacity of DHMTs in implementing HSR is weak.

- Cross Cutting Issues

  These issues relate to the roles of MOH, MRALG, MOF, MOJ and CSD which were discussed in relevant workshops with regard to implementing Health Reforms which are hereby enumerated:

  1. Establishment of Health Boards

     The Law provides for option for Local Authorities to create Service Boards but Health feels these Boards are essential in implementing the Reforms in health.

2. Health Financing Mechanisms and Management

   Matters relating to Conditional and Unconditional Grants need unanimity between the GoT and Donors as well as:

   Joint Accounts

   Auditing Mechanisms

   Equalisation Grants and

   The possibility of initiating a UNIVERSAL CODING SYSTEM.

3. Human Resource Issues

   These issues centred around DELINKAGE of Personnel from Civil Service Department

   Incentive Packages

   Equalisation Assistance to poor and marginalised districts.

4. Health Service Delivery

   MOH responsible for Quality Control and giving directions on Referral System linkages as well as Performance Monitoring.

5. Legal Issues need to be tackled jointly by the MOH and MOJ.

RECOMMENDATIONS ARISING FROM SITUATION ANALYSIS.

1. Strengthen the Capacity of DHMTs in Planning, Management and Implementation of District Health Services
2. Capacity Building for RHMTs to provide Technical and Managerial Support to DHMTs
3. Urgent Need for Rehabilitation of Physical Infrastructure.
4. Installation of Radio Communication Equipment to improve the Referral System.
5. Upgrading Skills of Health Care Providers

OUTCOME OF THE WORKSHOP

- The Workshop Participants then brainstormed based on their existing knowledge of Health Reform and the Proposed JICA Project. The Representative from MOH elaborated on the central issues pertaining to the Reforms and how it relates to both Ministries of Health and Local Government and stressed on the importance of attitude change and Community Empowerment as well as the need for Information Sharing. The member stressed also need to repel fears about HSR and that it does not

present any threats.

- The RAS was extremely positive in assuring Government Commitment to the Reform Initiatives in Health.
- The discussions continued the following day with each District presenting their common stand.
- The Teams from Kilombero and Morogoro Rural Districts made the most impressive presentations stressing on wanting Managerial skills, minimal information on health reform, communication problems and poor state of the physical infrastructure. So far Kilombero District conduct 3 Interagency meetings, Joint Planning and have a strategy on Power sources. They also carry out Community based DOTS in TB control and are executing a Project on Insecticide Treated Bednets (ITN). Morogoro Rural are rather advanced in Evidence based Planning due to their relative advantage in working closely with TEHIP and AAMP. Kilosa District is somewhere in the middle with the highest number of health facilities but weak Planning and poor communication system due to difficult terrain. Ulanga District presented a bleak health situation. The infrastructure is extremely poor consisting of old buildings some dating back to German Colonial times. The District itself is Remote and experiences Staff shortages as a result. The problems of Morogoro Urban relate to problems of the Urban poor with over crowding. Their facilities are however overstaffed due to excess number of trained spouses in the Municipality.

CONCLUSIONS

The key message arising from the discussions on Health Reform is to recognise that Reform is Real and demands Change in attitude for districts from Dependence on Central Administration to Autonomy and that the process will be gradual but inevitable

The discussions too have helped to enhance Justification for the JICA Project Proposal.

The output from the discussions can be summed up by the need to accomplish the following:

1. Need to Strengthen Management Capacity in all the Districts. It is expected that this will result in improving Planning and Budgeting.
2. The currently available personnel will be utilized to the best and be allowed to undergo Continuing Education and efforts should be directed to

Recruiting in order to reach adequate Staffing Levels.

3. A programme of Rehabilitation for existing health facilities should be made for each district. Priority Rehabilitation Plan should be available.
4. Exchange of information among Districts is necessary
5. Communication Issues predominate, so each District should have a Plan. As for transport each district should have a plan detailing how they are going to be self sufficient in transport.
6. Each District should have an Integrated Supervision Plan to involve all health care providers
7. The Region should work out a Technical Equipment Strategy.
   District official efforts need to be supplemented with Community efforts.

## 4. WAY FORWARD

Having exchanged views and constraints prevailing, the content of Workshop discussion was well noted by the Mission Team as well as JICA Tanzania Office and the MOH. The Workshop was found not only useful but necessary in order to mobilize participants and cultivate the sense of ownership of the forthcoming project. All participants were left with certain homework to work on in their respective positions in the next few months. The further opportunity to share development is considered critical since the HSR is a dynamic evolving process.

Participants were provided with some key documents such as MOH Health Sector Plan of Works and Plan of Action, JICA funded Situational Analysis Report. Further, participants requested MOH to provide them with key policy documents and guidelines which Ms. Hashimoto will follow up.

As a general note, participants are not yet fully aware of their responsibility within the new framework and therefore they suffer from massive anxiety. It is important to inform them as to what is happening in the MOH headquarters and receive feedback from the district implementators. The communication must be bilateral. The forthcoming project is desired to intend to strengthen this communication line and true collaboration of districts, regions and the central Ministry.

Attachment: List of participants

LIST OF PARTICIPANTS AT THE DISTRICT HEALTH SERVICE CAPACITY BUILDING WORKSHOP IN MOROGORO
2-3 December 1999

| | First name | Last name | Title/Designation | | Address | Tel | 2-Dec | 3-Dec |
|---|---|---|---|---|---|---|---|---|
| 1 | N.D. Eshukurwa | Sumari | RAS | RS | BOX 650 Morogoro | | O | |
| 2 | Jonah | Mwakiluma | Regional Administrative Officer | RS | BOX 650 Morogoro | | O | |
| 3 | Mduhu | Salum | Regional Education Officer | RS | BOX 650 Morogoro | | O | O |
| 4 | Grayson | Kikwesha | Ag. Regional Planning Officer | RS | BOX 650 Morogoro | | O | O |
| 5 | Ferdinand | Fupi | RMO | RHMT/RS | BOX 110 Morogoro | | O | O |
| 6 | Edward | Mwanga | Regional Laboratory Technologist | RHMT | BOX 110 Morogoro | | O | O |
| 7 | Margareth | Wapalila | Regional MCH Coordinator | RHMT | BOX 110 Morogoro | | O | O |
| 8 | Livingston | Sankey | Ag. Regional Health Secretary | RHMT | BOX 110 Morogoro | | O | O |
| 9 | Leo | Mulokori | Ag. Regional Pharmacist | RHMT | BOX 110 Morogoro | | O | O |
| 10 | Anna | Gutapaka | Regional Nursing Officer | RHMT | BOX 110 Morogoro | | O | O |
| 11 | Nicholas | Masaoe | Regional Health Officer | RHMT | BOX 110 Morogoro | | O | O |
| 12 | Jackson | Minja | Regional Cold Chain Officer | RHMT co-opted | BOX 110 Morogoro | | O | O |
| 13 | Seleman | Amri | Regional Radiographer | RHMT co-opted | BOX 110 Morogoro | | O | O |
| 14 | Mary | Magomi | Coordinator, Eastern Zonal Training Center | EZTC | BOX 1060 Morogoro | | O | O |
| 15 | Theonest | Mlolere | District Health Officer | Kilombero | BOX 47 Ifakara | | O | O |
| 16 | Esther | Ntyangiri | District Nursing Officer | Kilombero | BOX 47 Ifakara | 120 | O | O |
| 17 | Theresia | Kundy | Planning Officer | Kilombero | BOX 263 Ifakara | | O | O |
| 18 | Fred | Lwilla | DMO | Kilombero | BOX 47 Ifakara | | O | O |
| 19 | Nico | Chiduo | DMO | Kilosa | BOX 14 Kilosa | | O | O |
| 20 | Angelbert | Mkundo | District Nursing Officer | Kilosa | BOX 14 Kilosa | | O | O |
| 21 | Michael | Kessy | District Cold Chain Officer | Kilosa | BOX 14 Kilosa | | O | O |
| 22 | Jumanne | Teggo | HMIS Coordinator | Morogoro Rural | BOX 1862 Morogoro | 4851 | O | O |
| 23 | Peter | Nkulila | DHMT Member | Morogoro Rural | BOX 1862 Morogoro | 4851 | O | O |
| 24 | Harun | Machibya | DMO | Morogoro Rural | BOX 1862 Morogoro | 4851 | O | O |
| 25 | Alexander | Baguma | Municipal Health Officer | Morogoro Urban | BOX 166 Morogoro | | O | O |
| 26 | Nuru | Ahmed | Nursing Officer | Morogoro Urban | BOX 166 Morogoro | | O | O |
| 27 | Paulo | Baruti | Municipal Director | Morogoro Urban | BOX 166 Morogoro | | O | |
| 28 | Rogatus | Mbena | Clinical Officer | Morogoro Urban | BOX 166 Morogoro | | O | O |

| | First name | Last name | Title/Designation | | Address | Tel | 2-Dec | 3-Dec |
|---|---|---|---|---|---|---|---|---|
| 29 | Nelson | Mwasaga | Economist | Morogoro Urban | BOX 166 Morogoro | | O | O |
| 30 | Samson | Mweta | District Health Officer | Ulanga | BOX 4 Mahenge | | O | O |
| 31 | Pascal | Mbena | DMO | Ulanga | BOX 4 Mahenge | | O | O |
| 32 | Ali S.S. | Mwegole | Ag. DED | Ulanga | BOX 4 Mahenge | | O | O |
| 33 | Edwin | Bisakala | District Nursing Officer | Ulanga | BOX 4 Mahenge | | O | O |
| 34 | Henry | Kitange | Medical Officer in Charge of Regional Hospital | Regional Hospital | BOX 110 Morogoro | | O | O |
| 35 | Tatu | Kasuku | Hospital Matron (Regional Hospital) | Regional Hospital | BOX 110 Morogoro | | O | O |
| 36 | Diwan | Mruttu | Deputy Medical Officer in Charge of Regional Hospit | Regional Hospital | BOX 110 Morogoro | | O | O |
| 38 | Ahmed | Hingora | Head, PHC Secretariat | MOH | BOX 9083 DSM | | O | O |
| 39 | Kazuko | Hashimoto | Health Cooperation Planning Advisor | MOH/JICA | BOX 9450 DSM | | O | O |
| 37 | Philip | Hiza | Facilitator | Consultant | BOX 6544 DSM | 75397 | O | O |
| 40 | Noko | Fuwa | Japanese Mission Team | JICA/TOKYO | | | O | O |
| 41 | Keishi | Tsuchito | Japanese Mission Team | JICA/TOKYO | | | O | O |
| 42 | Akira | Endo | Leader, Japanese Mission Team | JICA/TOKYO | | | O | O |
| 43 | Takehiro | Susaki | JICA Tanzania Office | JICA/Tanzania | BOX 9450 DSM | 113727 | O | O |

⑥ 地方自治省による地方分権説明資料
(Status of the Implementation of the Local Government Reform Programme)

MINISTRY OF REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

# STATUS OF THE IMPLEMENTATION OF THE LOCAL GOVERNMENT REFORM PROGRAMME

*(A brief prepared for the JICA Delegation who met the Permanent Secretary, Ministry of Regional Administration and Local Government in Dar es Salaam on 1st December 1999)*

DAR ES SALAAM
DECEMBER, 1999

# STATUS OF THE IMPLEMENTATION OF THE LOCAL GOVERNMENT REFORM PROGRAMME

*(A brief prepared for the JICA Delegation who met the Permanent Secretary, Ministry of Regional Administration and Local Government in Dar es Salaam on 1st December 1999)*

## Introduction:

The Local Government Reform Programme seeks to improve the quality of and access to public services provided through or facilitated by local government authorities. In order for the local government authorities to be able to effectively undertake this task of improving on the delivery of services they should possess the following features:

- Largely autonomous institutions;
- Strong and effective institutions underpinned by possession of human and financial resources as well as authority to perform roles and functions;
- Institutions whose leaders are elected on a fully democratic process;
- Institutions which will facilitate participation of the people in planning and executing their development plans and foster partnerships with civic grounds;
- Institutions with roles and functions that will correspond to the demands for their services;
- Institutions which will operate in a transparent and accountable manner thus justifying their autonomy from central government interference.

## Amendment of the Local Government Acts, 1982

2. An act to amend the Local Government Acts, 1982 was passed by Parliament in February, 1999. That law (Act No. 6 of 1999) paves the way for the implementation of the reform of the local government system. Among other things, the Act seeks to do the following:

- to set out the new relations between central and local government including doing away with the concept of proper officer and assistant proper officer to councils;

- to give councils the authority to employ and manage their staff in terms of promotion, professional development and discipline;

- to give councils the authority to approve their plans and budgets;

- To enable Central Government to provide block grants to local government authorities;

- to strengthen democracy, accountability and transparency in the conduct of council business; and

- to implement the decision to devolve authority to the people through institutions which are close to them i.e. wards, village councils, hamlets and neighbourhoods.

3. As a strategic imperative, it has been decided to have the Local Government Reform Programme implemented in phases. The first phase involving 35 local government authorities will start in January 2000 followed by the second phase also to involve another batch of 35 local authorities a year later. The local government laws as amended also allow for phased implementation of sections thereof. The minister responsible for local government is thus empowered to issue regulations and procedures providing for the phased implementation of the law. The regulations which will be issued by the minister will, among other things, relate to:

- employment and staff management by local government authorities;
- local government financial management regulations;
- code of conduct for council employees;
- division of responsibilities among various levels of local government authorities;
- participation by the people in planning and implementation; and
- elections of grassroots leaders i.e. for hamlets, urban neighbourhoods and village councils.

**Appraisal of the Local Government Reform Programme (LGRP)**

4. In Government of Tanzania and the donors who are supporting local government reform carried out a joint appraisal on the LGRP in February – April, 1999. The Appraisal Team was specifically required to analyze the programme and confirm whether the design of the programme had taken into account the national policies relating to:

- decentralization of authority to the people;
- strengthening of the principles of good governance and gender equality

- improvement of and access to services;
- the existing capacity for the implementation of the programme
- the existence of the will to reform the local government system on the part of the Government and other stakeholders
- the extent to which major stakeholders were involved in the preparation of the programme; and
- the programme implementation strategy as a whole.

5. On the whole, the Appraisal Mission came up with a positive evaluation of the programme. The mission thus recommended to the Government and its development partners (donors) that the programme be supported and that they (government and donors) should mobilize the resources required for its implementation.

6. The following are some of the key recommendations made by the Appraisal mission.

(i) that the start-up period of the first phase be prolonged to allow necessary preparations to be put in place and enable a stronger local involvement;

(ii) that the system of block grants be introduced in stages over three to five years in order to phase in the reform more gradually and to allow the local authorities to adjust gradually;

(iii) that the monitoring and evaluation framework should be revisited and immediate attention should be given to developing the modalities for this;

(iv) that the modalities for running the Zonal Reform Teams which will assist the ministry (Local Government Reform Team) in building the capacity of the local authorities in the management of the reform should be reconsidered with a view to strengthening their operational capacity to support the reform process at local authority level;

(v) that ways and means to strengthen and broaden the governance component of the programme should be considered, more attention being given to mechanism for activating people in local governance especially at sub-district level; and measures to combat corruption should also be given more explicit attention;

(vi) that ways and means to strengthen programme activities at district level should be considered since the programme appeared to be too top-heavy and too consultant driven. Thus, the amount of resources to be spent on consultants and their role should be considered more critically; and

(vii) That the inclusion of a budget support component in the programme whereby the practical and organizational reforms at district level are accompanied by some additional resources to promote local development and alleviate poverty be considered. The reform should be accompanied by significant increases in transfers to local authorities.

