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Analysis from a Capacity Development Perspective

Project for Strengthening District Health Services in the Morogoro Region, Tanzania

February 2008 IFIC/JICA

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Case study Report on Capacity Development

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Challenging the Development of District Health Management and Sustainable Health Systems

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The analysis and recommendations of this report do not necessarily reflect the official views of JICA. It is the fruit of a collaborative effort by the study group on "CD analysis on Morogoro Health Project," organized by JICA.

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Preface

Although the term “capacity” used in “capacity development” originally refers to the “ability,” Japan International Cooperation Agency (JICA) defines it as the ability of developing countries “to set and attain goals, and to identify and solve the development issues of their own countries”; in other words “problem-solving abilities.” JICA also regards capacity development (CD) as “the ongoing process of enhancing the problem-solving abilities of developing countries by taking account of all the factors at the individual, organizational and societal levels.”

Based on the idea that CD is a useful concept in reexamining the nature of its projects, JICA attaches importance to the systematization and accumulation of lessons and experiences for future use by continuously analyzing previous cooperation activities from a CD perspective.

JICA has implemented many technical cooperation projects and programs in the health care sector in developing countries. Recently, JICA has increased its assistance to the public health services of developing country governments, not limiting it to primary health care or specific diseases. The Project for Strengthening District Health Services in the Morogoro Region in Tanzania is consonant with this trend. This project is designed to strengthen human resources and the management infrastructure for the delivery of regional health services in line with the health sector and decentralization reforms. The project has two major characteristics. First, it has had a significant impact on CD by respecting ownership and leadership by the stakeholders in Tanzania and by serving as a catalyst for networking among the various actors involved. Second, it has achieved a complementarity of modalities by taking advantage of the sector basket fund for sustainable financing.

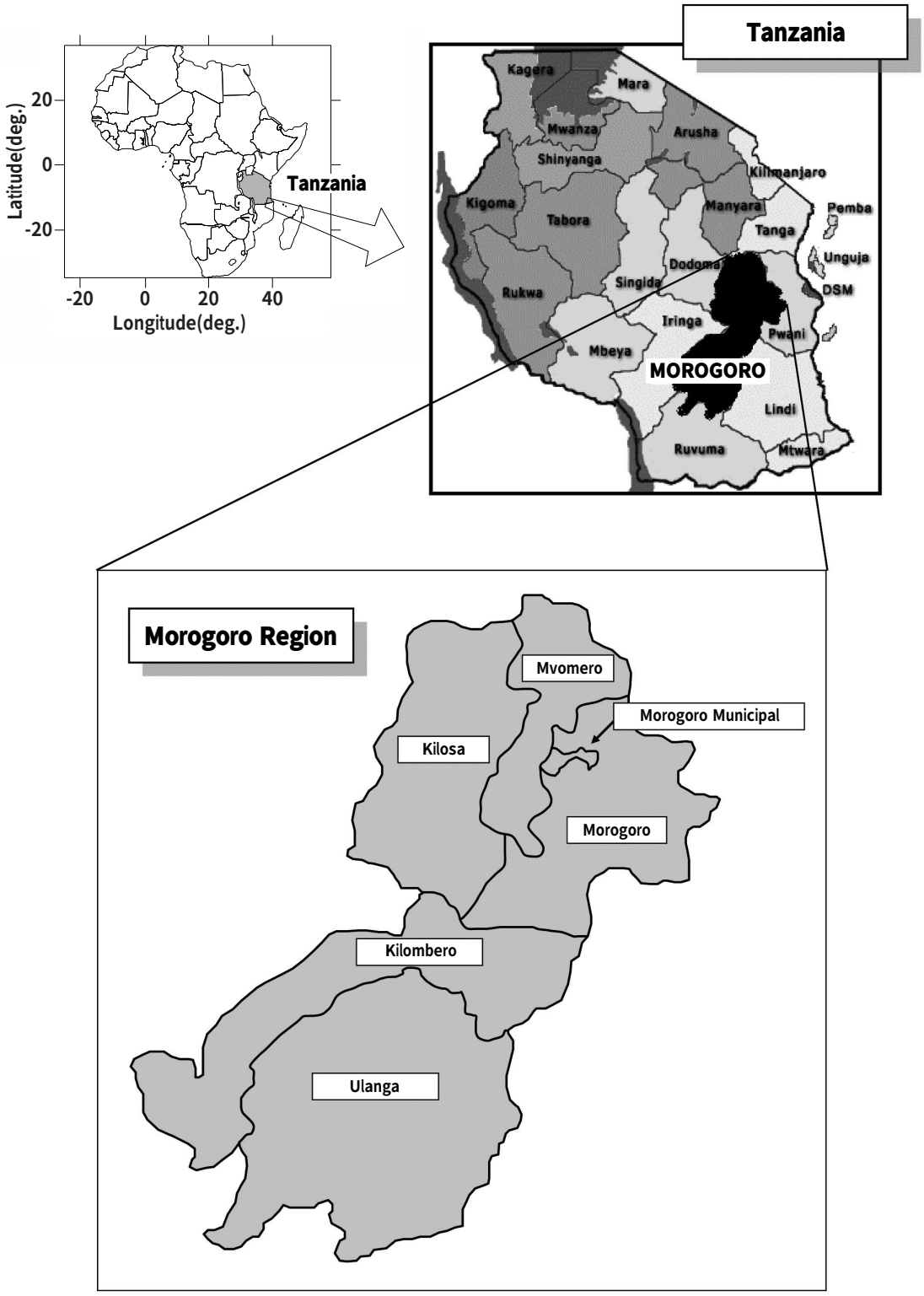
With the focus on these characteristics, this study report has drawn lessons and made recommendations from the perspective of CD support. These lessons and recommendations suggest viable options for enhancing the capacity of developing countries in the health care and other sectors. They also provide useful suggestions as to what should be done to coordinate the cooperation modalities of different donors under the sector-wide approach.

In this way, we hope that the lessons and recommendations obtained from this research will be further deepened through on-site practice and discussions.

Finally, we would like to express again our gratitude to all those involved in the Morogoro Health Project (MHP), who responded to interviews and cooperated in the realization of the present study.

December 2007
Hiroshi KATO
Director General
Institute for International Cooperation
Japan International Cooperation Agency

Location Map



Contents

List of Figures, Tables and Boxes

Summary

■Background and Purpose of the Case Study

Capacity Development (CD) has been attracting attention since the 1990s. This was based on the recognition that assistance in the past did not necessarily lead to sustainable development and the achievement of development outcomes in developing countries. CD is defined as "the ongoing process of enhancing the problem-solving abilities (capacity) of developing countries by taking into account all the factors at the individual, organizational, and societal levels."

The importance of the concept of CD is articulated in the Paris Declaration on Aid Effectiveness, which was adopted in 2005. The declaration emphasized the necessity of endogenous efforts by developing countries for capacity development and of the coordinated support for such efforts by donors. Given this, how to operationalize the concept of CD into actions has become the next challenge for both developing countries and aid agencies.