**Action Plan and Budget of LGRP for the Period July, 1999 – December, 2004.**

7. The Ministry of Regional Administration and Local Government revised the Action Plan and Budget taking into consideration the recommendations and suggestions of the Joint Government and Donors' Appraisal Mission on LGRP. The action plan now covers the period July 1999 to December 2004 as summarized in the following table:

| PHASE | TIME FRAME |
|---|---|
| Preparation for Phase I | January – December 1999 |
| Mobilization Phase I | July – December 1999 |
| Implementation Phase I | January 2000 – December 2001 |
| Mobilization for Phase II | July – December 2000 |
| Evaluation of Phase I | January – April 2001 |
| Implementation of Phase II | January 2001 – December 2002 |
| Mobilization of Phase III | October – December 2001 |
| Implementation of Phase III | January 2002 – December 2003 |
| Consolidation of the Reform | January – December 2004 |

This sequencing has been adopted by the Interministerial Coordinating Committee of Permanent Secretaries as one which will also guide the implementation of the sectoral reforms implemented at the local level. The sectoral reforms include the Health Sector Reform and the Education Sector Development Programme.

8. What follows is a summary of some of the major outputs of the reform initiatives which will be pointed out under each of the LGRP components:

(i) **Governance Component**

- Stakeholders and especially the people to own the programme and participate in its implementation;

- More power on decision making and implementation to be provided to the people;

- Capacity to be provided to the councils in developing and implementing poverty alleviation projects;

- Gender issues to be considered in the execution of council activities as far as possible.;

- Level of accountability on the part of the councillors to be enhanced;
- Equal access to public services to be put in place;

- Strengthening of rule of law and adherance to rules and regulations;

- Improvement of relations between councillors and staff;

- Provision of civic education to enable the people to appreciate their rights and duties to their councils;

- Local authorities to conduct their affairs in a democratic manner including involvement of the people in planning and implementation;

- Councils to carry out their functions and responsibilities with transparency and accountability to the taxpayers;

- Level and quality of services provided by councils to be enhanced.

(ii) **Restructuring of Authorities**

- Councils to assume structures that will conform to the situation and needs of their areas;

- Councils to have structures which serve to improve service provision and which relate to existing financial situation;

- Councils to remain with the core functions necessary for service provision.

(iii) **Local Government Finances**

- Councils to be able to step up revenue collection from own sources;

- A fair and more rational division of revenue between Central and Local Government;
- Grants to measure up with expenditure responsibilities of councils;
- Council to be more serious in the management of its finances;
- Council to enhance accountability in the use of its finances;

- Local Government Financial institutions (LAPF and LGLB) to be studied and strengthened in order to support the local government system.

(iv) **Human Resource Development and Management**

- Councils to have the authority to employ and manage their staff;
- Staff to be recruited on merit and in a competitive and transparent manner;
- Councils to have staff with required qualifications and in proper numbers;
- Local Government Service Commission's and Teachers Service Commission's role and functions to be redefined;
- Councils' employees to be trained.

(v) **Legal Component**

- Laws to conform to reform requirements;
- Regulations for guiding council operations to be in place;
- Stakeholders to have a better understanding of the local government laws;
- Local government laws to be simplified and made available;
- A better system of legislating bylaws and enforcing them to be instituted

(vi) **Programme Management**

- The Ministry responsible for local government to be strengthened and have capacity building undertaken.

**Implementation Highlights**

9. As a result of the appraisal, the Action Plan and Budget document of the LGRP was revised to take account of some of the mission's recommendations which were accepted by the Government and Donors. On the strength of that, the Government allocated in its 1999/2000 budget TZS.43,750,000/=; a total of TZS 7.2. billion has been pledged by Donors through the Common Basket Fund for the year 1999/2000 namely the Netherlands, Finland, Norway, Denmark, Ireland, DFID, UNCDF and European Union. It is expected that other Donors will soon decide to also join the basket.

10. M/S PricewaterhouseCoopers Ltd have been selected after a competitive tender procedure, to support the Local Government Reform Team (LGRT) in the recruitment and management of the Zonal Reform Teams for a period of one

year after which the management of the same will pass on to the LGRT. Following the advertisement of the Zonal Reform Team posts in the local papers, quite an impressive response was received. Applicants with required qualifications were short-listed for interview. Interviews were conducted and 15 specialists in good governance, financial management and human resource development and organization were selected to form five Zonal Reform Teams of 3 members each. The Zonal Reform Teams members have undergone a four week orientation course relevant to their work and have been posted to their stations of work.

11. Preparations have been made for the introduction of a computer-based system of financial management and accounting, also known as Platinum system in some 28 local government authorities. Out of these, 16 are among the 35 Phase I local government authorities. The system has clear advantages including effective controls of expenditure, up-to-date maintenance of financial records and timely preparation of financial statements and reports such as quarterly reports, final accounts and bank reconciliation statements which are crucial for decision making by the council and council management. Training of staff who will operate the Platinum system will have been completed by mid December 1999. Computer hardware have been procured and installation of software will be done in readiness to start operation in the 28 local government authorities early in the year 2000.

12. The Local Government (Urban Authorities) Act No.8 of 1982 as amended by Act No.6 of 1999 allows the establishment of urban councils within the area of jurisdiction of an urban authority. The relevant clause has been invoked in the bid to establish three municipal councils and a city council within the Dar es Salaam. The boundaries of the municipalities and the wards forming them have been gazetted and the general public have been invited to lodge any objection to the establishment of the councils with the Ministry of Regional Administration and Local Government within 60 days. The order establishing the councils was laid before the Parliament during its October 1999 session as required by law. This move will lead to the establishment of legal structures at municipal and city levels which will prepare the way for the restoration of democratically instituted councils in Dar es Salaam after the general elections planned for October, 2000.

13. The Ministry of Regional Administration and Local Government prepared draft regulations which will guide the multi-party elections of Village Councils, Chairpersons and Committees of Mitaa (Neighbourhoods) and Chairpersons of Vitongoji (Hamlets). The draft regulations were a subject of discussion at meetings organized for the following stakeholders:

- National representatives of registered political parties
- Returning Officers for these elections who also happen to be the Council Directors

- District Commissioners
- Regional Administrative Secretaries
- Regional Commissioners

These meetings provided valuable contributions for making the elections not only free and fair but also cost effective. The elections are now being conducted country-wide and are expected to be concluded by the second week of December 1999.

**Interface Between the LGRP and Sectoral Reforms**

14. Both the LGRP and Sector Reforms aim at improving on the delivery of and access to services. An important intervention in this is the need to have decentralized management of staff by respective local authorities. This means that staff of appropriate numbers and qualifications should be recruited and managed by the local authorities in terms of promotions, professional development and disciplinary procedures. The law allows for the establishment of service boards at local authority level but this has been left to the discretion of the local authorities and when such boards are established they should be accountable to the respective local authorities. It is however emphasized that the decision as to the organizational structure at the local level rests with the local authorities although they will be technically assisted in this task by the Zonal Reform Teams and the Regional Secretariats.

**Conclusion**

15 The continued commitment on the part of the Government to reform the local government system needs to be effectively complemented by a vigorous mounting of awareness creation which will be more effective if it will be approached on a joint basis between the LGRP, the Public Sector Reform Programme, the Health Sector Reform, and the Education Sector Development Programme. Already, some steps have been taken to establish a National Joint Advocacy Task Team. This task team as well as similar ones to be established at the local level will be instrumental in conveying the right messages on the reforms and minimize fears of the reforms among stakeholders.

16 In addition to enjoying political commitment, the programme will also have the support of the people of Tanzania who for a long time have demonstrated a wish to have a reformed system of local government which can answer to their demands for improved services. With proper mobilization therefore it is possible for the people to become the major sponsors of the programme. And with the support of development partners like JICA, efforts to reform the local government system will be effectively augmented and the programme will stand better chances of success.

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⑦ 他ドナー資料
⑦－1 GTZ

# United Republic of Tanzania
# Ministry of Health
# and
# German Technical Cooperation (GTZ)

# District Health Support Project (DHSP)
# Tanga region

GTZ PN.94.2095.1

# Plan of Operations
# January 1999 – December 2002

The **District Health Support Project (DHSP)** supported by **GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit)** is a bilateral German-Tanzanian health project running formerly since 1994 as Family Health Project (FHP). It is aiming at the improvement of all district health services in Tanga region. It is supporting the main concepts of the health sector reform as described in the Plan of Work 1999-2002. Although still a bilateral project it is conceived fully in line with the Sector Wide Approach (SWAP) and is increasingly using national accounting systems which meet the requirements of transparency and efficiency.

DHSP is planned and has to be seen as one out of five projects, which are commonly, and comprehensively supporting the Tanzanian health sector. These other GTZ supported projects are

- Reproductive Health in Tanga and Lindi Region
- MPH Course at Muhimbili University College Dar es Salaam
- Joint Government and Church Services (Christian Social Service Commission)
- AIDS Control in Mbeya Region.

The project planning is based on the results of a project progress review by the team of all DMO in Tanga region and M.Mapunda and Dr.B.Schmidt-Ehry 1998. The planning workshop took place at Panori Hotel in Tanga Municipality in April 1998 (ZOPP 5). The German Government by the end of 1998 approved the project-planning document.

The plan of Operations follows the planning matrix, which was worked out at this workshop. The present document covers the entire project period. Adjustment may be done in the annual plans of work or at the occasion of a mid-term review, which is planned for the end of 2000.

This Plan of Operations has been prepared by the DHSP team of coordinators and was compiled by the RHMT and all DHMT in a meeting in May 1999.
The budgets allocated to the different outputs are tentative. They are not binding and can be adjusted according to new challenges and/or unforeseeable circumstances.

**District Health Support Project (DHSP)**
GTZ PN. 94.2095.1

Regional Medical Officer Tanga Dr.William Mwengee Tel. 053-801619

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| Project Purpose: | Reformed District Health Services in Tanga Region provide effective and efficient preventive and curative health care |
|---|---|

| Indicators | 1999 | 2000 | 2001 | 2002 | Remarks |
|---|---|---|---|---|---|
| P1<br>Utilisation rate of out-patient-departments in hospitals and health centres/ dispensaries is steadily increasing and lies by 5/2002 above 0.8 new contacts / person /year in each district | | | | | |
| P2<br>90% of the children under 1 year are DTP 3 vaccinated in each district | | | | | |
| P3<br>Proportion of caesarean sections lies between 3 and 5% out of all expected births in the district and between 7-10% out of all hospital deliveries (WHO Target) | | | | | |
| P4<br>Increasing number of first line health services (FLHS) meet minimal quality criteria (rating assessment based on health information system results and supervision checklist) | | | | | |

**Output 1: The DHSP Co-ordination unit at national level promotes and co-ordinates the contributions to the health sector-reform (HSR) within a sector wide approach (SWAP) effectively**

| Indicators | 1999 | 2000 | 2001 | 2002 | Remarks |
|---|---|---|---|---|---|
| 1.1 Number of HSR-related strategies which are implemented and evaluated jointly with other partners of the SWAP, resulting in complementary activities | | | | | |
| 1.2 Communication (reports, meetings) with German projects, partners is organised satisfactorily | | | | | |
| 1.3 At least 2 bilateral review meetings with the Ministry of Health (MOH) take place each year | | | | | |
| 1.4 At least half yearly reporting on health sector development to German partners | | | | | |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | Respons. | Budget | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | | | |
| 1.1. Ensure overall monitoring of DHSP (and MPH Course) including feedback to Region and Districts | | | | | | | | | | | | | | | | | | | | |
| 1.2. Provide technical backstopping and information of policy decisions from central level | | | | | | | | | | | | | | | | | | | | |
| 1.3. Ensure control of financing agreements, financing flow and procurement | | | | | | | | | | | | | | | | | | | | |
| 1.4. Organise meetings with all German partners in health sector (GTZ, DED, CIM) | | | | | | | | | | | | | | | | | | | | |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 1.5. Ensure close links with the MOH and partners through meeting, information, co-operation | | | | | | | | | | | | | | | | | | | | |
| 1.6. Provide financial support in joint MOH / Partners reviews and evaluations of the HSR | | | | | | | | | | | | | | | | | | | | |
| 1.7. Organise co-operation with relevant institutions /NGO in the country and the region | | | | | | | | | | | | | | | | | | | | |
| 1.8. Document and report on the development of HSR process with newsletter (Rundbriefe) | At least 2 newsletters per year | | | | | | | | | | | | | | | | | | | |
| 1.9.Design and follow up of studies regarding HSR, private providers, gender etc. | | | | | | | | | | | | | | | | | | | | |
| 1.10. Organise study visits and exchange views on implementation of SWAP | | | | | | | | | | | | | | | | | | | | |
| 1.11. Organise the continuation of the MPH Course at the IPH in DSM | The course starts in Oct. 1999 | | | | | | | | | | | | | | | | | | | |
| 1.12. Organise a mid-term review and other monitoring meetings | | | | | | | | | | | | | | | | | | | | |
| 1.13. Observe and participate in international discussion on public health strategies | | | | | | | | | | | | | | | | | | | | |
| 1.14. Organise / participate in regional networking of German-EZ | A workshop takes place at latest by March 2000 | | | | | | | | | | | | | | | | | | | |