This research is one of a series of case studies designed to serve as a reference in order to reflect the concept of CD in actual cooperation activities by the Japan International Cooperation Agency (JICA). It takes up the Morogoro Health Project (MHP; April 2001 to March 2007) as a case and analyzes the experience in supporting the CD of the local government, which is crucial for improving basic social services in developing countries. In particular, the case provides useful suggestions as an example of an effective CD support, where JICA's technical cooperation has been coordinated with Tanzania's own efforts as well as assistance by other development partners; complementing each other with other aid modalities such as a sector basket funds; and finally lead to tangible results in achieving the objectives of the Tanzanian development policy and strategies.

This study, by analyzing the MHP as a case, is intended to extract the lessons learned in planning and implementing effective technical cooperation for capacity development. It is also intended to analyze the role played by Japanese experts in supporting endogenous efforts for CD by the developing countries.

■The Social and Political Environment in Tanzania: Background to the Case Study

In development assistance for Tanzania, an important factor is that two major reforms, the Health Sector Reform (HSR) and the Local Government Reform Programme (LGRP), are being actively pursued.

In 1994, the Ministry of Health and Social Welfare (MOHSW) initiated the HSR ahead of reforms in other sectors. The HSR was designed to devolve authority for health services to local government authorities. The goal was to have local government authorities that were closer to the citizens and to provide health services more effectively to the community by means of the decentralization of the health sector. Furthermore, in 1999 Health Sector Basket Fund (HSBF) through the adoption of a Sector-Wide Approach (SWAp) was examined and introduced as an independent source of revenues for local health services. This established the financial foundation for the local government authorities to independently plan and implement health activities.

Furthermore, the introduction of the LGRP in 2000 defined the roles of the central and local governments: the former formulates policies and the latter provides administrative services, including the planning, implementation, and monitoring of various projects and programs. Accordingly, in the health sector, local districts have come to carry out health and medical services on their own. As a result, the function of the MOHSW has changed to focus on the formulation of the policies as well as technical backstopping and support to the local authorities.

However, the solidification of the political and financial foundations for the reforms mentioned above, did not necessarily result in the expected provision of health services that meet local needs. Considering this fact, MOHSW introduced a policy that would give priority to strengthening the management capacity of the regional and district health administrative organizations. Against such a background, the MHP was started with the aim of taking the Morogoro Region as a pilot area and creating a model for region-district partnerships for better service delivery.

■Progress and Outcomes of this Project

(1) Project Formulation Period: Project Formulation Based on the Country's Initiative

During the formulation period for this project, the Chief Medical Officer (CMO) played an important role in taking up the leadership of the HSR. The formulation of the project involved close and frequent information-sharing and consultations between the CMO and the policy advisor assigned to the MOHSW as a JICA long-term expert at the time. The CMO was a specialist in the health sector, having had experience serving as the Dodoma Regional Medical Officer (RMO). As such, he was fully aware of the problems of the weak management capacity of the local governments as a major impediment to effective service delivery. For this reason, the CMO referred to requesting assistance from the experts: **"I do not want them to just lend a hand to the health services, but rather to inform us of what can be done to have the region and districts continue to carry out their activities. I would like them to act as a 'catalyst.' "** The CMO's expectation from the project was for "Tanzanian autonomous development."

(2) First Half of the Project: Building Relationships of Trust through Trial and Error

During the first half of the project, an extensive situational analysis of the current status of the health facilities in the target region was conducted and routine visits to the districts were made frequently. The foundation for a **horizontal network between the districts** was laid through these district visits as well as through the installation of radio communications. In addition, **communication between the region and the districts** was also strengthened by having the members of the Regional Health Management Team (RHMT) supervise the network together. Likewise, **communication between the Council Health Management Teams (CHMTs) and health facilities** was enhanced through the introduction of communication tools.

Frequent discussions with the counterparts (CPs) were held from right after the start of the project in order to elaborate the specific contents of the activities and to establish the performance indicators. **The approach of the experts was to play a facilitative role as catalysts** contributing to the enhancement and sense of ownership and partnership on the part of the CPs. This led to the formulation of an action plan that was fully agreed and owned by the Tanzanian side. The CPs, who devoted a great deal of time to the above process, committed themselves to the project to the extent of setting objectives by themselves and carrying out their activities to achieve the objectives. Through this phase, a sense of ownership and commitment was fostered and strengthened among the CPs.

(3) Second Half of the Project: Establishing a Self-reliant Health Management System

Every CP had rotated their participation in all activities for three and a half years since the project was launched. After October 2004, however, cross-district Working Groups (WGs) were established for each outcome and they were introduced into all activities. As a result, since the RHMT members naturally belonged to the WGs, this WG-unit strategy expanded not only in the cross-district horizontal network but with the vertical lines of each operation. What is more, consideration was also given to **"the utilization of**

and cooperation with local resources," including the latent human resources and organizational capabilities of universities, research institutions and other sources both within and outside the Morogoro Region.

By paving the way for WG activities and making other administrative officials and the general public aware of this as a tangible outcome, the commitments from district and regional governors were augmented. In addition, the idea of contributing various expenses incumbent on the project activities via district health budgets also came to be examined due to this. Thus, it became possible for **project activity expenses to be allocated in district health budget planning and for the HSBF to be used as an independent revenue source for local health.**

(4) From the Extension Period through to Project Completion

In order to ensure an autonomous operational structure for the activities on the Tanzanian side after the completion of the project, logistics and coordination capabilities were strengthened so that those involved could continue with activities like those of the WGs on their own.

The establishment of project activities in the Morogoro Region and their modeling and systematization for diffusion and expansion to other regions were explored by the concerned parties. Moreover, activities such as the development of educational materials and publications that compiled experiences, outcomes, and lessons from the activities were also actively carried out.

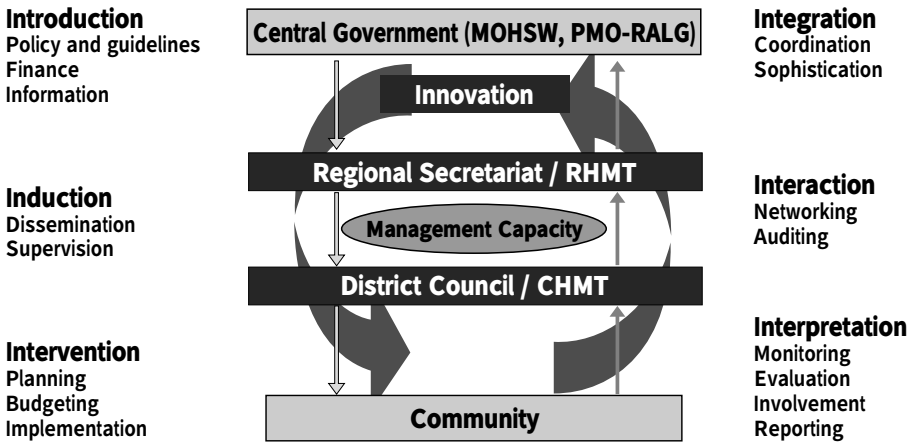
At the same time, for the experiences and activities that were organized and made into educational materials by the CPs themselves, opportunities were provided to present them externally, and a program of mutual visits to examine the feasibility of applying them in other regions was conducted. Through this, the confidence of the CPs was fostered and a foundation was laid for dissemination and expansion.

■Features of and Lessons from MHP from a CD Perspective

(1) A Sustainable Health System from a Comprehensive Perspective

Figure 1 is an image of the health system that comprehensively illustrates the respective ways in which the central government, regional governments, district governments, and communities are all involved through the MHP.

Figure 1 Sustainable Health System



Source: Sugishita (2006c) p. 14

As the above figure shows, it is important that both systems, those that draw out the needs from the bottom up and those that provide services from the top down, interplay and function as a sequence of systems. As a result, this ensures development whereby local health administration services can reach the residents in an appropriate manner.

Thus, the MHP was positioned **in between these bottom up and top down approaches. Targeting regions and districts that were acting as bottlenecks, it fostered health administration management with the goal of organizational enhancement.** As a result, the district health administrative team accurately determined the health needs of the community, and it became possible to formulate this as a district health planning and budgeting operation. At the same time, these activities led to the creation of a sustainable health system by means of the acquisition of a sector basket fund positioned from the top within the health SWAp.

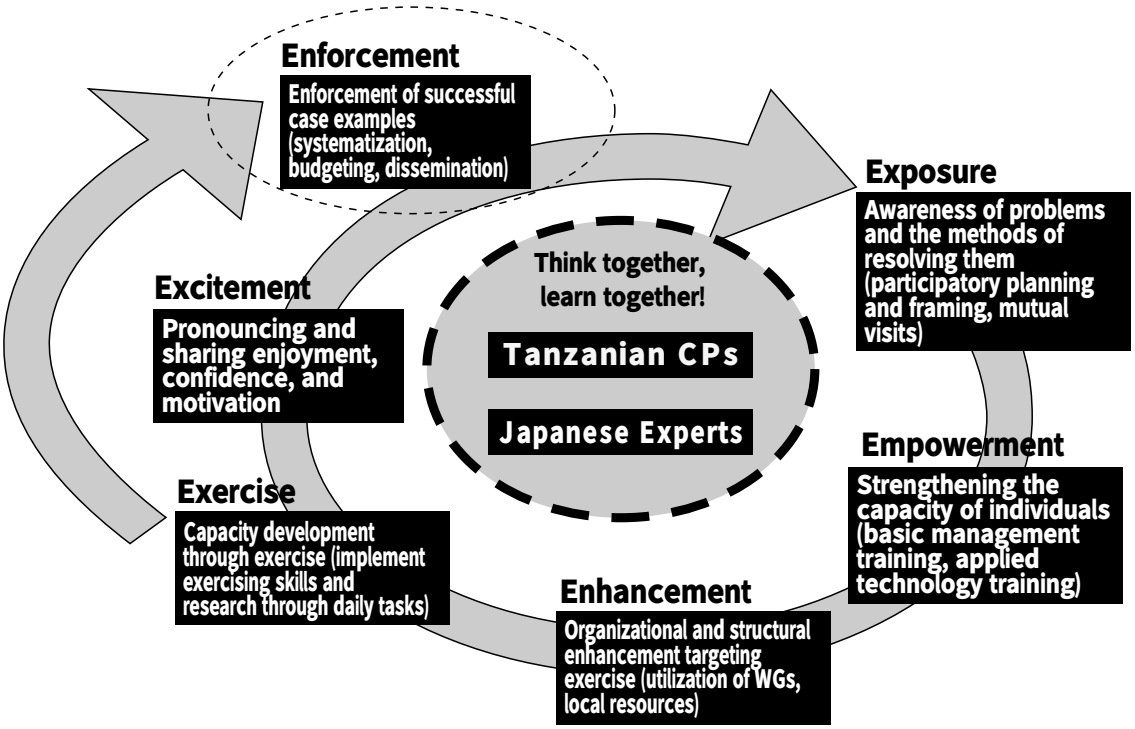
(2) Ownership

There are believed to be two significant sets of factors behind the fostering of ownership on the Tanzanian side through the MHP. The first is the **attitudinal factors** between the parties of Japan and Tanzania in which the Tanzanian side took the lead in project formulation and planning, while Japanese experts provided catalytic support. The other is the **strategic factors,** in which the configuration of project activities and local resources were utilized until a system was set up in which RHMT/CHMTs worked to address health problems within the region as a team.

For the **"catalytic support"** which constitutes the focal point of the attitudinal factors, RHMT/CHMTs did not wait for instructions from the central government. Instead, such support was characterized by an emphasis on **Japanese experts and CPs thinking together and learning from one another** in order to allow for the implementation of health services independently and flexibly at the regional level. This posture of serving as catalysts also serves to explain the importance of the presence of the Japanese experts as foreigners. It was precisely because they served as "catalysts" for a limited period that they were at times able to play an intermediary role between the various stakeholders, as well as occasionally proposing ideas from a different point of view. Due to their genuine "interaction" through mutually thinking together and learning from one another, CPs that were imbued with leadership capabilities were fostered. Along with this, teamwork was created among the CHMTs as well as the WGs that were formed for each health issue. It can be said that these facts comprise the quintessence of catalytic support.

Figure 2 denotes this catalytic support in a more systematic manner, expressing this concept by means of the **5Es (Exposure, Empowerment, Enhancement, Exercise, and Excitement).**

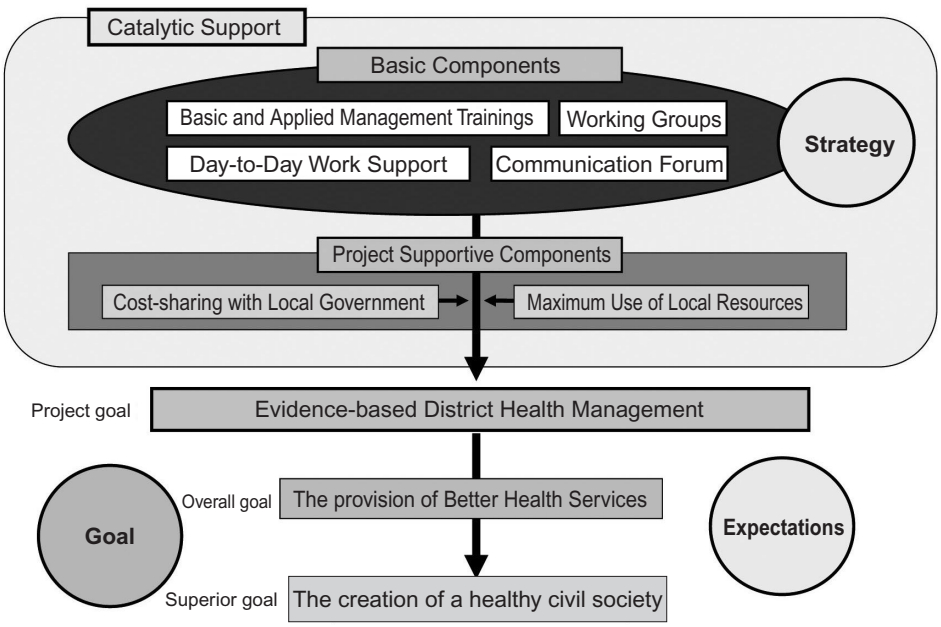
Figure 2 Catalytic Support (5Es) and 1E (Enforcement)



Source: Created by the authors from the MHP (2005).

As for the strategic factors, Figure 3 compiles the process for raising independently developed local health services. This combines the configuration of activities for realizing CD, as well as providing the supporting foundation from local costs and resources used to carry out these activities in a sustainable manner.