**Output 2: The capacity of the Regional Health Management Team (RHMT) of Tanga Region to perform its functions in support, co-ordination, monitoring an inspection of the health districts is enhanced**

| Indicators | 1999 | 2000 | 2001 | 2002 | Remarks |
|---|---|---|---|---|---|
| Annual work-plan of RHMT is established by May each year and implemented for the fiscal year (July to June) | | | | | |
| At least 80% of the programmes of relevant Donors and NGO's as well as 100% of all Vertical Programmes are integrated into the District Health Plans (DHP) | | | | | Milestone: The programmes of donors and NGO, as well as the vertical programmes taken into account for this indicators will be selected till 8/99 |
| An increasing number of inspection visits conducted, documented and followed up through appropriate actions | | | | | |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 2.1. Organise trainings on new roles and tasks of RHMT and the needed technics and skills in communication, moderation etc. | | | | | X | X | X | X | | | | | | | | | | RHMT | | Supported by DANIDA |
| *2.1.1. Equip the districts with computer equipment and train DHMTs* | *The indicator from 2.1.2 comes here!!!* | | | | X | X | X | | | | | | | | | | | *RHMT* | | *PC equipments to be provided by October 99 by KfW* |
| *2.1.2. Training of the DHMTs on quality management* | *Till 6/2000 two members of each DHMT are trained to handle the computer* | | | X | | | | | | | | | | | | | | *RHMT* | | *Support by DANIDA* |
| *2.1.3. Organise training of DHMTs in district management (health reform)* | | | | | | X | X | X | | | | | | | | | | *RHMT* | | |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 2.2. Support RHMT in working out annual Regional Health Plan | | | X | | | | X | | | | X | | | | X | | | RHMT DHMT | | |
| 2.3. Renovate offices of the RHMT ensuring minimum standards | | | | | | X | X | X | X | | | | | | | | | RHMT DHSP | | |
| 2.4. Establish information unit (including subscription to scientific journals) | By 12/99 a library is established in the meeting room of RHMT in Tanga | | | | X | X | | | | | | | | | | | | RHMT DHSP | | |
| 2.5. Facilitate RHMT to support and monitor outbreak management in the district, and develop further the concept | | | | | X | X | | | | | | | | | | | | RHMT | | |
| *2.5.1. Strengthen the task force by appropriate training* | | | | | X | X | | | | | | | | | | | | RHMT | | |
| *2.5.2. Organise workshops together with other partners in order to develop a comprehensive.concept* | | | | | X | X | | | | | | | | | | | | RHMT | | In co-operation with MSF |
| *2.5.3. Training of DHMTs in outbreak management* | | | | | X | X | | | | | | | | | | | | " | | |
| *2.5.4. Improve organisation of the emergency unit* | | | | | X | X | | | | | | | | | | | | " | | |
| 2.6. Support annual DHMT meeting of Tanga Region | | | X | | | | X | | | | X | | | | X | | | RHMT DHSP-CO-T | | |
| 2.7. Promote advocacy in HSR and SWAP at regional and district level | | | | | | | | | | | | | | | | | | RHMT CO-DAR | | |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| *2.7.1. Organise meetings to promote health sector in SWAP* | | | | | | | | | | | | | | | | | | " | | |
| 2.8. Organise a follow-up of the on-going reforms | | | | | | | | | | | | | | | | | | " | | |
| 2.9. Support RHMT to hold one annual planning meeting on Health related projects with donors / NGO / vertical programs | | | X | | | | X | | | | X | | | | X | | | RHMT CO-T | | |
| 2.10. Support RHMT in formulation of research proposals identified by districts and fund raising | By 1/2000 several study proposals written by the DHMTs or the RHMT for field studies are available (especially for master course students) | | | | | | | | | | | | | | | | | RHMT CO-T | | Cooperation with NIMRI |
| *2.10.1. Assist the districts to define health related topics* | | | | | | | | | | | | | | | | | | " | | |
| *2.10.2. Assist the district to formulate research proposals* | | | | | | | | | | | | | | | | | | " | | |
| *2.10.3. Organise financing of the research* | | | | | | | | | | | | | | | | | | " | | |
| 2.11. Organise regular supervision of the districts | At least quarterly supervision visits to each district | | | | | | | | | | | | | | | | | RHMT | HSPS (DANI DA) | |

## Output 3: District Health Boards (DHB) in the District of Tanga Region are established and functional

| Indicators | 1999 | 2000 | 2001 | 2002 | Remarks |
|---|---|---|---|---|---|
| 3.1 District Health Boards in 6 Districts constituted with own account and funds by 6/2000 | | | | | |
| 3.2 District Health Boards in 6 Districts have taken over responsibility for staff of public health service by 12/2002 | | | | | Only 2 are left |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 3.1. Adapt proposal of formation composition and functioning of DHB | | X | X | X | X | X | | | | | | | | | | | | CO-Tga, DSM RHMT, DHMT HSRIT | | |
| 3.2. Organise advocacy campaign for health personnel, for District Leaders, Council, Ward Development Committee, NGO, Health Personnel and general Public | An action plan for all districts is elaborated in close collaboration with the RHMT by 9/1999 | X | X | X | X | X | | | | | | | | | | | | DHSP, MoH RHMT, DHMT | | |
| 3.3. Support preparation of by-laws and directives | | X | X | X | X | X | X | | | | | | | | | | | DHSRIT, DED | | |
| 3.4. Support work of selection committee | | X | X | X | X | X | X | | | | | | | | | | | DHSRIT | | |

| Activities | Indicators | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 3.5. Support MoH and Ministry of Local Government to familiarise DHB members and DHMT on roles and functions | | X | X | X | X | X | X | X | | | | | | | | | | Co Tga, DSM DHMT RHMT | | |
| 3.6. Support establishment of DHB account and monitor regular flows of fund | By 12/99 there are 4 DHB with accounts, by 6/00 | X | X | X | X | X | X | X | X | | | | | | | | | DHSP DED, DHB | | Internal auditing |
| 3.7. Organise periodic reviews of functioning of DHB | | | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | DHB | | Prepare agreement with DED |

**Output 4: Existing and alternative health financing schemes in Tanga Region ensuring equity arc further developed and implemented**

| Indicators | 1999 | 2000 | 2001 | 2002 | Remarks |
|---|---|---|---|---|---|
| I-4.1. Percentage of actual income from cost sharing schemes in relation to potential income at district hospitals and FLHS shows an increasing trend | | | | | Milestone: A study of the potential income is done till 6/2000 |
| I-4.2. Increasing number of FLHS per district in which cost sharing scheme is introduced | | | | | The number of FLHS with cost sharing systems is known and followed up |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | Responsible | Budget | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | | | |
| 4.1. Support training courses by IPH/MUCHS and MOH on Financing and FAMS for relevant district staff (in Dar) | | | | | | | | | | | | | | | | | | | | |
| 4.2. Assist District hospitals to develop and implement consistent and comprehensive collection and accounting scheme | At all hospitals less than 3 collection points | | | | | | | | | | | | | | | | | | | Should be done with local authorities |
| 4.3. Support development of equity oriented cost sharing scheme for FLHS in line with FAMS | | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | DHMT | | " |

| Activities | Indicators | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 4.4. Support dissemination (information, advocacy) campaign of cost sharing schemes | All health facilities taking user fees have a well visible price list for services | | | X | X | | | | | | | | | | | | | DHMT, DED, Chairman / Councillor | | Involve DED, DC |
| *4.4.1. Advocacy to councillors, WDC, VDC* | | | | | | | | | | | | | | | | | | | | |
| *4.4.2. Advocacy to health workers* | | | | | | | | | | | | | | | | | | | | |
| 4.5. Monitor functioning of cost sharing scheme of FLHS | | | | | | | | | | | | | | | | | | | | |
| *4.5.1. Assess daily practice* | | | | | | | | | | | | | | | | | | | | |
| *4.5.2. Conduct training /assessment –workshops* | | | | | | X | X | X | X | X | X | X | X | X | X | X | X | MUCH | | |
| *4.5.3. Conduct operational research* | | | | | | | | | | | | | | | | | | | | |
| 4.6. Study community perception and methods of community involvement | | | | | | X | X | | | | | | | | | | | RHMT, DHMT | | Health economist to be recruited |
| 4.7. Develop models for community based Health Insurance Scheme for Tanga | By 12/99 one community (e.g. a parish) is identified and willing to test this approach | | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | RHMT | | Operational research |
| 4.8. Improve and apply cost sharing exemption mechanism | | | | | | | | | | | | | | | | | | | | |

## Output 5: The management capacity of District Health Management Teams in Tanga Region is enhanced

| Indicators | 1999 | 2000 | 2001 | 2002 | Remarks |
|---|---|---|---|---|---|
| 5.1: Yearly District Health Plan based on the National planning guidelines and including resources of all partner is available before beginning of financial year | | | | | |
| 5.2. At least 80% of all planned supervision visits by the DHMT are actually carried out according to the standard checklist in each district.<br>Target: 4 visits per year in each health facility | | | | | |
| 5.3. DHMT meetings conducted at least once per month in each District and decisions taken documented. | | | | | |
| 5.4 At least 80% of DHMT members trained comprehensively in Human Resources Management by end of 12/2000 | | | | | |

| Activities | Indicators | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 5.1. Support DHMT's management needs assessment and further training | | | | | | | | | | | | | | | | | | RHMT, CO-T | | |
| *5.1.1. Training on relevant topics* | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | " | | |
| *5.1.2. Training on data analyses, computer skills* | See 2.11 | | | | | X | X | | | | | | | | | | | " | | |

| Activities | Indicators | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 5.2. Adapt planning procedures of District Health Plan (DHP) including needs of District hospitals (including recurrent-development) | | | | | | | X | | | | X | | | | X | | | " | | 4 module-DHMT Course.<br><br>Covers 5.3. - 5.6 |
| 5.3. Organise training for key hospital staff on management skills (training modules) | | | | | | X | X | X | X | | | | | | | | | DHMT, RHMT | | |
| 5.4. Monitor quality of planning/implemen-tation of DHP | | | | | | | | | | | | | | | | | | RHMT, DHMT,C O-T | | |
| 5.5. Familiarise DHMT with principles of staffing, career planning | By 6/2000 a human resource management concept is elaborated | | | | | X | X | X | X | | | | | | | | | RHMT, DHMT | | |
| 5.6. Organise training and follow -up for DHMT's on team building and leadership | | | | | | X | X | X | X | | | | | | | | | RHMT, DHMT | | |
| 5.7. Support quality management in the district | | | X | | | | X | | | | X | | | | X | | | DHMT/ RHMT | | DANIDA Funded |
| *5.7.1. Training on quality assurance (baseline study)* | | | | X | | | | | | | | | | | | | | " | | |
| *5.7.2. Conduct a base study in order to establish a set of key-indicators* | | | | | X | | | | | | | | | | | | | | | |
| *5.7.3. Inıroduce performance oriented bonus scheme* | By 6/2000 a concept is elaborated by the RHMT | | | | | X | | | | | | | | | | | | DHMT/ RHMT | | DANIDA Funded |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| *5.7.4. Training on quality circle approach* | | | | | | X | X | | | | | | | | | | | | | |
| *5.7.5. Continuous monitoring and supervision* | | | | | | | | | | | | | | | | | | | | |
| 5.8. Support DHMTs in preparation and establishment of an indent drug supply system | | | | | | | | | | | | | | | | | | RHMT CO-Tng CO-DAR | | Piloted in Morogoro, maybe in Tanga by 2001 |
| 5.9. Provide districts with emergency drugs for emergencies | | | | | | | | | | | | | | | | | | RHMT | | |
| 5.10. Support DHMT Lushoto with supplies and funds for plague control | | | | | | | | | | | | | | | | | | RHMT, DHMT, CO-T, CO-DAR | | |
| 5.10.1 Research alternative strategies (community based) for efficient plague control | | | | | X | X | X | | | | | | | | | | | RHMT CO-T | | |

## 6. Measures to improve performance of staff in District hospitals and FLHS implemented

| Indicators | 1999 | 2000 | 2001 | 2002 | Remarks |
|---|---|---|---|---|---|
| 6.1. 100% of the Health Units have at least one staff member trained in case management of malaria, childhood diseases (IMCI), Tuberculosis (DOTS) by 12/2001 | | | | | Milestone: Till 9/1999 the exact number of trained staff is known. |
| 6.2 At least one quality circle of health professionals is established in each District Hospital each year | | | | | |
| 6.3. For all FLHS procedures and guidelines for the indent drug supply are introduced together with corresponding staff training by 12/2000 | | | | | |

| Activities | Indicators | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 6.1. Support training of health workers (HWs) to enhance clinical and communication skills | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | RHMT DHMT | | Mainly training on Malaria and IMCI |
| *6.1.1. FLHS need up- grading on skills (RMA to Clinical officers)* | | | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | " | | |
| *6.1.2. Support the up grading skills on malaria control* | | | | | | | | | | | | | | | | | | " | | |
| 6.2. Make guidelines for treatment and procedures available for HWs | | X | | | | X | | | | X | | | | X | | | | DMO, HS | | Guideline to be made available in the district |

| Activities | Indicators | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 6.3. Initiate quality assurance systems (e.g. peer review circles for staff performance) | | | | X | X | X | X | | | | | | | | | | | DHSP, DHMT | | |
| 6.4. Organise training of decision makers on disciplinary procedures | | | | | X | | | | X | | | | | | | | | RHMT | | Local authorities to be included |
| 6.5. Initiate incentives system for good performance | | | X | X | X | X | X | X | X | | | | | | | | | DHMT | | |
| 6.6. Improve procedure for supervision visits | | | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | DHMT | | Checklist |
| 6.7. Support advocacy on community rights and obligations regarding quality of health care | | | | | | X | X | X | X | X | X | X | X | X | X | X | X | DHMT RHMT | | Training on quality care 6.7. + 6.8 = social mobilisation |
| 6.8. Organise theatre and film sessions in communities for information and mobilisation | In each districts either film or theater sessions take place | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | DHMT, DHSP | | |
| 6.9. Support professional associations (Tarena, TPHA, TAMA, etc.) to ensure ethical conduct | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | DHMT, RHMT, DHSP, FLHS | | Organise meeting with Tarena |
| 6.10. Support training for and implementation of indent drug system | | | | | | X | X | X | X | | | | | | | | | DHMT | | |
| 6.11. To strengthen the control activities against malaria | By 2000 all DHP contain specific activities for better malaria control | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | DHMT | | cooperation with PSI |

## 7. Physical infrastructure and essential equipment of health facilities improved

| Indicators | 1999 | 2000 | 2001 | 2002 | Remarks |
|---|---|---|---|---|---|
| I-7.1: At least 80% of essential equipment in the district hospitals (water supply, autoclave, microscope, suction machine) is functional or replaced within one month in case of break-down | | | | | Till 12/99 a system to monitor this indicator is in place in all districts |
| I-7.2. All rehabilitation measures according to district priorities and criteria of community participation are implemented by 12/2202 | | | | | Attention: This indicator should be removed |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 7.1. Support rehabilitation of health facilities in close collaboration with the councils / DHB | | | | | | | | | | | | | | | | | | RHMT<br>DHMT<br>CO-T<br>CO-DAR | | |
| 7.2. Strengthen District/Regional maintenance units | | | | | | | | | | | | | | | | | | | | |
| *7.2.1. Implement the most important recommendations of the HTCT for Tanga Region* | | | | | | | | | | | | | | | | | | | | Include. Role of Bombo Hospital? |
| *7.2.2. Give support to make run the Reg. maintenance workshop* | | | | | | | | | | | | | | | | | | RHMT<br>CO-T | | |
| *7.2.3. Finalise the concept in order to make the approach sustainable* | | | | | | | | | | | | | | | | | | RHMT<br>CO-T | | |

| Activities | Indicators | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 7.3. Support implementation of appropriate waste disposal measures in HFs | | | | | | | | | | | | | | | | | | RHMT<br>DHMT | | |
| 7.4. Provide supplementary essential equipment according to District priorities | By 12/99 all DHMT have an updated list of equipment | | | | | | | | | | | | | | | | | RHMT<br>DHMT | | Inventory? |

| 8. The contribution of non-governmental health facilities to the District health systems is improved | | | | | |
|---|---|---|---|---|---|
| **Indicators** | **1999** | **2000** | **2001** | **2002** | **Remarks** |
| 8.1. Increasing share of non- governmental Health facilities (n-g HF) in each district | | | | | |
| 8.2. By 02/2000 all n-g HF are covered by DHMT activities (planning, supervision, training) | | | | | |
| 8.3. By 12/2000 more than 80% of n-g HF apply HMIS and FAMS | | | | | |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8.1. Conduct a baseline study on potential of non-governmental providers in the Districts | | | | | | | | | | | | | | | | | | RHMT / DHMT CO-T | | Involvement of Private H. Association |
| 8.2. Make sure that n-g HF are covered by DHMT activities (planning supervision, training) | % of n-g HF supervised | | | | | | | | | | | | | | | | | | | |
| 8.3. Support n-g HF in using the tools and regulations within DHS | % of n-g HF reporting (MTUHA) | | | | | | | | | | | | | | | | | | | |
| 8.4. Contact associations of private providers and CSSC for co-operation | | | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | DHC? | | |
| 8.5. Establish incentive schemes (promotion funds) for n-g HF | | | | | | X | | | | | | | | | | | | | | Concept has to be worked out |

| Activities | Milestones | 1999 | | | | 2000 | | | | 2001 | | | | 2002 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | II | III | IV | I | II | III | IV | I | II | III | IV | I | II | III | IV | Responsible | Budget | Remarks |
| 8.6. Provide technical assistance for establishing and running n-g HF | | | | | | | | | | | | | | | | | | | | |
| 8.7. Co-operate with the church run HF for training purposes | | | | | | | | | | | | | | | | | | | | Help see their perfor-mance |
| 8.8. Co-operate with private pharmacies | nbr. of private ph. included | | | | | | | | | | | | | | | | | | | |
| *8.8.1. Study the importance and possibilities to cooperate* | | | | | | | | | | | | | | | | | | | | |
| *8.8.2. Organise seminars on different topics (prescription, ess. drug, MSD etc)* | | | | | | | | | | | | | | | | | | | | |

Mradi wa Uimarishaji
wa Huduma Muhimu za Afya
Mradi wa Pamoja Kati ya Wizara
ya Afya Tanzania na IDRC Canada

TEHIP
MUHUMA

Tanzania Essential
Health Interventions Project
A Joint Initiative of Tanzania's Ministry of Health and
Canada's International Development Research Centre

# FREQUENTLY ASKED QUESTIONS

## What is TEHIP?

*The Tanzania Essential Health Interventions Project is a collaborative venture between Tanzania's Ministry of Health and Canada's International Development Research Centre. TEHIP was established to test innovations in planning, priority setting and resource allocation in the context of ongoing health reform. Funding is provided by both the Governments of Canada and Tanzania.*

## What does TEHIP do?

*TEHIP examines the feasibility of institutionalizing a more evidence-based approach to planning in the specific context of decentralization at the District level in Morogoro Rural and Rufiji Districts.*

## What Questions does TEHIP address?

*How and to what extent can district health plans be more evidence based (e.g. evidence from burden of disease, cost-effectiveness, community voice and system capacity); how and to what extent can such plans be implemented; and how, to what extent, and at what cost do such planning interventions have an impact on population health?*

## How was TEHIP conceived?

*Over a period of three years following publication of the WDR 1993 Report "Investing in Health", a series of broad consultative design conferences were held at international and national levels involving health development and research practitioners from a wide variety of multi-lateral, bilateral, government and academic institutions (World Bank, WHO, IDRC, CIDA, UNICEF, Edna McConnell Clark Foundation and the Government of Tanzania) to agree on the hypotheses to be tested and the approach to be taken.*

## What is the time frame of TEHIP?

*Support to the project officially commenced in late October 1996, while support to Districts and to the Tanzanian research community began in 1997. The project will at minimum, unfold over 4 annual district health planning cycles ending in 2001.*

## Why does TEHIP include Research with Development?

*Following the WDR '93, there has been growing interest in basing systems development on a foundation of evidence. How to do this is unknown, especially at the District level where health reforms are delegating more responsibility and authority. Therefore TEHIP is about testing a new process of planning and priority setting. Tanzania has recognized that the health reform process includes research. All TEHIP research is conducted by consortia of Tanzanian research institutions.*

**What is happening now?**

*Full time research is underway in the areas of:*

- *Health Systems:* *DHMT Planning and Implementation Processes*
- *Health Behavior:* *Household Trends in Utilization of Essential Health Interventions*
- *Health Impacts:* *Direct demographic surveillance of mortality and morbidity*
- *Planning Tools:* *Development of practical tools for priority setting and planning*

**Regular Development activities at the district level addressing**

- *direct funding support to district health planned activities for essential health interventions training and delivery (IMCI, ITNs, EPI, STD, TB-Dots)*
- *financial and administrative support and capacity building (e.g.) Provision of training in computers, DHMT office refurbishment, funding support to transport and communications, strengthening budgeting and accounting of the district health plan, implementation of a Cost Tracking System at facility level.*
- *Capacity building to address areas of weakness e.g. team building, delegation, management, communication, planning, reporting.*
- *Community involvement initially targeting community-driven health facility rehabilitation and maintenance.*

**What is TEHIP's role in defining the Essential Health Interventions Package?**

*TEHIP does not prescribe the package, but proposes and tests principles by which District Planners can improve technical and budget allocation efficiency and select the best mix and coverage of cost-effective interventions in response to their priority burdens of disease.*

**What are TEHIP's envisaged outputs which will promote and assist Health Sector Reform?**

*The importance of cost effectiveness and sustainability cannot be understated. Through piloting research and development activities, TEHIP will progressively design and formulate, a series of "Tools". The ultimate tool kit should provide the necessary "ingredients" which will permit all districts within the country to quickly and effectively understand and implement decentralized health service delivery. Examples under test are tools for cost tracking, community voice, district health budget planning matrix, burden of disease analysis cost effectiveness, district health planning, etc.*

**For more information please contact (see below)**

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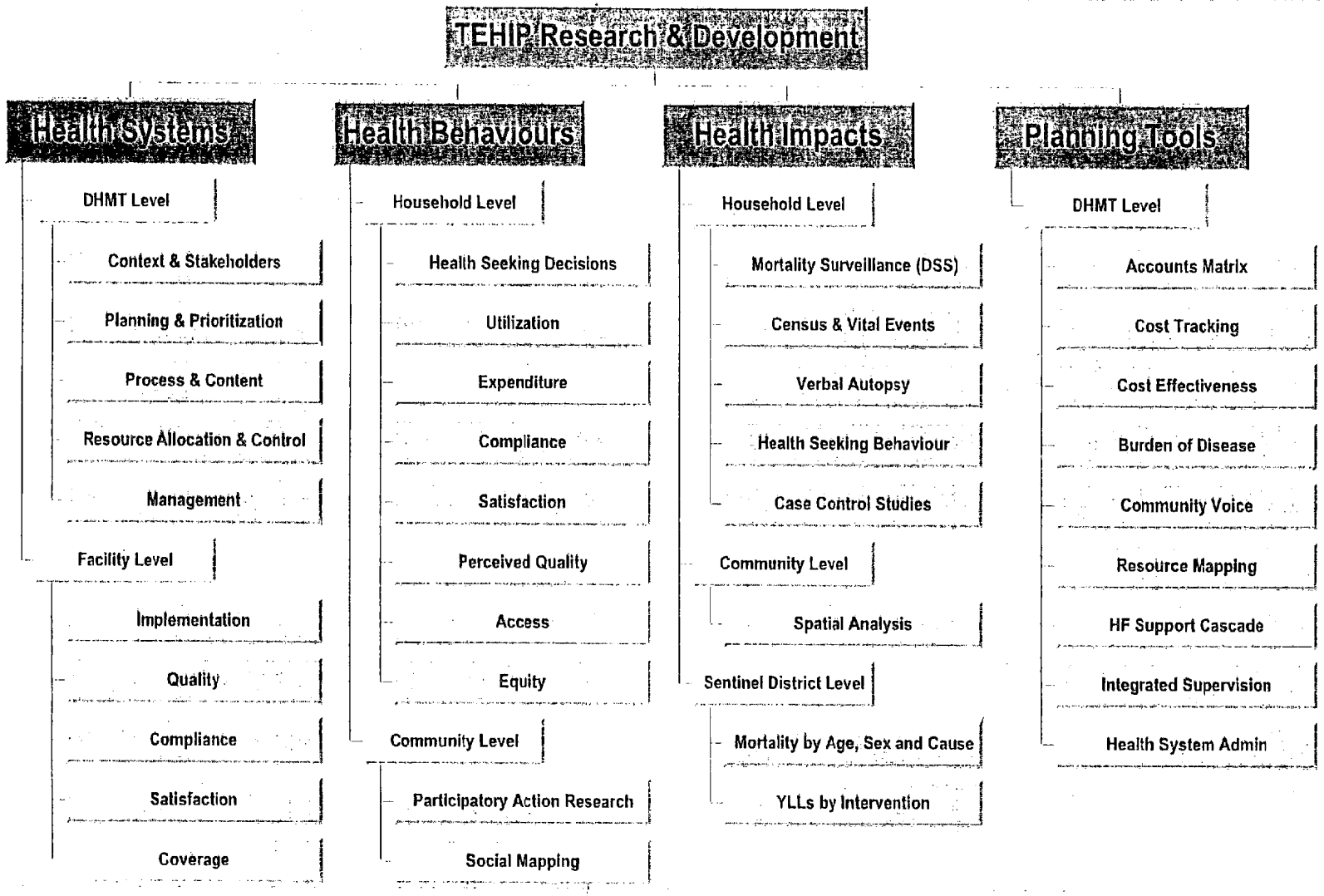
# District, Community, and Household Level Research in TEHIP




Tanzania Minstry of Health / IDRC TEHIP Essential Health Interventions Project

PROJECT: TANZANIA ESSENTIAL HEALTH INTERVENTIONS PROJECT (TEHIP) A FOUR YEAR JOINT INITIATIVE BETWEEN MOH TANZANIA AND IDRC - CANADA (1997/8 -2000/01)

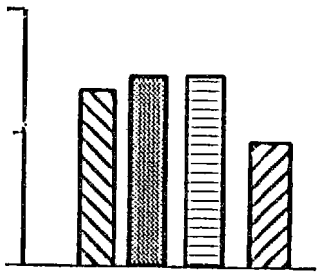
COUNTRY: TANZANIA, EAST AFRICA

DISTRICTS: MOROGORO (R) AND RUFIJI DISTRICTS

| NARRATIVE SUMMARY | SUSTAINABLE RESULTS | VERIFIABLE INDICATORS | MEANS OF VERIFICATION | CRITICAL ANALYSIS |
|---|---|---|---|---|
| PROJECT GOAL<br><br>To test the feasibility and measure the impact of an evidence-based approach to health planning at the district level | LONG TERM EFFECT/IMPACT<br><br>• New knowledge experiences and developments concerning this approach to health sector reform and health delivery service delivery.<br><br>• New knowledge on the value and use of health management information at the district level in determining the type, scale and cost of essential health interventions<br><br>• Wiser health investment decisions in the health sector. | V.I. TO GOAL<br><br>• Results included in health reform strategies and plans at the national and district level.<br><br>• Appropriate levels of support to and investment in evidence-based planning for essential health interventions at the district level. | • Scientific journals<br><br>• Government Health Budgets<br><br>• International Donor reports<br><br>• MOH reports<br><br>• MOH Policies and Plans | CRITICAL ASSUMPTIONS RE: GOAL<br><br>• That EHIP is accepted as a valid demonstration for health sector reform.<br><br>• That approaches and processes prove to be easily transferable and replicable.<br><br>• That policy and program planners at both the districts and national levels respond decisively to research findings and recommendation. |

| NARRATIVE SUMMARY | SUSTAINABLE RESULTS | VERIFIABLE INDICATORS | MEANS OF VERIFICATION | CRITICAL ANALYSIS |
|---|---|---|---|---|
| PROJECT PURPOSE/ OBJECTIVES<br><br>TEHIP will seek to:<br>a. Strengthen district level capacity to plan and set priorities using burden of disease and cost-effective analyses for resource allocation;<br><br>b. Increase district level capacity to effectively deliver the selected health interventions;<br><br>c. Assess and document lessons learned in district health planning and management systems/processes.<br><br>d. Measure the overall impact of delivered health interventions in terms of burden of disease (BOD). | SHORT- TERM EFFECT/IMPACT<br><br>• Increased capacity and knowledge at the district level to plan and deliver cost-effective essential health interventions.<br><br>• Increased knowledge and understanding at the district level of health planning and management systems/processes.<br><br>• Broad acceptance of the concept of health planning based on burden of disease and cost-effectiveness analyses. | V.I. TO PURPOSE<br><br>• Districts Health Teams understanding and working effectively evidence-based health planning techniques and processes.<br><br>• Improved communications between health authorities, health practitioners and communities.<br><br>• Priorities determined and resources allocated based on District Health Plans.<br><br>• Improved community effectiveness of essential health interventions | • MOH Reports and Plans<br><br>• District Health Plans<br><br>• District Health Budget<br><br>• Research results<br><br>• TEHIP Reports and Discussion Papers<br><br>• Monitor and Evaluation Reports | CRITICAL ASSUMPTIONS Re: PURPOSE<br><br>• That there is GOT commitment that levels of health funding for Rufiji and Morogoro (Rural) districts do not fall below levels specified in the Memorandum of Understanding.<br><br>• That GOT, Districts and communities accept and support the selected essential health interventions.<br><br>• That research findings are clear and plausible from a development planning viewpoint. |

| NARRATIVE SUMMARY | SUSTAINABLE RESULTS | VERIFIABLE INDICATORS | MEANS OF VERIFICATION | CRITICAL ANALYSIS |
|---|---|---|---|---|
| PROJECT OUTPUTS<br><br>1. Answers provided to three essential project questions. How, to what extent can:<br><br>i. District Health Management Team establish priorities and plan the allocation of resources according to local estimates of burden of disease and cost effectiveness of relevant interventions?<br><br>ii. District Health Plans be translated into the delivery of and use of the essential health interventions? and<br><br>iii. How, to what extent and at what cost does this have an impact on burden of disease?<br><br>2. District Health Teams having a demonstrated ability to plan and manage district level health resources. | OUTCOME<br><br>• Improved health planning and delivery of essential health interventions resulting in reduced burden of disease at the district level.<br><br>• Better comprehensive district health plans involving input from government, NGOs and the private sector.<br><br>• Improved ability to manage health resources at the district level.<br><br>• Improved allocation of health resources based on BOD priorities and cost-benefit analyses.<br><br>• District level health practitioners better motivated and more involved in planning and the delivery of essential health interventions. | V.I. TO OUTPUTS/ OUTCOME<br><br>• Evidence of change in District Health Planning<br><br>• Evidence of change in the allocation of health resources at the district level<br><br>• Evidence of acceptable financial management practices at the district level.<br><br>• Reduced mortality and morbidity levels.<br><br>• Community and consumer acceptance of health interventions introduced and the participatory approach employed in determining type and level of service needed. | • District Health Reports and Statistics<br><br>• Surveys<br><br>• TEHIP Field Reports<br><br>• TEHIP Research Reports<br><br>• Seminar and Workshop Proceedings<br><br>• Monitor and Evaluation Reports<br><br>• District Financial and Management Audit | CRITICAL ASSUMPTIONS Re: OUTPUTS<br><br>• That government continues to support the process of decentralized health planning and management at the district level and continues to provide appropriate financial and other support.<br><br>• That personnel attached to District Health Teams remain committed to the planning and implementation process and remain active in District Health systems.<br><br>• That the selected health intervention(s) are within the district's capacity to manage and implement on a sustainable basis.<br><br>• That TEHIP and other health resources flowing to participating districts are managed and used efficiently and effectively. |

| NARRATIVE SUMMARY | SUSTAINABLE RESULTS | VERIFIABLE INDICATORS | MEANS OF VERIFICATION | CRITICAL ANALYSIS |
|---|---|---|---|---|
| 3. Delivery and use of the selected health interventions improved and expanded. | • Increased coverage and community confidence in essential health interventions. | • An understanding of the obstacles affecting health resource allocation decisions at the district level. | | |
| **PROJECT INPUTS ($.000S)**<br>a. Delivery of Health Interventions $8,811,000<br>b. Research Project funded $3,011,000<br>c. District Health Facilities Improved $ 600,000<br>d. TEHIP Management & Admin. $2,680,550<br>e. WHO Technical Support $1,100,000<br>f. EHIP/TEHIP Evaluation $ 240,750<br>**TOTAL $16,443,200**<br>====== | CASH FLOW PROJECTIONS FROM IDRC - CANADA<br>  <br><br>Year # 1 (1996-1997) $4,002,250<br>Year # 2 (1997-1998) $4,289,850<br>Year # 3 (1999-2000) $4,404,100<br>Year # 4 (2000-2001) $3,747,100<br>**TOTAL $16,443,300**<br>====== | | • TEHIP Field Reports<br>• TEHIP Financial Reports<br>• TEHIP Project Audits<br>• Monitor and Evaluation Report | CRITICAL ASSUMPTIONS Re: INPUTS<br>• That the commitment of GOT to the process of delegating authority to the district level continues with respect to the planning and allocation of health resources.<br>• That District Health Authorities are willing to accept the delegated responsibility.<br>• That financial management controls for TEHIP and GOT funds at the district level are adequate. |
| | | | | |