Figure 3 Process for Strengthening Capacity that Enables Autonomous Development



Source: Sugishita (2006c)

"Management training" was basically carried out at the "WG-level," and the different members applied the capacity that they acquired throughout their "daily activities." Through opportunities to publicize the outcomes of this, "information sharing" was conducted with all of the stakeholders, which in turn promoted the strengthening of organizational capacity.

As a support strategy for autonomous development, **"cost sharing" was facilitated** for project activity expenses targeting the district governments within the project. Independent revenue sources were proactively utilized in the health basket fund which was allotted to districts through the SWAp. Moreover, the promotion of **activities and collaboration with "local resources"** such as universities, research institutions, and Non-Governmental Organizations (NGOs) is thought to be highly sustainable in a cost and technological sense as well. While accessing local resources, it is important that the capacity to utilize and manage local resources should be imparted to the CPs.

(3) Visualizing the Outcomes

In aiming to position project outcomes in a comprehensive manner and enforcing them through the understanding and support of the concerned parties, it is essential to **visualize the outcomes and express them internally and externally** to the extent possible. For the MHP, the management capacity of the various health administration teams was visualized in an easily understood manner through the six qualitative indicators of the Hexagon-Spider-Web-Diagram (HSWD).

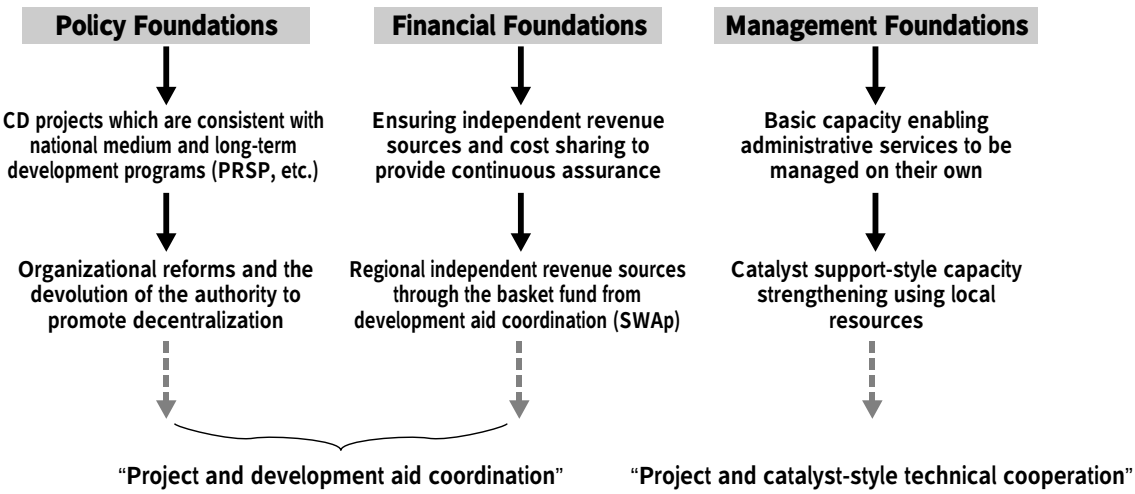
Moreover, the outcomes from activities by the WGs were turned into visible outcomes such as "publications," and the CPs consciously created venues to publicize these both internally and externally. This not only promoted endogeneity in the form of **"backing up CPs as catalysts,"** but from the perspective of comprehensiveness **"acknowledgement from a wide range of actors"** also served as an important component for autonomous development.

■Lessons for Future Technical Cooperation

(1) Perspective of Comprehensiveness: Creation of an Autonomous Development System and Comprehensive Consideration

The three pillars of **policy, financial, and management** aspects are essential for the creation of an autonomous development system. Figure 4 illustrates the sort of policies that are required of each of these from the three foundations that are bolstering sectoral reforms.

Figure 4 Three Foundations of the Tanzanian Health Sector



Source: Sugishita (2006a) p. 117

From this figure, it can be seen how strengthening the policies of the government in the partner country as well as the budget support backing this up are required in order to enhance the policy and financial foundations. This inevitably entails coordination between the government and the development partners, as well as among the development partners, as a prerequisite. Strengthening the capacity of the management foundations in local areas is needed over and above the policy and financial foundations in order for the organizations and individuals of the partner country to carry out projects independently. The claim could be made that the catalytic support from the MHP contributed in this area.

When providing CD support, it is **necessary to examine development visions based on assessments of the capacity on the ground from the three foundations adopting a comprehensive perspective.** The outcomes of this are then used to ascertain bottlenecks and accurately narrow down entry points for support. At the same time, it is indispensable that not only the direct targets of support, but also actors who are involved in the initiatives from the three foundations be attracted from a wide spectrum and incorporated into stages such as implementation.

When this is done, various different schemes, such as policy advisors and development studies, will be devoted to the multilevel organizations of the partner country, such as the central and regional governments, as well as government agencies for planning and implementation. This should be done on account of the limitations that are present at the project level, and will likely result in making it possible to further expand project outcomes. From this perspective, the strategic formation of a "JICA program" is sought.

(2) Perspective of Endogeneity: Peripheral Support Emphasizing the Self-reliance of Developing Countries

For the sake of supporting the CD of the partner country, consideration must be given to mechanisms to foster a sense of ownership on the part of the partner country through the support process. It is necessary **to specifically clarify the extent to which the counterpart side is willing to make commitments in a policy, financial, and personnel sense to the project from the project formulation stage.** If this cannot be elicited from them satisfactorily, then a resolution to go so far as suspending the cooperation is necessary.

Cost sharing with the partner country will not be achieved easily; it is something that should be examined from the project formulation and implementation stages over a medium- to long-term time frame. When performing this, it goes without saying that the project should be positioned upon the policy foundations of the partner country. It is also necessary to call attention to the significance of activities and their outcomes that are sufficient to convince the developing countries to bear the financial costs.

(3) Systemization and CD Support Period for the sake of Positioning Self-reliant Initiatives

Starting during the project implementation period, it is essential to **systematize the project outcomes from a policy-wise institutional point of view, and also to give rise to a cycle of strengthening self organization.** The purpose of this is to set in place initiatives from the project as independent efforts of the partner country after the end of cooperation from JICA.

When considered from the partner country's program orientation, developing partners should think about support on the basis of a medium- to long-term outlook. However, this is not necessarily the same as implementing CD support projects over a long time frame. In the event that CD demonstrates enhancement of the self-reliant problem-solving abilities of the partner country, then **consideration must be given to somehow transitioning to self-reliant initiatives by the partner country without support, on the premise that CD support from the development partners has a definite end point.**

Introduction

1. Background and Purpose of the Case Study

In recent years, growing importance has been attached to capacity development (CD) in international efforts towards increased aid effectiveness and the achievement of development results. CD has been attracting attention since the 1990s. This was based on the recognition that assistance in the past did not necessarily lead to sustainable development and the achievement of development outcomes in the developing countries. CD is defined as "the ongoing process of enhancing the problem-solving abilities (capacity) of developing countries by taking into account all the factors at the individual, organizational, and societal levels."