KILOMBERO HEALTH SUPPORT (KHS)

Credit 7F-01716.03 PHASE I (1.07.99 – 30.06.2002) CHF 2'900'000.—

## 1.1 EXECUTIVE SUMMARY

### 1.2 Introduction:

The three-year Phase I of Kilombero Health Support incorporates two SDC funded projects which were formerly known as the St. Francis Designated District Hospital Project and Kilombero District Health Support. This integration fulfils one of the objectives in each of the previous Project phases and is in line with Tanzanian health policy aiming at achieving a comprehensive district health plan and delivery system.

The definition of this phase has very much been influenced by the ongoing Health Sector Reform (HSR) development process together with its Programme of Work (PoW) outlined under the umbrella of Sector Wide Approach. In this respect KHS objectives and activities are in line with strategy 1 of the Health Sector Reform Support Programme (HSRSP) and its PoW, which directly relates to decentralised management of health services and the overall improvement of district health services. This approach, through the KHS, will prepare and guarantee for a smooth streamlining of the district's health delivery system into the wider national HSRSP at the end of this phase.

In the previous phases of the two projects a lot has been achieved in terms of strengthened management and planning capacities of the Hospital and the District Health Management Team. The quality of care within the health facilities has been improved and the involvement of the communities in solving own health related problems through Community Based Health Care has been enhanced.

### 1.3 Kilombero Health Support

During the current phase I which covers the period from July 1999 up to June 2002, the Support shall give emphasis to further strengthening of the district and hospital management and institutional capacities to contribute towards the implementation of the HSR as well as in gender balanced development. The Support has the following objectives:

1. Strengthened organisation of health services in Kilombero district
2. Provision of cost effective clinical and public health packages assured
3. Quality assurance of district health services improved
4. Improved resource and logistics management and planning
5. Human resource capacity to implement HSR in the district is available
6. Intersectoral collaboration and public/private mix strengthened
7. Strengthened community health development.
8. District Council capacities to support the implementation of HSR strengthened.

### 1.4 Support Activities

The district health system will be restructured in accordance to the Health Sector Reform. This will include the establishment of a District Health Board (DHB) together with facility management committees. The capacity of the District Council together with that of its health office and the hospital will be strengthened with a view of general improvement in implementing HSR activities. Special activities targeted towards preventive measures through health education and community participation with attention on gender balanced development will be addressed.

### 1.4 Overall Costs for the Support

The Swiss contribution to this Support phase I amounts up to **SFr. 2,900,000.-** This amount does not include the Tanzania Government contribution which is estimated at SFr. 700'000.- per year.

## 2. INTRODUCTION, CONTEXT AND BACKGROUND

### 2.1 Introduction:

Kilombero is one of the five districts of Morogoro region. It is situated about 416-km Southwest of Dar es Salaam. It covers an area of 14'818 sq. km and has an estimated population of 255'700 inhabitants with a growth rate of 3.4% annually. The population is composed of 40 local tribes divided in three main religious groups. The average size of a household is 8 people.
Administratively the district is divided into five divisions, 19 wards and 50 villages. The district headquarters (Ifakara) is easily accessible by rail and by road while two small airstrips exist. Telephone and other means of communication are extremely limited.
The infant mortality at 128/1000 and maternal mortality rate of 216/1000 is quite high even when compared to Tanzanian rates (National: 82/1000 and 163/1000 respectively). These high mortality rates are mainly due to water borne communicable diseases, malaria, HIV/AIDS as well as to severe malnutrition.
The district has a total of 46 health facilities, comprising of 2 hospitals, 4 health centres and 40 dispensaries, 16 of these belong to the government, and 9 each belong to NGOs and to Parastatals and the rest is private. Given the size and population of the district, the above-reflected number of facilities represents a good coverage with a ratio of 1: 5600. The district has a fairly adequate number of trained health staff. All government health facilities have on average two trained staff while those facilities belonging to the church lack qualified staff.

### 2.2 Health Situation

Despite the good health facilities distribution network, the quality of health services has remained weak as reflected by the prevailing high mortality rates. This is mainly caused by among other factors the lack of essential supplies including drugs in health facilities, the weak performance of health workers in clinical and nursing procedures, the low staff morale, the crumbling physical infrastructure as well as lack of preventive measures. This situation has led to the frustration of both the staff and the community at large.
Apart from the aspect of insufficient resources, the organisational and management inadequacies typical of a centralised government structure continue to prevail at the district level. The weak capacity of the District Health Management Team (DHMT) is evidenced through the slow implementation of activities and a weak system of delivering health services.
One other aspect, which contributes to the weakening of the system in general, is the lack of community involvement in supporting the system. As a result communities are loosing confidence and sense of ownership on facilities supposed to serve them.

### 2.3 Background

SDC has been supporting the St. Francis Designated District Hospital (SFDDH) at Ifakara in different activities since 1978. This support became more comprehensive beginning 1992, when SolidarMed was given the mandate to support the project under phase I (1992 – 95).
The Kilombero District Health Support (KDHS) is a much younger project dating back to 1995 when its first credit was approved to cover phase I (1996 – 98).
Prior to the ending of both project phases in June 1998, SDC had in the course of 1997 proposed a merger of the two projects in order to enhance the integration of the districts health services hence paving the way towards a comprehensive district health delivery system. The proposed integration

which is in line with the government policy, gave birth to the current "Kilombero Health Support" (KHS).
The outlining of the original KHS three year phase (1998 – 2001) had been formulated during a logical framework workshop with a wide stakeholders participation in September 1997. However, on SDC request, the full implementation of the plan was kept on hold. The postponement was necessary to allow the Tanzanian health authorities to clarify on several issues relating to health sector reform (HSR) development process. In view of this postponement, a one-year KHS interim phase was instituted. The interim phase objectives and activities reflected the first year Plan of Operations of the postponed longer-term phase.

The longer-term phase document however, had to be reviewed during a three days workshop in the beginning of 1999. This review was necessary in order to take on board fresh developments emanating from the health sector reform development process as well as to assess which activities had been accomplished during the interim period hence need not be included in the current phase. This exercise concluded with the outlining of an updated KHS Project Document, defining the present three-year (1999 – 2002) KHS phase I.

### 2.4 Tanzania Health Sector Reform (HSR)

HSR aims at restructuring the delivery of health services through decentralisation with the ultimate goal of improving the health status of the population. The reform will be implemented through the HSRSP Plan of Work which has identified 8 strategies in order to achieve the changes envisaged. Strategy 1 of this plan is targeted towards the strengthening of districts health delivery systems in order to improve access, quality and efficiency of primary health services.
The strategy focuses on the need of decentralising by devolution all health management, planning and resource allocation powers from the centre to the district council levels. It aims at restructuring of the district health system and the building of the necessary capacities to facilitate decision making and prioritisation to take place closer to the community. This arrangement will culminate in the establishment of District Health Boards, which will have the overall responsibility in overseeing and ensuring that the district's health delivery system is improved and maintained.
Since the future of the Tanzanian health sector development process is greatly going to be determined by the implementation of the reform, the KHS plan is closely linked and tailored in line with activities outlined under strategy 1 of the HSRSP Plan of Work, which is " to improve access, quality and efficiency of primary health (district level) services".

## 3. Overall Goal and Objectives of the Support:

### 3.1 Overall Goal

The overall vision of the support is **to contribute to improved health status of the population of Kilombero district, in particular the vulnerable groups.**
In order to contribute to this vision, the KHS immediate goal is **to have a comprehensive health system established which is functional, effectively managed and gender sensitive, to benefit the Kilombero district communities.**

### 3.2 Support Objectives of SDC

In line with the government policy as entailed in the HSR strategy outlined above, SDC's objective for this Support is to ensure that by the end of the phase, the district will have sufficiently developed the required systems and capacities needed to guarantee for the smooth integration into the jointly supported Health Sector Reform Support Programme (HSRSP).

Within the overall objective of improving access, quality and efficiency of the district primary health services, SDC will maintain emphasis on continued improvement of the district health office capacity to plan, manage and implement health activities. This emphasis will further be expanded to cover the district's local authority planning and finance departments. Specific efforts in this regard will be made to facilitate the streamlining of the district's overall financial management in line with the central government accounting system. This will involve the training of the district's accounting staff as well as the introduction of a computerised accounting system together with a compatible software, similar to the one installed and in operation at the central level (Platinum). In terms of structures, efforts will be made to facilitate the establishment of a District Health Board, which will spearhead for a decentralised management of the district health delivery system. Overall, the objective is to put in place all the conditions that are necessary (at a later stage) to allow the district authorities together with its health office to operate and effectively manage the earmarked (conditional) block grant funding under Local Government Reform (LGR) and HSRSP due to be launched in the beginning of January 2000.

Additionally, for the purpose of facilitating the district council to assume the new role of a strong devolved local government authority and in order to assure that the systems and structures referred to above are sustainable, SDC will extend support to the strengthening of districts capacity to plan and manage health sector activities. This among other aspects will involve advocacy for both the Health Sector and Local Government reforms. This support will directly be linked to the cross cutting Decentralisation and Democratisation" (D&D) support programme as contained in our CP.

## 4. PARTNERS AND PEOPLE CONCERNED / BENEFICIARIES

### 4.1 Beneficiaries

The beneficiaries of this project will basically remain the population of Kilombero district. Overall, the communities particularly those located in Community Based Health Care (CBHC) pilot villages stand to gain more through their active involvement in planning, implementation and evaluation of activities taking place within their vicinity.

Special attention however, will be targeted towards assembling gender desegregated information with a view of addressing gender equality and equity issues which would ultimately benefit more the female part of the population. Furthermore, the CBHC approach will enhance the active and equal participation of women and men in community based health activities in order to ensure that they both benefit on equal terms.

Health workers totalling 980 who are currently employed in the hospital, peripheral health facilities and the district health office will be part of the beneficiaries of this support through capacity building.

The district Council and its leadership as a whole will be important target group members. The district authority will benefit through a special support aimed at enhancing their capacities to supervise and implement HSR activities in the district.

### 4.2 Collaborating Partners

The Ministry of Regional Administration and Local Government (MoRALG) together with the Ministry of Health (MoH) will continue providing funds for recurrent expenditures to the district primary health services and to the SFDDH in accordance to clause 3 of the Designated District Hospital (DDH) Agreement (cf item 8.2 below). At the national level, SDC will liase and consult with these bodies for issues relating to policy and financial contributions. At the district level, the District Council and the office of the District Executive Director (DED) in particular, will be the key collaborators for ensuring project ownership and implementation.

The Diocese of Mahenge is a major party of this collaboration as it is the owner of SFDDH infrastructure including a number of peripheral dispensaries in Kilombero district.
The two district based training institutions (the Nurses Training Centre and the Clinical Officers Training Centre), the Ifakara Centre, Plan International, and the African Medical Research Foundation (AMREF) are other important health stakeholders in the district. The Irish Aid presently involved in supporting the district to prepare a district development plan promises to be one of the major future support collaborators in the district.

## 5. RESULTS OBTAINED SO FAR

The following is an overall assessment of the achievements and constraints so far encountered by the two projects prior to their termination on 30 June 1999, the interim period inclusive. (A detailed assessment for both the projects can however be obtained in the respective Project Document)

### 5.1 Kilombero District Health Support

Considerable achievements have been made in implementing objectives of this Support. Among those ranking high is the establishment of Community Based Health Care (CBHC) in five villages of the district. Not only the training of facilitators was achieved in this area, but also a number of concrete activities were identified and solutions formulated through a participatory way. Under this initiative, three dispensaries and two health staff houses were constructed / rehabilitated with active community involvement. A good number of households within the district are now aware of the need for construction of latrines as a preventive measure. Furthermore, in three of the villages under CBHC, the communities were able out of their own initiative to start Cost Sharing schemes within their health facilities. These villages now have a guaranteed constant supply of drugs with sufficient bank reserves to meet other facility consumables. During the interim phase ten new villages have been mobilised/prepared under the CBHC approach ready to undertake community health related activities in the present phase.
Concerning the strengthening of DHMTs planning and management capacity this has partly been accomplished. This partial achievement is mainly due to the existing weak quality of part of the team members. More emphasis in capacity building will be given to the remaining team members in the current phase. The district's health office financial and stock keeping systems have been reorganised and strengthened. The computerised financial accounting together with streamlined stock keeping has facilitated regular control of resources.
The capacity of peripheral health facility workers has been strengthened through short courses training, establishment of an effective supervision and monitoring system as well as on introduction of a performance appraisal system.

### 5.2 St. Francis Designated District Hospital

Due to pending differences with the Diocese, funds meant for the hospital were not disbursed in the interim period. However, the hospital continued to render some basic services albeit with many constraints due to inadequate resources.
Prior to the suspension of SDC support, the following achievements had been recorded. The restructuring of the organisational set-up for efficiency and in accordance to the HSR had been concluded. In this respect, roles of the various hospital bodies (Board of Governors, Hospital Management Committee etc) were defined and team management introduced. Rules and procedures for transparent accounting and reporting were in place. Staff performance based appraisal system improved the human resource management leading to staff motivation. Computerisation of the hospital's accounting and cost sharing system improved revenue collections. The hospital is now able to cover 20 % of its recurrent costs through cost sharing. However, the absence of a well

functioning exemption mechanism threatens the exclusion of the poor. Overall, the hospital management had become more transparent and democratic.
The hospital underwent major rehabilitation of its infrastructure and is now in good condition except for its corridors planned to be finalised in the current phase.
On the medical side, combined efforts through the upkeep of medical records, adequate supplies, and staff upgrading as well as the introduction of routine medical audits had assured for a relatively good quality of care.

## 6. EXPECTED RESULTS AND OBJECTIVES OF THE PHASE

### 6.1 Objectives and Strategies

The under-mentioned objectives refer to both the components of this Support, i.e. for the SFDDH and the district PHC services. The detailed Support strategies, activities, indicators and assumptions for each objective are reflected under annex 1. Each component of the Support will outline separate annual Plan of Operations with special attention to the development of gender sensitive activities based on gender desegregated information currently obtainable from the Health Management Information System (HMIS). The PoO will be submitted to the KHS Steering Committee for approval prior to funds disbursements and implementation.

### 6.2 Objectives (refer annex 1 for detailed strategies, activities, indicators and assumptions)

a) Strengthened organisation of health services in Kilombero District

b) Provision of Cost Effective Clinical and Public Health Packages assured

c) Quality assurance of district health services improved

d) Improved Resource and Logistic Management & Planning

e) Human resource capacity to implement health sector reform in the district is available.

f) Intersectoral collaboration and public/private mix strengthened

g) Strengthened community health development

e) District Council capacities to support the implementation of HSR strengthened.

## 7. ORGANISATIONAL SET-UP FOR IMPLEMENTATION

### 7.1 Organisational Set-up *(also see fig.1 in annexes)*

The management structure adopted for this phase is only for transitional purposes. Under the ongoing health sector reform, it is envisaged that a District Health Board with overall responsibility of overseeing the district health delivery system will be established. In the meantime, the Support will continue to be organised and managed in a way outlined below.
The organisation of the Support is schematically represented in figures 1-2. Figure 1 depicts the Support organisation and figure 2 outlines the flow of funds. These figures outline the set-up representing the relationships between Tanzanian and Swiss authorities in connection with this Support at the various levels.

At the national level there will be an intergovernmental Agreement between the governments of Tanzania and Switzerland. The Ministry of Regional Administration and Local Government (MoRALG) and Ministry of Health (MoH) will be the partner ministries on the Tanzanian side, while SDC will be the partner on the Swiss side. In order to be in line with government policy of decentralisation and local government reform, MoRALG will be the main partner ministry responsible for the Support implementation. The MoH will be responsible for technical and policy issues. The responsibilities of each party shall be outlined within the provisions of an intergovernmental Agreement.

### 7.2 Support Implementation

The Support will be implemented by the Kilombero DHMT for the district health component reporting to the District Executive Director (DED) and by a Management Committee for the hospital component, reporting to the Hospital Board of Governors.
The overall Support supervision and co-ordination will be assured through a **Steering Committee** (SC). The SC will comprise representatives of the two ministries, SDC, SolidarMed representative, District authorities, Regional Medical Officer, District Medical Officer (DMO) of Kilombero, SFDDH Medical Director, Ifakara Centre, Member of SFDDH Board of Governors, the Diocese and any other active partner within the sector in the district. The DMO/Kilombero, together with the SFDDH Medical Director will comprise the SC's joint Secretariat.
The Steering Committee will meet twice a year in order to decide on policy issues, approve progress, financial (audit) and annual plans of operations and discuss any other major policy, conceptual or financing issues.
SDC office in Dar es Salaam (with support of SolidarMed field office) through its membership to the Steering Committee will have the direct responsibility of supervising the operational implementation of this Support.
The specific tasks to be performed by SolidarMed field office on behalf of SDC is attached as Annex 2 and will be specified in a separate task oriented contract between the two parties. Among other things, SolidarMed field office (on behalf of SDC) will assist in the day to day financial monitoring, capacity building and general technical backstopping at district and hospital Support levels. In order to ensure co-ordination, SolidarMed representative will be a member of the Support's Steering Committee.

### 7.3 Flow of Funds and Auditing (see also figure 2)

Support-related funds will be disbursed through two main levels.

1. In Switzerland, SolidarMed will receive from SDC payments in respect of its task mandate as outlined in annex 2 and in accordance to a contract between SDC and SolidarMed.
2. In Tanzania, SDC Dar es Salaam office will be responsible for the direct disbursement of funds to the two Support components, namely to the SFDDH Account for the hospital and to the Health Sector Reform Account for the district health services. The transfers will be effected based on a quarterly financial disbursement plan in line to an approved Plan of Operation. SolidarMeds' field expert will be responsible for the financial monitoring of the two components operations. The two component management team/committees will present half-yearly financial statements with progress reports to the SC for approval.
3. Additionally, SDC Dar es Salaam office will effect direct payments to AMREF office in Dar es Salaam in accordance to provisions of a contract to be entered between the two parties (AMREF & SDC), in respect of AMREF's services rendered to the district for CBHC approach promotion.

For purposes of auditing, the Steering Committee (SC) will appoint one local auditing firm to be responsible for the auditing of the two component accounts. These audits will review each component's accounts once a year and present them to the SC for approval.

## 8. MEANS & BUDGET

### 8.1 Means

- Local technical assistance will consist of two long-term positions. One CBHC Co-ordinator under AMREF contract for the phase duration and one Gender Specialist for the first two years to introduce gender mainstreaming to all SDC funded health projects in Kilombero district. Additionally, a long term technical backstopping support on task based contract will be secured through SolidarMed (refer annex 3). It also includes short-term local consultancy services.
- Training needs in management and for the improvement of quality of care have been identified. Detailed training plans will be outlined and presented to the Steering Committee for approval.
- Capital investments will include rehabilitation of dispensaries and their staff houses under CBHC with active community participation. A new construction of a Maternity waiting home at the hospital together with hospital corridor rehabilitation will be supported.
- Material and equipment includes drugs, computers, vehicles, motorbikes, bicycles and other health facilities supplies. Bicycles and motorbikes are meant for CBHC implementation and health facilities supervision and monitoring. The vehicles are for replacement purposes only.
- Apart from the normal operating expenses, which include stationery, fuel, personnel costs and CBHC activities, the social marketing of impregnated bed nets as a continuation of the current KINET Project (under IHRDC) activities will be sustained by the district beginning year two of the phase, while the epidemiological study/backstopping for malaria will be provided by STI in the context of HSRSP Credit Proposal.
- Other additional aspects include gender-mainstreaming activities, capacity strengthening of the local district authorities for HSR implementation. (cf. objective 8 - annex 1)
- SDC administered funds shall cover for additional monitoring and supervision contracted tasks as well as for an evaluation exercise foreseen to take place at the end of the phase.

### 8.2 Budget (Phase 01.07.99 – 30.06.02)

The overall Swiss contribution Support budget amounts to **SFr. 2,900,000.-** Additionally, the Tanzanian Government annual contribution through MoRALG and MoH to the district health services amounts to approximately TShs. 111.0 Mill. (SFr.236,170.-) plus the Essential Drug kits. For the Hospital, Tanzania contributes an amount of TShs. 214.0 Mill. (SFr.455'000.-) per year.

**KHS - BUDGET IN SFr.**

| | 1999/00 | 2000/01 | 2001/02 | TOTAL 1999-2002 |
|---|---|---|---|---|
| **TA: 1 District Health Support (DHS)** | **479,000** | **564,000** | **534,000** | **1,577,000** |
| **36 Technical Assistance** | **94,000** | **94,000** | **94,000** | **282,000** |
| - Technical Assistance (SolidarMed) | 64,000 | 64,000 | 64,000 | 192,000 |
| - Technical Assistance (AMREF) | 30,000 | 30000 | 30000 | 90,000 |
| **35 Programme Costs** | **385,000** | **470,000** | **440,000** | **1,295,000** |
| - Training and capacity building | 50,000 | 50,000 | 50,000 | 150,000 |
| - Material/Equipment/Vehicles | 60,000 | 75,000 | 25,000 | 160,000 |
| - Capital Investments | 120,000 | 90,000 | 110,000 | 320,000 |
| - Operational expenses | 115,000 | 215,000 | 215,000 | 545,000 |
| - Local Consultancies | 40,000 | 40,000 | 40,000 | 120,000 |

| | | | | |
|---|---|---|---|---|
| **TA 2 Gender Balance Mainstreaming** | **35,000** | **35,000** | **15,000** | **85,000** |
| 36 Technical Assistance (Gender Spec.) | 20,000 | 20,000 | 5,000 | 45,000 |
| 35 Operational costs | 15,000 | 15,000 | 10,000 | 40,000 |
| **TA 3 SDC Administered Funds** | **100,000** | **100,000** | **100,000** | **300,000** |
| 35 Operational costs (SDC) | 50,000 | 50,000 | 50,000 | 150,000 |
| - Operational costs (D & D) | 50,000 | 50,000 | 50,000 | 150,000 |
| **Total Costs for DHS** | **614,000** | **699,000** | **649,000** | **1,962,000** |
| | | | | |
| ***TA: 4 SFD District Hospital*** | 298,000 | 303,000 | 232,000 | 833,000 |
| **36 Technical Assistance** | | | | |
| - Technical Assistance (SolidarMed) | **63,000** | **63,000** | **63,000** | **189,000** |
| **35 Programme Costs** | **235,000** | **240,000** | **170,000** | **645,000** |
| - Training and Capacity building | 55,000 | 65,000 | 65,000 | 185,000 |
| - Material/Equipment/Vehicles | 25,000 | 55,000 | 10,000 | 90,000 |
| - Capital Investments | 55,000 | 15,000 | - | 70,000 |
| - Operational costs | 85,000 | 90,000 | 80,000 | 255,000 |
| - Local Consultancies | 15,000 | 15,000 | 15,000 | 45,000 |
| **TA: 5 Gender Balance Mainstreaming** | **15,000** | **15,000** | **15,000** | **45,000** |
| 35 Operational costs | 15,000 | 15,000 | 15,000 | 45,000 |
| **TA: 6 SDC Administered Funds** | **20,000** | **20,000** | **19,000** | **59,000** |
| 35 SDC Operational Costs | 20,000 | 20,000 | 19,000 | 59,000 |
| **Total costs for SFDDH** | **333,000** | **338,000** | **267,000** | **938,000** |
| **TOTAL FUNDS FOR TA: 1,2,3,4,5&6** | **947,000** | **1,037,000** | **916,000** | **2,900,000** |

***NOTE for TA 4:*
*Prior to the start of the one-year interim phase in July 1998, SDC suspended its fund disbursements to SFDDH pending a resolution on differences between SDC and the Diocese. The differences originate from an isolated but serious financial mis-management on the part of the hospital Medical Director. Since the problem was not resolved within the period of the interim phase, SDC funding remained suspended for the whole duration.*
*SDC's position and condition regarding the release of funds (resumption of our support) now earmarked under TA 4, is*

1) *to implement the decision made by MoH of replacing the current Medical Director;*
2) *to re-institute the financial management & control systems which were established and in place prior to the suspension.*

## 9. GENERAL ASSESSMENT, COMMENTS AND OPINION:

The integration of the previous two projects (SFDDH & KDHS) into Kilombero Health Support is in line with the national policy, thus paving the way towards a comprehensive district health delivery system. The success of this approach will highly depend on convincing the Diocese (as owner of the hospital) to go along with the envisaged structural changes within the health sector reform. The hospital plans should be designed in a way that corresponds to the needs emanating from the peripheral lower health facilities as well as to the population of the district. In order to do this a well defined district referral system has to be elaborated and be put in place.

One of the main phase objectives is to support the implementation of the health sector reform, which entails the restructuring of the existing system with the ultimate aim of decentralising the delivery of health services for improved performance. The establishment of District Health Boards under the auspices of HSR is intended to facilitate the district's autonomy in making decisions concerning health priorities. However, in order to guarantee that sector decentralisation succeeds, there is an absolute need of having the ongoing decentralisation process (under the Local Government Reform) implemented at the district level. Even though KHS envisages limited support towards specified local government strengthening activities, these will only be confined to those areas having a direct bearing on the districts health delivery system. However, for purpose of implementing the HSR, an overall decentralised and functional local government system remains indenspesable.

The district's CBHC approach initiated two years ago with AMREF support is showing promising results in terms of community's empowerment in solving self identified health issues. It is thus planned to maintain and extend this approach to an additional ten villages during the current phase with backstopping support from AMREF. There is however an urgent need to identify alternative strategies of the approach with a view of reducing its intensity as well as costs in order to allow for a faster but cost effective coverage of the whole district.

Despite the fact that funds disbursements to SFDDH remained suspended for the whole duration of the interim phase, it is our opinion that the recent initiatives by all the partners involved under the leadership of MoH, will lead to resolving the pending/prevailing differences. Once a solution is reached, it will allow for quick disbursement to prevent an eminent decline of services rendered by the hospital.

KHS will cease to be a "Regie" project under a Supporting Agency (SolidarMed) during this phase. Alternatively, SDC will enter into a task-oriented contract, which specifies assignments SolidarMed will perform on its behalf. A list of mandated tasks to SolidarMed in respect of the district health office and the Hospital is attached in annex 2. This mandate will cover 70% of a full time SolidarMed's expert to be positioned in Kilombero and is the minimum requirement that SolidarMed needs to accept this offer.

In case the pending differences with the Diocese in respect of SFDDH are not resolved within October 1999, hence resulting into a reduced mandate, SDC will have to look for alternative arrangements to fill the gap.

The change from a Regie to task contract will not only act as a test period but also allow local capacities to assume ownership and direct role and responsibility in Support implementation.

Overall, it is our opinion that the progress so far recorded under KHS, together with the implementation of the current phase objectives/activities, these will facilitate for the establishment of the necessary environment thereby guaranteeing KHS smooth entrance to the jointly supported Health Sector Reform Support Programme currently under preparation.

This collaboration support has been discussed and fully endorsed by the Swiss Embassy and the Sectorial Division Human Resources.

## 10. MOMENTS FORTS

The "moments forts" for SDC within the KHS development process shall continue to be through the Project's Steering Committee. The Steering Committee discussions on plan of operations, budgets, financial, operational and audit reports will be important occasions for SDC to assess progress of the project. Since the project will now be a directly SDC implemented project, the Programme Officer responsible will allocate more field visit time to the project area for acquaintance in project operations. Briefings with AMREF for CBHC component and SolidarMed on assigned tasks shall serve as useful moments to keep track on project developments.

## 11. MONITORING AND EVALUATION

During the planning process a set of verifiable indicators per each objective and activities were developed for purpose of monitoring progress made within the phase duration (refer Annex 1). These will regularly be compared to the field developments as reflected in the various progress reports to be submitted to the Steering Committee (SC) meetings. In this regard the two Project components will submit half-yearly progress and financial reports as well as one annual audit report to the SC for approval and monitoring purposes.
Both the Hospital Management Committee and the District Health Management Team will be able to assess progress on their respective component activities through their usual weekly management committee meetings. Additionally, the component management committees will be able to continuously monitor progress of the specific health facilities within the district in accordance to an outlined set of guidelines, which have been established during the previous phase.
At the beginning of the third year of the phase an evaluation exercise will be carried out. The purpose of this evaluation will be to establish on whether the districts health delivery system (including the hospital) is adequately equipped for the integration into the national HSRSP. This will involve assessing the potentiality of the system to sustain the achievements so far made under a budgetary support arrangement/setting.