"Problem-solving abilities" refer to the "ability to set and achieve objectives" and the "ability to identify and resolve development issues." The first feature of the concept of capacity development (CD) is the emphasis on the developing countries' ownership and leadership in solving development problems by themselves. Secondly, by defining capacity as "problem-solving abilities," the CD concept lays stress on the endogenous nature of CD. This means that capacity is not something to be transferred from outside, but rather something that continuously develops through the endogenous efforts of the developing countries themselves. This is based upon reflections which concluded that a large proportion of past assistance has undermined the existing capacity of the developing countries and attempted to make a simple transfer of the technology, knowledge, and systems of the developed countries from the outside. Under the concept of CD, the development partners are required to provide assistance in such a way that it fully utilizes the existing capacity of developing countries and supports their endogenous efforts by operating as a "catalyst." The third characteristic of the CD concept is the understanding of capacity as aggregate of diverse elements and of CD as a dynamic process of change through the interaction of these elements. It is recognized that successful efforts to promote CD require attention not only to capacity at the individual and organizational levels, but also to the policies, institutions, and systems that serve as the enabling environment which influences the behaviour of the individuals and organizations.

The concept of CD as mentioned above has been elaborated through a series of studies by the United Nations Development Programme (UNDP) and discussions at such international for as the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC). The concept is now internationally accepted; and the importance of CD is widely recognized by developing countries and donor countries alike as a means for the improvement of aid and development effectiveness. In particular, the importance of CD is highlighted as a critical element in achieving development objectives and is clearly specified in the Paris Declaration on Aid Effectiveness, which was adopted in 2005 by more than 100 countries. The declaration articulated the necessity of endogenous efforts by developing countries for capacity development and the need for coordinated support from development partners for these efforts. Given this, how to operationalize the concept of CD into actions has become the next challenge for both developing countries and aid agencies.

The Japan International Cooperation Agency (JICA) has actively taken part in international discussions on CD and has also made efforts to reflect the concept of CD in its assistance, having established CD as the objective of its technical cooperation. As part of such efforts, it has published a report entitled "*Towards Capacity Development (CD) of Developing Countries Based on their Ownership (2006),*"

which describes the relationship between the concept of CD and JICA's cooperation. In addition, it has conducted a series of case studies designed to serve as a reference in order to reflect the concept of CD in its assistance. This study takes up as one of its case studies the Morogoro Health Project (MHP; April 2001 to March 2007) and analyzes the experience in supporting the CD of the local government, which is crucial for improving basic social services in developing countries.

In Tanzania, Health Sector Reform (HSR) has been promoted as a national policy since the middle of the 1990s, and the decentralization of health services has been advanced. Furthermore, against this background, as a part of efforts under the Sector-Wide Approach (SWAp), Health Sector Basket Fund (HSBF) was introduced to ensure independent revenue sources for the local health services. This allowed the reinforcement of the financial foundations to promote decentralization under the HSR. However, it has been gradually recognized that the weak human resources and management capacity have impeded the efforts of local governments to fulfill the responsibilities transferred to them from the central government and provide effective health services.

The MHP has been carried out, through a pilot project in the Morogoro region, to establish a model to strengthen the comprehensive capacity of the local governments to plan, implement, and manage public health services that meet the needs of the community. The main target of the project was the district governments that deliver health services, and the regional government, which plays a guiding and supervisory role with respect to the district governments.

Comprehensive CD support for local government authorities is a new area of assistance for JICA, so it came down to a trial and error situation. Furthermore, at the time that the MHP was initiated, the concept of CD described above had not yet been established internationally. Therefore, the cooperation was not necessarily carried out with a full awareness of the CD concept from the beginning. However, the end result was that MHP turned out to be an excellent CD initiative in a number of ways. These include factors such as: (1) the emphasis on country ownership and leadership; (2) the support for endogenous efforts in a facilitative manner; (3) the comprehensive approach to CD; and (4) the establishment of a sustainable system through cooperation with a diverse range of actors and networking.

Furthermore, in the MHP, the CD support was conducted (1) based upon the Tanzanian development policy and strategies, (2) being coordinated through the country's own efforts as well as assistance from other development partners, and (3) in a way that complemented other aid modalities such as the sector basket fund. Thus, it produced tangible results in achieving the objectives of the development policies and objectives. The importance of such issues as alignment, coordinated support, and complementarity are emphasized internationally to enhance aid effectiveness. Given this situation, the experience of the MHP is considered to have provided many useful suggestions as an example of CD support.

This case study, by analyzing the MHP, is intended to extract the lessons learned in the planning and implementation of effective technical cooperation for capacity development. It is also intended to analyze the role played by Japanese experts in supporting endogenous efforts for CD by the developing countries.

2. Methodology of the Case Study

For this case study report, reference was made to the outcomes of the field study prepared by a consultant. The analysis and writing were carried out jointly by the Research Group of the JICA Institute for International Cooperation, the Health Administration Team (Group Ⅲ) of the Human Development Department, JICA Tanzania office, and a consultant.

The following members were involved in carrying out this case study.

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Tomohiko SUGISHITA	JICA Senior Advisor, Advisor to the Human Development Department
Ikuo TAKIZAWA	Chief, Health Administration Team (Group Ⅲ) of the Human Development Department
Satoko MIWA	Senior researcher and Senior Assistant to the Director General, Institute for International Cooperation (concurrently with the post in the secretariat)
Yoichiro KIMATA	Researcher, Aid Strategy Team, Research Group, Institute for International Cooperation (concurrent with post in secretariat)
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Sachiyo ITO	Researcher, Aid Effectiveness Team, Research Group, Institute for International Cooperation (until April 2007)
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< Consultant >	
Risako IMAI	Kokusai Kogyo Co., Ltd.

As shown in Table 0-1, the framework for this case study is comprised of “Basic Analysis Perspectives” and “Points of Analysis.” It was conducted by reviewing the processes from project formulation through to implementation and evaluation in chronological order and extracting factors which may serve as lessons.

For this study, information was collected and analyses were performed by reviewing the literature, such as related reports, materials, publications, as well as conducting interviews with the concerned parties on both the Tanzanian and Japanese sides and by other means. The field study itinerary (February 3 - March 2, 2007) can be found by referring to Appendix 1, while the interview lists can be found by referring to Appendix 2 and 3, respectively.

Table 0-1 Case Analysis Perspectives and Points

Basic Analysis Perspectives	
Did it have consistency with the SWAp within the framework of bilateral technical support and development aid coordination? Was it somehow harmoniously positioned as a CD project in the health sector while placing value on the independence of and autonomous development by the Counterpart (CP)? Was it implemented effectively and efficiently and achieve outcomes?	
Points of Analysis	
1. Project Design	1) Was the project positioned and formulated with the objective of reforming the health system in a manner consistent with the SWAp? 2) How were the responsibilities and roles of the Tanzanian stakeholders coordinated in the project amidst the changing relationship between the central and local governments due to decentralization? 3) In what manner were the project design and implementation structure created in response to the changing policy environment and unique regional characteristics of the partner country during the project implementation stage?
2. Process of improving CD (endogeneity / comprehensive-ness) in the project	1) Through what process were the attitudes, ownership, and so on of concerned officials in the partner country (central, local governments) fostered in this project? 2) In what manner was the implementation process for this project, which was arranged as catalytic support, evaluated from a CD (endogeneity) perspective, and is there the possibility of sharing this as a valid approach? 3) What sort of schemes were employed to assess the aforementioned changes? (establishment of indicators, etc.) 4) What sorts of schemes were there for the planning of the project activities on the Japanese side?
3. Challenges for systematization (including performance reviews and future prospects)	1) How were business models for the sustained delivery of services established throughout local areas through CD projects in the local health sector? 2) What should be done to enable Morogoro's experience to be applied to other regions? 3) How will Morogoro's experiences be systematized through the central government? 4) How should an independent, sustainable structure be established to provide feedback on the outcomes from this case by combining SWAp and decentralization policies? 5) In the future, how should the attention of other development partners be called to the initiatives from this case? How can it be harmonized with the initiatives of other development partners?
4. Role of major actors in overall project activities	1) How were the departments in charge in the JICA headquarters, JICA Tanzania office, Japan embassy in Tanzania, other health experts active on the ground, the domestic support committee, and others involved in project management? Were there any points or issues devised for things like the implementation, monitoring, and evaluation of CD projects? 2) How were local resources utilized in order to ensure the operation and continuity of effective CD projects? 3) What sort of transitions did the catalytic support from Japanese experts undergo over the four stages from the project's initial stage, to its mid-term, completion, and extension periods in order to foster the ownership of the Tanzanian side? 4) In what manner were Japanese experts and the JICA Tanzania office involved in ensuring financial autonomous development via cost sharing with the Tanzanian Government (local municipal governments, etc.) 5) What were the CD effects of technical cooperation by way of cooperation modalities?

Source: CD Case Study of the Morogoro Health Project (MHP), public tender documents

3. Composition of this Report

This report is composed of four chapters in total.

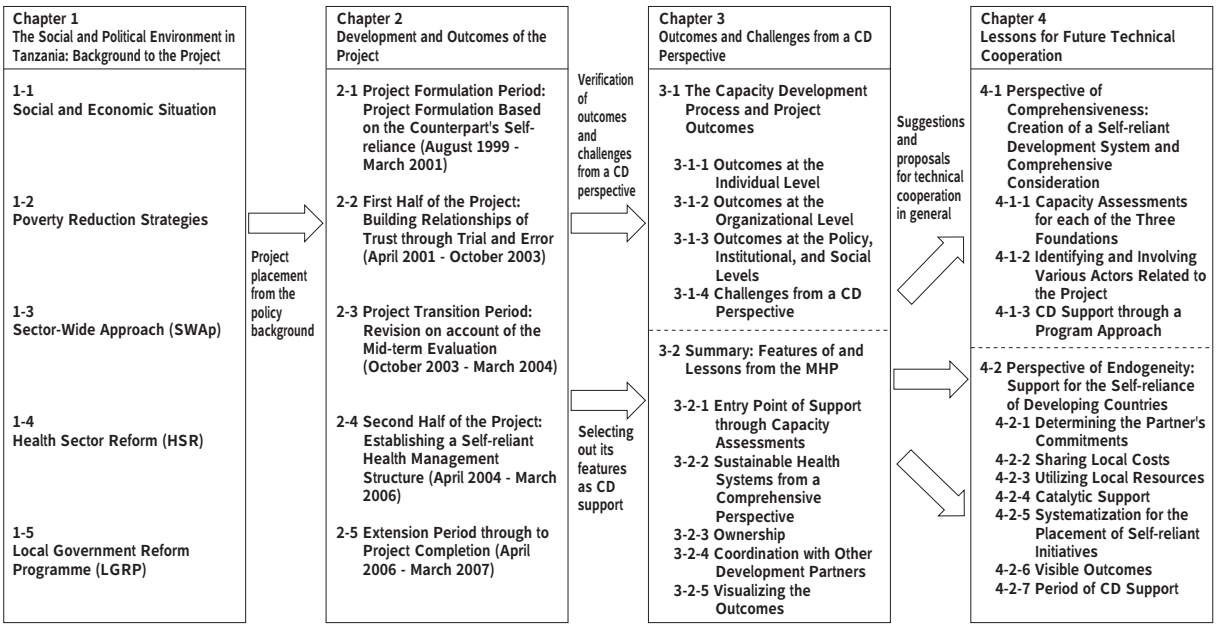
Chapter 1 gives a general outline of Tanzania's HSR and Local Government Reform Programme (LGRP) as the background to the formation of this project. It will describe how the mechanism for providing local health services has changed and what responses the Tanzanian Government has taken.

Based on the political background mentioned in Chapter 1, Chapter 2 follows up on the process of how the project was requested, formulated, and implemented, and will reveal the manner in which a method of trial and error was carried out between the Tanzanian side and Japanese experts.

Chapter 3 will take up the implementation process delineated in Chapter 2 and reexamine it from a CD perspective. This chapter will organize subjects like the outcomes and challenges at the individual, organizational, institutional, and social levels, as well as features of this case project and schemes put into practice by it.

Finally, based on the lessons in this implementation process suggestions and proposals for the implementation and operation of future technical cooperation will be compiled in Chapter 4 from the perspectives of "complexity" and "endogeneity."

Figure 0-1 Composition of this Report



Source: Created by the Authors

Chapter 1 The Social and Political Environment in Tanzania: Background to the Project

This case study will take up and illustrate a general overview of the Morogoro Health Project (MHP). Before proceeding with this, however, it will begin with a synopsis of what sort of social and economic situation Tanzania was in as the historical backdrop to when the project was requested and formulated. It will also outline the manner in which the HSR, decentralization, and other national development strategies were worked out.

1-1 Social and Economic Situation

In May 1992 Tanzania transitioned from single-party rule under the Revolutionary Party to a multi-party system, and in October 1995 elections for the president and members of parliament were conducted for the first time under this multi-party system. Tanzania is said to be one of the most politically stable countries among the countries of Africa. Since the introduction of the multi-party system, the political and social situation has remained stable under the leadership of the governing CCM (Chama Cha Mapinduzi, Revolutionary Party). In 2000, President Benjamin William Mpaka was reelected, and in 2005 the former Minister of Foreign Affairs and International Cooperation Jakaya Mrisho Kikwete was inaugurated as the new president, with both of them representing CCM.

Diplomatically, since 2001 Tanzania along with Kenya and Uganda have comprised the East African Community (EAC). In striving to strengthen regional cooperation, it has entered an EAC customs union that came into effect beginning in January 2005. Furthermore, it served as the chair country for the Southern African Development Community (SADC) for one year starting in August 2003. As an important member, Tanzania has played the important role of a mediator in Eastern and Southern Africa. Moreover, it also displays diplomatic leadership aimed at achieving peace in Burundi and the Democratic Republic of the Congo in order to stabilize the Great Lakes region as a whole.

In addition, since 1995 Tanzania's economic situation has been showing favorable growth as a result of the implementation of the development strategies described above. Over the five year period from 2000 to 2004 the country has displayed a real economic growth rate that is at the high level of 5.8%. This growth has largely come about as a result of the development of the mining industry, which is centered around gold (over this period the mining industry had an average yearly growth rate of 15.2%). The average yearly growth rate over this same period for the agricultural sector, which constitutes 80% of Tanzania's labor population, remained at 4.8%. For this reason, the stable development of rural areas, which comprise roughly 80% of the total population and some 80 to 90% of those living in poverty, will be a challenge for the immediate future. It is important that poverty reduction be achieved in a visible manner that does not unevenly distribute the benefits of growth solely to urban areas.