## 12. PROPOSAL

Vu ce qui précède, nous vous proposons d'accorder un crédit de

**CHF 2'900'000.-**

pour la mise en oeuvre du projet "Kilombero Health Support, Phase I (KHS)". L'engagement se fera à la charge du crédit de programme de CHF 3,8 milliards concernant la continuation de la coopération technique et l'aide financière bilatérale en faveur des pays en développement selon l'AF du 15 décembre 1994. Les dépenses découlant de cet engagement seront imputés à l'article budgétaire 202-3600-002.

Annex 1

# KILOMBERO HEALTH SUPPORT OBJECTIVES, STRATEGIES, ACTIVITIES, INDICATORS AND ASSUMPTIONS FOR PHASE I (July 1999 up to June 2002)

## Objective: 1 Strengthened organisation of health services in Kilombero District

Strategy

1.1 Establish and operationalise a district health structure in accordance with the health sector reforms.

Activities

1.1.1 Establish a gender sensitive Task Force to spearhead HSR implementation.
1.1.2 Promote HSR through advocacy
1.1.3 Recruit Gender balanced development specialist for district's health programme.
1.1.4 Promote formulation of by-laws to establish gender sensitive boards according to the Local Government Act
1.1.5 Form, train and make gender sensitive DHB and Health Facility committees functional
1.1.6 Strengthen planning and management capacity of DHMT & SFDDH
1.1.7 Review and re-define roles, functions and responsibilities of the DMO, DHMT and SFDDH in accordance with the HSR
1.1.8 Review the composition of the Steering Committee, its terms of reference and mode of operation

Indicators

- Task Force established and functional
- Patners aware of the HSR
- By-laws established and accepted
- Gender balanced representation is assured
- ToR's DHBs and Health Facility Committees in place and operational

Assumptions

- HSR policy support from central level is sustained
- Political will to implement reforms exists at national, district and diocesan level
- The Local Government Act is operationalised as planned
- Competent and dedicated members are available to the DHB

## Objectives: 2 Provision of Cost Effective Clinical & Public Health Packages assured

Strategy

2.1 Give appropriate health education and promote improved sanitation.

Activities

2.1.1 Train an expert health educator
2.1.2 Develop and operationalise a health education strategy
2.1.3 Identify and apply effective health education materials
2.1.4 Develop and distribute appropriate health education materials
2.1.5 Promote the use of locally appropriate VIP latrines
2.1.6 Promote sanitation

**Indicators**

- Health educator in place and working by 2001
- % of households with VIP latrines
- Health education materials in place

Strategy 2.2. Control endemic diseases

**Activities**

2.2.1 Design, implement and evaluate community based DOTS for tuberculosis
2.2.2 Promote use of insecticide treatment for bednets for malaria control
2.2.3 Facilitate distribution of Ivermectin in endemic villages
2.2.4 Operationalise results of research on cost-effective health interventions
2.2.5 Design, implement and evaluate tools for prevention of anaemia in the community
2.2.6 Control outbreaks of epidemic diseases in the district.

**Indicators**

- Analysis of the cure rate of TB established
- Analysis of cost-effectiveness of TB treatment by DOTs
- Coverage of ITNs
- Re-treatment rate
- % of target population treated annually
- Evidence based medicine used
- Programme for prevention of anaemia in place
- % children given blood transfusion for anaemia reduced

Strategy
2.3 Improve delivery of well-defined reproductive and child health services

2.3.1 Improve coverage and quality of ante-natal care
2.3.2 Improve obstetric care
2.3.3 Provide family planning services to men and women
2.3.4 Improve STD/HIV/AIDS control
2.3.5 Improve immunisation activities of EPI diseases
2.3.6 Introduce and implement integrated management of childhood illness (including childhood anaemia)

**Indicators**

- % pregnant women seeking ANC at first, second and third trimesters
- % birth asphyxia reduced
- Reduced maternal mortality rate from 404 to 300 per 100,000
- Increased awareness of family planning methods in men and women
- Increased utilisation of family planning methods by men and women
- Proportion of peripheral health centres using syndromic approach for STD
- 90% of infants are fully immunised

**Objective: 3 Quality assurance of district health services improved**

Strategy
3.1 Improve the delivery of health care services within the hospital

Activities
3.1.1 Promote research and encourage small investigations with a likely direct effect on the quality of health care
3.1.2 Make an assessment of and improve the referral system, including maternity waiting facilities
3.1.3 Monitor the use of treatment guidelines
3.1.4 Practice clinical meetings, post-mortem discussions, morning reports, literature reviews, guest visits, training ward rounds and other such practices that aim at maintaining and improving the professional quality of services in the hospital
3.1.5 Improve and expand on the medical audit system which is in place
3.1.6 Use regular patient/client feedback to improve the perceived quality of services
3.1.7 Establish day care services for relatively minor surgical procedures at SFDDH
3.1.8 Improve the quality of hospital staff by training or replacement
3.1.9 Ensure the proper management of patients

**Indicators**
- Availability of Medical Audit reports
- Improved community perception of quality of the hospital services and attitude of its workers (via social survey or client service evaluation forms)
- Number and type of quality assurance inquiries carried out
- Pre-post assessment study on quality of health care

**Assumptions**
- Competent clinical hospital staff are in place

Strategy
3.2 Improve health care services in peripheral health facilities (public and private)

**Activities**
3.2.1 Promote the use of data from the HMIS and other monitoring tools (collection, filing, analysis, action, reporting) to address the needs for health coverage in the district.
3.2.2 Tune health care to gender disaggregated local epidemiological patterns and medical equipment to health facilities accordingly
3.2.3 Develop standards of care for different levels of health facilities
3.2.4 Establish a practice of "medical auditing" and other quality assurance mechanisms in peripheral health units
3.2.5 Make an assessment of the overall district referral system (both static facilities and the referral dynamics) and implement recommendations
3.2.6 Conduct effective supervisory visits
3.2.7 Practice performance appraisal of health units.
3.2.8 Develop and implement rehabilitation maintenance plans for health facilities
3.2.9 Ensure proper management of patients
3.2.10 Use regular patient / client feedback to improve the perceived quality of services

Indicators
- Number of actions taken based on use of monitoring data
- Number of medical auditing reports available
- Number and type of quality assurance schemes carried out
- District referral system is in place and operational
- Establishment and availability of services of Kibaoni H.C
- Community perception of the quality of the services and attitudes of HW's in social surveys
- Coverage of services (service indicators)
- Number of supervision days per health facility

Assumptions
- Health units are well equipped
- The time spent on operating the HMIS is in balance with the rest of the workload of the health personnel
- Health workers are committed to improving the quality of their services toward the community
- Medical audit and other quality assurance measures are or can be made acceptable within the organization culture of the health services in Kilombero

**Objective: 4 Improved resource and logistic management and planning**

Activities
4.1.1 Develop manuals & guidelines for management of materials, finances, human resource, stock keeping, procurement, investment, transport and communications
4.1.2 Ensure use of tools and instruments for management of resources (planning, execution, supervision, monitoring and reporting)
4.1.3 Initiate a quarterly self-evaluating process
4.1.4 Perform regular control/supervision of resources
4.1.5 Ensure that the performance appraisal system is used in a transparent and gender sensitive way
4.1.6 Collect and up-date data on human, financial and material resources entering & leaving the district health system

Indicators
- Higher work output / productivity per person
- Reduced loss and more efficient use of non-human resources
- Increased life time of capital equipment
- Account books, stock ledgers, log books etc. maintained and up to date
- Manuals, guidelines and other management instruments available and used
- Reduced variation between expenditures and budget

Assumptions
- The capacity to use the various manuals and instruments exists or can be built
- Female and male personnel with the required skills can be trained or recruited
- Remuneration / employment conditions are sufficient to retain skilled personnel
- Government implements pay reforms

Strategy
4.2 Establish a cost-effective mechanism of purchasing and distributing drugs and supplies according to the indent system.

**Activities**

4.2.1 Develop and establish a common system for storage, procurement and distribution of drugs
4.2.2 Prepare the district health staff for distributing drugs and supplies according to an indent system
4.2.3 Ensure that drugs/supplies are available in Health Facilities
4.2.4 Establish a monitoring / management system for drugs/supplies

**Indicators**

- Availability of a standard set of essential drugs in Kilombero health facilities
- Availability of joint report on the possibilities of sharing storage facilities and procurement system
- Relevant personnel at health facilities trained to use the indent system
- Average availability of basic drugs per Health Facility increases from 2 weeks/month to 4 weeks/month by December 2000
- People changing their behaviour of rushing for drugs when they arrive

**Assumptions**

- The indent system will be more effective and sustainable in securing adequate, equitable and un-interrupted drug supply to the district health facilities than the kit system
- Sharing of storage facilities is of mutual advantage to the district, hospital and pharmacy
- Drug price factors, inflation and ordering / delivery time are sufficiently predictable and contained to maintain the purchasing power of the revolving fund

Strategy

4.3 Provide, maintain and replace equipment based on assessment/monitoring of health facility needs.

**Activities**

4.3.1 Establish investment plans to take care of provision and replacement of resources according to the minimum package and implement accordingly
4.3.2 Establish mechanisms which make sure that maintenance & repair needs are identified on time and take care of properly
4.3.3 Build capacity to ensure ongoing maintenance at user level
4.3.4 Strengthen the SFDDH equipment maintenance system to provide back-up support to the district

**Indicators**

- Equipment in good working order in each health facility by the end of the phase
- Availability of an investment plan, resources allocated accordingly by July 2000
- Availability of repair log books showing regular services for major items of capital equipment in the district health services by July 2000
- All major newly bought equipment has been assessed on its cost effectiveness using available (WHO) guidelines
- Presence of a technician

**Assumptions**

- Minimum package for health exists
- Minimum required funds for procurement, maintenance and repair of equipment are allocated in the budgets and actually disbursed

- Maintenance / back-up services for high technology equipment are available in the country

Strategy
4.4 Maintain, rehabilitate and construct health facilities according to the district health plan

Activities
4.4.1 Provide information and support to assist communities to plan, rehabilitate, construct and maintain health facilities according to priorities of their localities
4.4.2 Assist community in establishment of maintenance funds for health facilities
4.4.3 Maintain / rehabilitate hospital building according to the needs
4.4.4 Construct maternity waiting home
4.4.5 Pilot in 2 villages in managing funds for rehabilitation of their health facilities

Indicators
- Rehabilitation projects have been successfully implemented, according to the district health plan
- Communities have contributed 20% to the costs of construction and rehabilitation (including labour and local materials)
- 50% of government health facilities have a maintenance fund

Assumptions
- Regularly sustained maintenance of the total district health infrastructure is within the financial capability of Kilombero district
- A District Health Plan exists

Strategy
4.5 Ensure efficient and effective use of transport and communication resources for health services

Activities
4.5.1 Adapt MoH transport management guidelines
4.5.2 Improve communication facilities in line with the requirements of the referral system
4.5.3 Increase efficiency of transport by coordinating the use of transport facilities in the district

Indicators
- Existence of and compliance with adapted transport management guidelines
- Proportion of kilometers (as per log book) devoted to patient referral, integrated supervision and other goal related activities
- Availability / sharing of an inventory/summary report on the possible use of existing communications
- Improved patient referral patterns
- 2 ambulances are allocated to Mangula / Mlimba Health Centres by 2000

Assumptions
- The absolute number of vehicle under control of the health services and other wise in the district is sufficient and affordable to cover the district health transport needs (including referrals)
- A variety of communication channels is available in the district that can be more effectively and efficiently used

Strategy

4.6 Ensure a dependable financing mechanism, based on mobilisation of local resources and a diversity of reliable development partners.

Activities

4.6.1 Increase the contribution from cost-sharing to a level which does not violate the principles of equity
4.6.2 Formulate a mechanism for exemption of the poor at hospital and peripheral level
4.6.3 Examine ways of introducing alternative health financing mechanisms and select an option for testing in the district
4.6.4 Extend cost-sharing to additional peripheral facilities
4.6.5 Increase the income from non-medical activities e.g. catering, accommodation
4.6.6 Explore possibilities of cost reduction
4.6.7 Expand the number of development partners
4.6.8 Actively "market" the KHS

**Indicators**

- Cost sharing income covers 25% of expenditures at the end of the phase (SFDDH)
- Availability and application of a fair yet workable exemption policy by July 2000
- Existence of fund raising initiatives
- Cost-reducing measures taken, extent of reductions shown in financial reports
- 50% of Health Facilities have introduced cost-sharing

**Assumptions**

- Cost sharing and reaching the poor are compatible objectives in Kilombero
- Workable exemption and waiver measures can be implemented.
- Having multiple contributing financial partners is compatible with development of sustainability.
- There is still scope for increasing finances through fund-raising
- There is still scope to expand the number of cost-beneficial initiatives to strengthen the financial basis of health care in Kilombero District
- Indent system is not undermining the cost-sharing initiative

**Objective: 5 Human resource capacity to implement health sector reform in the district is available.**

Strategy

5.1 Develop capacity building system, which will continually improve the capacity of female and male health workers in the district.

Activities

5.1.1 Contribute to curriculum development of existing training institutions, including gender sensitivity on health issues
5.1.2 Offer the opportunity for foreign students to study elective topics
5.1.3 Promote exchange of medical staff
5.1.4 Develop/prepare a training policy and plan for the district
5.1.5 Conduct seminars, bedside teaching, study tours and applied research
5.1.6 Practice technical exchange with other projects and districts
5.1.7 Send selected staff for training courses, preferably in the district, country or region on an equal opportunities basis
5.1.8 Organize internal workshops for district staff

5.1.9 Organize training for medical and non-medical staff working in health facilities, including gender awareness
5.1.10 Create mechanism for continuing education and promotion of self-study in the district
5.1.11 Strengthen the abilities of DHMT & SFDDH in "capacity building"

**Indicators**

- Reflection of continuing education / quality assurance activities in training plans, budget and organization structure
- Maintained or increased proportion of competent students in the local health training institutions recruited from Kilombero District
- Up to date and relevant curricula including gender issues
- Maintained or increased number of students from elsewhere attached per year
- Maintained or increased percentage of staff trained or up-graded per year
- Maintained or increased number of staff trained by expert visitors
- Exchange visits between Kilombero and other districts taking place
- At least SFDDH and 10% of health facilities having an appropriate resource centre
- Increased proportion of health and non-health workers in the health sector involved in continuing education activities per year
- At least 25% of health facilities having or forming part of a functioning continuing education committee
- Evidence of training being conducted

**Assumptions**

- Adequate financial and material resources in training institutions
- Female and male workers in Kilombero District are trainable
- Quality assurance practices are acceptable to health workers in Kilombero district
- National training curricula are relevant for the local needs
- Female and male workers are interested in professional self improvement
- Female and male health workers have access to a minimum of resources and organizational support to implement what they will learn.