1-2 Poverty Reduction Strategies

In 1997 the Tanzanian Government formulated the National Poverty Eradication Strategy (NPES) as a national development strategy. Then, in 1999 it announced Vision 2025, which stipulated the course for long-term development in Tanzania (improving the quality of life, ensuring good governance and the rule of law, and a competitive economy). Taking these as its basic policies, in 2000 it was the first among other

countries to formulate a Poverty Reduction and Strategy Paper (PRSP), initiating Poverty Reduction Budget Support (PRBS) the next year in 2001.[1] Following this, it created the Tanzania Assistance Strategy (TAS) in 2002, and the National Strategy for Growth and the Reduction of Poverty (NSGRP; or MKUKUTA in Swahili) in 2005 to serve as its second poverty reduction strategy.[2] In parallel with the setting in place of such policy foundations, it also established financial foundations such as the Public Expenditure Review and the Medium-Term Expenditure Framework (MTEF), and developed laws one after another. This was done for the implementation of the national development plans PRSP/NSGRP.

The First PRSP (2000) aimed to directly benefit specified impoverished groups via priority sectors such as health and medicine, education, and others. While holding to a policy of reducing poverty, the second poverty reduction strategy from April 2005 narrowed its focus down to "poverty reduction through growth and income," "improving the quality of life and social welfare," and "good governance and accountability." The health sector was integrated into the social welfare service cluster along with education, water, and the environment. Enhancing the policy foundation posed a challenge for the sake of enabling cross-sectoral activities and financial cooperation.

1-3 Sector-Wide Approach (SWAp)

The 1995 Helleiner Report criticized the proliferation of individual projects as imposing a significant burden on the part of the partner country, and pointed out that aid should be provided in a manner that is consistent with the policies of the partner country. In particular, the report clearly indicated that donor-led development aid acts as a hindrance to fostering ownership by the partner country. This is exemplified by the inefficiency of project implementation by individual aid agencies, as well as government employees in the partner countries losing out on opportunities to carry out their basic duties as a result of their having to deal with differing aid modalities. As a result, aid coordination designed to foster Tanzania's self-reliance was examined, and in 1998 a health SWAp was introduced ahead of the other sectors. Because of this, use of the HSBF was begun in 1999 as an independent revenue source for decentralized health systems.

Figure 1-1 illustrates by what sort of stages aid coordination was carried out in the project accounting and government general accounting systems. The "ownership of the partner country and the establishment of sustainability" are emphasized in the SWAp. It defines the objective as being to carry out budget drafting, execution, and evaluation and monitoring under the unified control of the partner country. Sugishita (2006) lists the following items as outcomes of the introduction of a health SWAp in Tanzania.

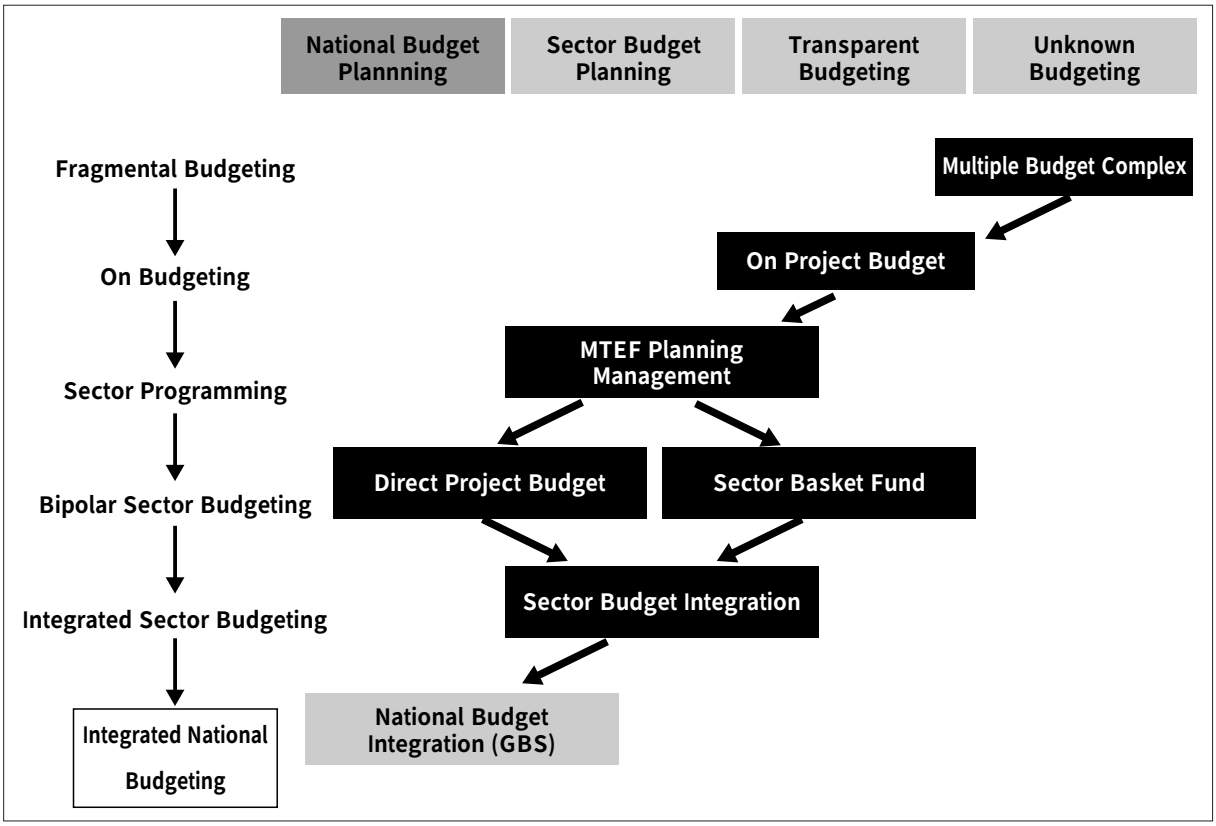
- A foundation was established by which the government and development partner were able to work together to implement development strategies in line with the nation's priority issues.
- The strategic aspects were clarified by means of sharing the monitoring system for the achievement of national objectives.
- Set the foundation for the sustainable and autonomous development of district health provision founded on a long-term outlook by means of stably ensuring revenue sources for health in local areas.
- Allowed comprehensive sector-spanning regional development to be conducted by means of strengthening collaboration between government functions and local government authorities.
- Can be expected to increase the efficiency and transparency of aid, as well as utilize resources

[1] Japan has contributed an amount of 500 million yen to PRBS through grant aid for debt relief on two occasions, once in March 2002 and again in March 2003. In 2004 Japan approved the input of substantial funding of non-project grant aid.
[2] MKUKUTA is the abbreviation for Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania.

efficiently via the centralized management of revenue sources by the state.

- By promoting health activities under the leadership of the local areas, it will raise the incentives to and motivation of the actual site, and allow for the implementation of more vigorous health activities.