**Objectives: 6 Intersectoral collaboration and public/private mix strengthened**

Strategy

6.1 Establish integrated district health planning involving all local actors, vertical programmes and other key stakeholders
6.1.1 Jointly formulate a District Health Plan, plans of operation and identify financing mechanisms
6.1.2 Establish regular co-ordinating meetings among DHMT members, health actors and other partners.
6.1.3 Promote the active participation of the DED in developing and implementing a renegiotiated agreement between the GOT and the Diocese in respect of the SFDDH
6.1.4 Establish a transparent district accounting system in line with the national guidelines
6.1.5 Create instruments to improve compliance with existing agreements
6.1.6 Promote the use of HMIS for monitoring the district health plan
6.1.7 Establish a practise of systematic collection and dissemination of field information through advocacy and networking at various levels
6.1.8 Establish and maintain an informal dialogue among various parties

6.1.9 Take systematic steps to ensure that the dialogue / communication with district authorities is functioning
6.1.10 Facilitate exchange visits between districts and between communities within the district
6.1.11 Develop guidelines for communication at district and community level.
6.1.12 Seek information about the most important contacts for maintaining a dialogue about the implementation of the health sector reforms

**Indicators**

- Availability of a widely supported Kilombero District Health Plan
- Occurrence of planning / review meetings at least once per year
- Availability of jointly drafted annual plans and proposals
- Minutes of the meetings conducted are available
- Satisfactory audit reports
- A joint monitoring mechanism is developed and operational

**Assumptions**

- The present interest and momentum of joint planning can be sustained
- Accounting capacity at the required level will be available
- The DDH agreement will be re-negotiated between the Diocese and the MOH
- The various collaborators agree to joint planning

**Objective: 7 Strengthened community health development**

Strategy

7.1 Extend coverage of sustainable, gender sensitive community health development activities substantially through "empowerment".

**Activities**

7.1.1 Extend CBHC approach to new communities
7.1.2 Continue implementation of CBHC in the district through Health workers, DHMT, CORPs and health actors
7.1.3 Link-up existing development initiatives with CBHC
7.1.4 Through supervision, training and management meetings, make health workers aware of health needs and resources in the community
7.1.5 Develop and promote the concept of home based care
7.1.6 Training of TBA's VHW's, TOT's, TOF's and TOC's
7.1.7 Maximise community participation and intersectoral/community involvement in planning and implementation or District Health Plans
7.1.8 Promote ownership of local health facilities and health concerns to community
7.1.9 Equip community facilitators with communication materials including stationery and teaching aids
7.1.10 Provide basic equipment and supplies to TBA's and VHW's
7.1.11 Introduce community based distribution of essential supplies for community based health interventions

**Indicators**

By the end of the phase:

- 10% of funds assigned to each Health Facility is under community control
- 2 health facilities are community owned (legal documentation, control of resources)

- in 50% of the communities, planning and decision making concerning health services is a participatory process
- in 50% of the communities, minutes of meetings are produced (PHC committee, Facility boards, village government)
- 50% of the communities have a board that deals with the health component
- 50% of all Health workers are conversant in CBHC and have integrated the CBHC approach in their interventions
- 50% of communities have identified and trained their community based resource persons and they are active
- 50% of communities undertake community development activities not directly linked to health and have successfully implemented at least 2 initiatives
- number of patients receiving home-based care in TB and AIDS
- no of TBA's and VHW's with standard equipment and supplies in working order
- availability of supplies at community level

**Assumptions**

- The present intensive approach toward initiation of CBHC can be extended to cover the whole district or a less intensive approach is possible with nearly similar effectiveness
- Communities have a minimum of resources and are sufficiently organized and motivated to take a (pro-) active interest in their health affairs
- District authorities are willing to empower communities.

**Objective 8: District Council capacities to support the implementation of Health Sector Reform strengthened.**

**Activities:**

8.1 Introduce and strengthen the district's financial accounting and management system in line with the central government system
8.2 Improve the planning and management capacity of the District Executive Director's office
8.3 Train district Councillors on their new roles and responsibilities in line with the Local Government Reform (LGR).
8.4 Train Ward and Village functionaries on PRA.
8.5 Train Community Development Staff on mobilisation and problem solving skills at community level.

**Indicators:**

- District's accounting in accordance to central government system introduced
- District's overall development plan in place
- Councillors aware of their roles and responsibilities
- Community Development Staff trained.

**Assumptions:**

- The ongoing decentralisation process through LGR is maintained.

Figure 1

# KHS ORGANOGRAMME

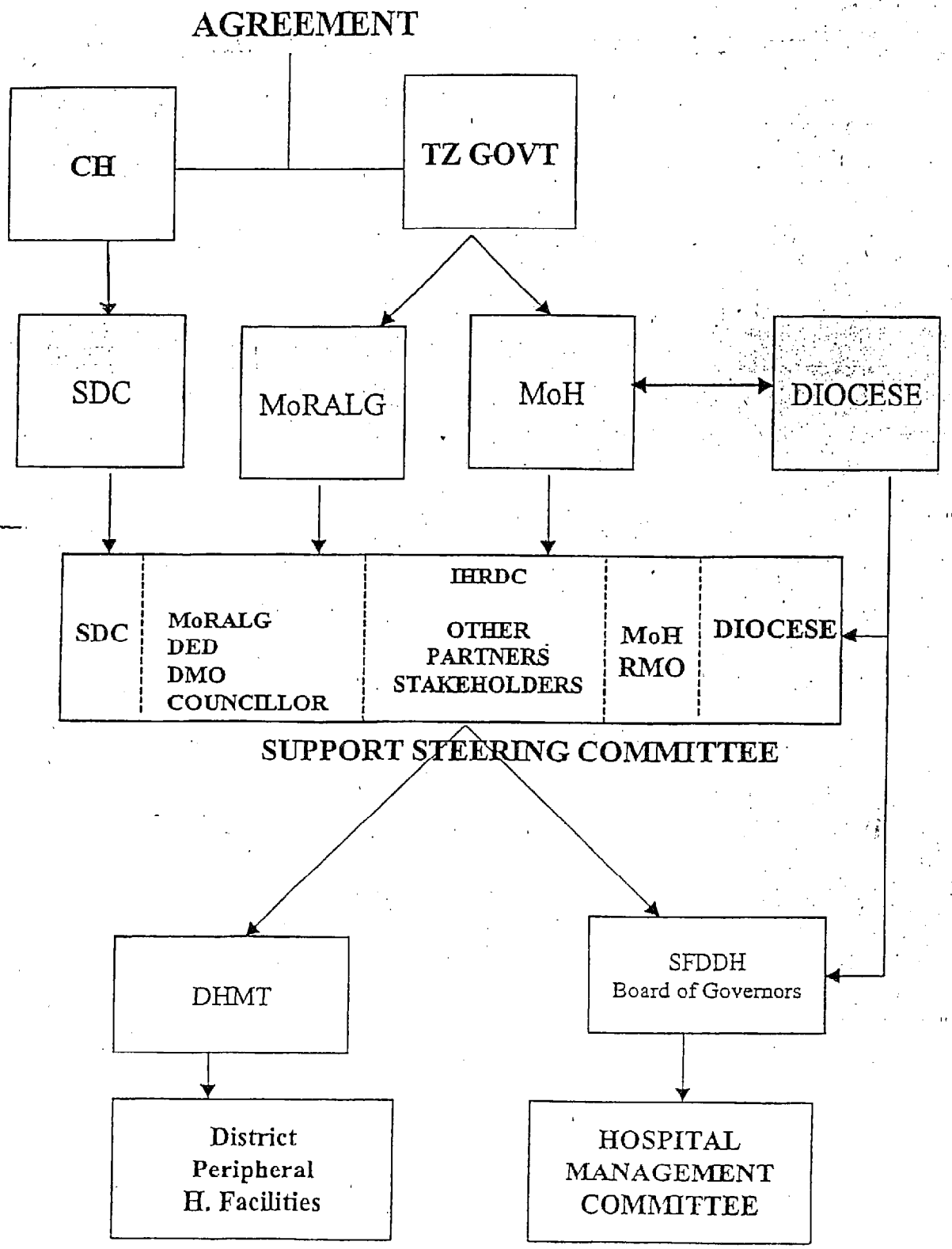
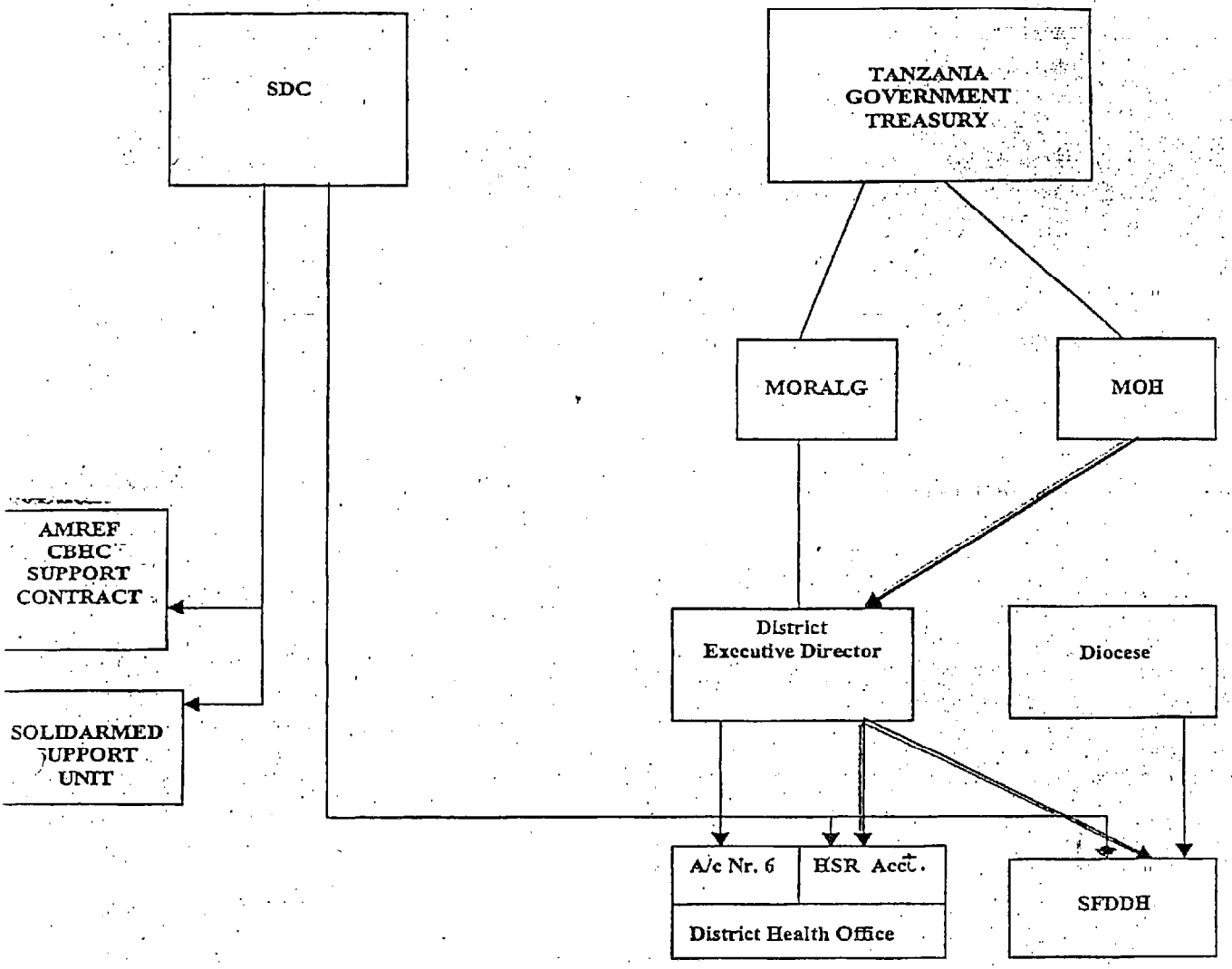


Figure 2

# KHS FLOW OF FUNDS CHART



ANNEX 2

TASK ORIENTED ASSIGNMENT TO SOLIDARMED FOR KILOMBERO HEALTH SUPPORT PHASE I (JULY 1999 – JUNE 2002):

List of tasks for Technical Assistance to the DHMT - Kilombero

| | | Days |
|---|---|---|
| Activities | Results | SM head |
| 1. Financial management*<br>- Preparation of documents for booking, control booking, reconciliation of bank/cash book, production of quarterly financial statements, establishment/review budget, budget comparison, financial controlling, financial analyses, cash flow analyses, collaboration with auditors, etc | 4 consolidated financial statements per year, availability of data ensured, system up to date, no irregularities, monthly budget comparisons, | 14/year |
| 2. TA to the DMO/DHO in planning & resource man, - development of yearly individual/DHMT PoO analyses of costs, utilisation of cars, store management, organisation of administrative tasks, human resource management, etc | Fuel consumption and log books analysed, PoO produced, planning instruments introduced, guidelines/rules/regulations developed, regular meetings with adm. Staff organised, cost comparisons done. | 10/year |
| 3. Moderation in management training for DHMT – Participation in staff meetings and SC meetings. | Training manual & report, Training topics used in daily work | 14 |
| 4. Assistance in preparation of Terms of Reference, working concepts, etc<br>– According to needs expressed by the DHMT | Availability of ToR's concepts, etc | 8 |
| 5. Computerisation of DMO's office<br>– HMIS, human resource database, data management, training of staff, maintenance equipment, etc) | MTUHA is computerised, HR database established, DHMT trained in use of computers | 6<br>+student |
| 6. Assistance to HSR task-force for impl. Of HSR<br>– dissemination of MoH information, identification of HSR activities to be implemented first, assistance for implementation | HSR documentation exists, HSR activities implemented (acc. To prioritisation) | 12 |
| 7. Assist. For constr/rehab. Of health facilities<br>– budget control, financial control, logistical assistance | Budget comparisons, financial statements, cost analyses done | 5 |
| Total number of days in a year for DHS | | 71 |

List of tasks for Technical Assistance to SFDDH

| | | Days |
|---|---|---|
| Activities | Results | SM head |
| 1. assistance in financial management<br>– introduction of cost-centred book keeping, financial analyses & control, training administrator | | 12 |

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| | | |
|---|---|---|
| 2. Assistance in Data management<br>– computerisationof medical statistics & registrat. Of patients | 2 new departments computerised, medical stt. & patient reg. Computerised | 10<br><br>+student |
| 3. Training of heads res. Management/planning<br>– organisation and execution of a six day workshop in planning/resource management (Topic to be identified with HMC). | Training manual & report, Training topics used in daily work | 10 |
| 4 Assistance in the preparation of ToRs, working concepts | Availability of ToRs and concepts | 10 |
| 6. Participation in HMC, BOG and other meeting | Individual reports to SDC | 8 |
| 9. Assistance for improvement of cost-sharing & exemption system<br>– introduction exemption system, improve supervision system, link c-s with medical statistics, links drug/pharmaceutical consumption To billing system | c-s income increased, income acc. To medical statistics | 12 |
| 11. Assistance in human resource management<br>– introduction of a fair system, introduction of new tools training head HR and administrator | Workers are satisfied & motivated, qualification of staff increased, all guidelines followed, etc | 8 |
| **Total number of days in a year for SFDDH** | | 70 |

Available working days per year:

| | |
|---|---|
| Days per year | 365 |
| Weekends | - 104 |
| Holidays | - 15 |
| Vacation | - 30 |
| **Tot. working days/yr.** | **216** |
| Working days for SDC | 141 |
| SDC meetings & consult. | 9 |
| **Tot.working days for SDC** | **150** |