Figure 1-1 Steps towards SWAp/GBS



Source: Sugishita (2006b)

1-4 Health Sector Reform (HSR)

In development assistance for Tanzania, an important factor is that two major reforms, HSR and LGRP, are being actively pursued (refer to 1-5 regarding LGRP). This section will describe the transformation of health policy and important foundations for the HSR.

1-4-1 Transformation of Health Policy

Against the trend of new public management in the early 1990s, the Tanzanian Government introduced the restructuring of central government ministries and agencies in order to respond to the needs of the people. In 1994 the MOHSW released the Health Sector Reform Policy and Guidelines. HSR was initiated ahead of reforms in other sectors, and was designed to delegate authority for health services to local government authorities (Table 1-1). The goal was to have local government authorities that were closer to the residents provide prompt health services to the community by means of the decentralization of the health sector. The same guidelines list the following challenges.

i) Regarding residents as “customers” when it comes to providing health services, it is necessary to convert to a viewpoint of “customer-oriented” services through health management teams.

ii) Processes for planning, budgeting, and reporting that would ensure the quality of health services must

be introduced.

iii) It is essential that the Regional Health Management Team (RHMT) provides the Council Health Management Teams (CHMTs) with technical and managerial support on a case by case basis according to needs.[3]

iv) Motivated and eager human resources should be allocated.

v) Pertinent and well-managed health infrastructure is required.

vi) A sufficient budget should be guaranteed.

vii) CHMTs must encourage the participation of residents and the medical care providers at health facilities, as well as act with accountability.

viii) Tools to evaluate the quality of health services and standard operating procedures should be adopted.

Table 1-1 Health Sector Reform and its Surrounding Policies

Year	Development Policy	Health Policy
1991	Public Sector Reform Programs	
1993	Civil Service Reform	
1994		Health Sector Reform Policy and Guidelines
1995	Vision 2025	Health Sector Reform Proposal 1996- 2000 (proposed the introduction of a SWAp)
1997	National Poverty Eradication Strategy	Proposal for a Sector-wide Improvement Program (SIP)
1998		Agreement on Health SWAp
1999	Tanzania Assistance Strategy(draft)	Health Sector Strategic Plan 1999-2002
		Health Sector Basket Fund
		Introduction of Comprehensive Council Health Plan
2000	Poverty Reduction Strategy Paper (medium-term development plan)	National Package of Essential Health Interventions
	(Millennium Development Goals)	Community Health Fund
2001	Poverty Reduction Budget Support	Tanzania Commission for AIDS (TACAIDS)
	Public Expenditure Review[4]	
	MTEF 2002-2004	
2002	Tanzania Assistance Strategy	National Health Policy(revised version)
		National Health Insurance Fund (NHIF)
		Global Fund for AIDS, TB and Malaria (GFATM)
2003		Health Sector Strategic Plan II 2003-2008
2004	Poverty Reduction Strategy Paper II (medium-term development plan)	Emergency Infrastructure Rehabilitation Program
	MTEF 2004- 2007	Tanzania HIV Indicator Survey (THIS)
2005	National Strategy for Growth and Reduction of Poverty= MKUKUTA (2005-2010)	TEHIP tools rollout (half of the districts)
	Joint Assistance Strategy (draft)	Guidelines for the Reform of Regional and District Hospitals
2006	Joint Assistance Strategy	

Source: Compiled from Cowi et al. (2007)

[3] CHMTs and RHMT are comprised of regional and district physicians and health officers, as well as staff members from regional and district hospitals and others. In districts they effectively serve as the health divisions for the government authorities, and at the regional level they play a role of technically supporting the region as branch agencies of the MOHSW.

[4] Public Expenditure Review by the Tanzanian Government through donor participation.

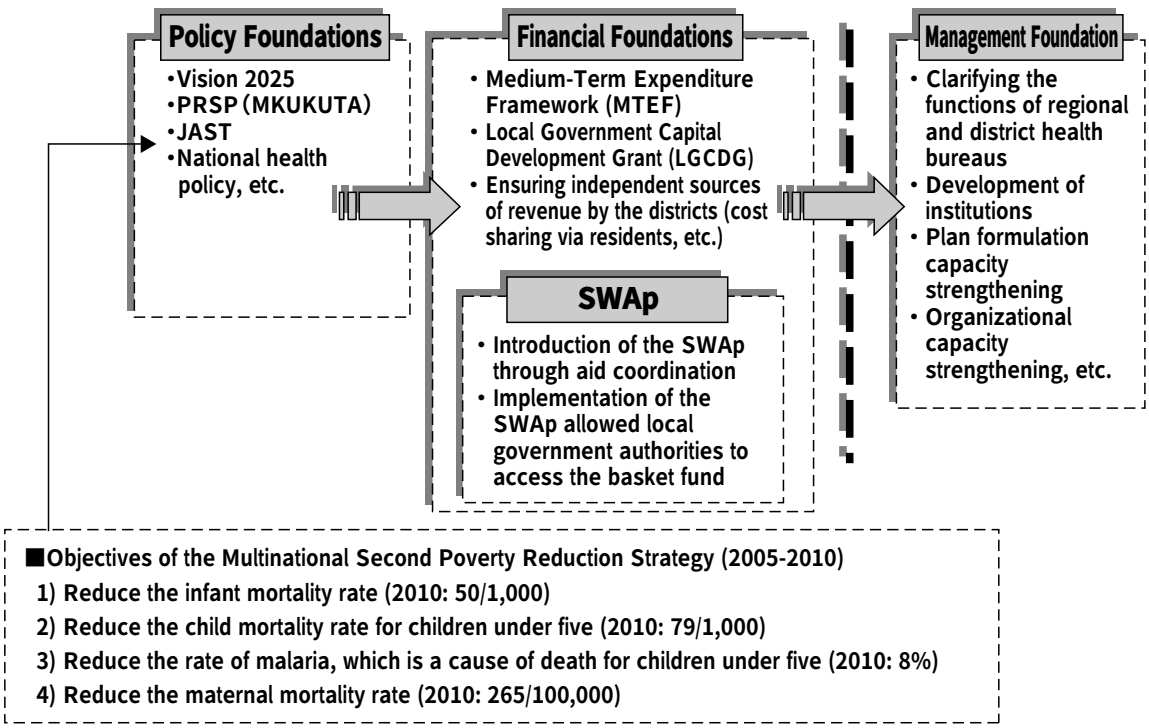
In order to set in place the independent financial foundations to promote the HSR, the Ministry of Health and Social Welfare (MOHSW) of Tanzania abolished budget management for health projects led by development partners that lacked accounting statements to aid agencies. It also sought fiscal management in line with the mid-term health expenditures plan based on health policy. As a result, in 1999 the HSBF through the SWAp was examined and introduced as an independent source of revenue for local health services. This established the financial foundation for the local government authorities to independently plan and implement health activities.

Traditionally, health service delivery was primarily provided by the government. However, as a result of the health sector reform, health and medical services came to be provided by the private sector, religious groups, and Non-Governmental Organizations (NGOs). Furthermore, by increasing the burden for medical costs borne by the public, the Tanzanian Government is aiming to strengthen revenue sources for health with an eye toward financial autonomous development. This will be accomplished through the phased introduction of cost sharing by starting to charge fees for medical treatment, community health funds, drug revolving funds, and national health insurance schemes.

1-4-2 The Three Foundations of HSR

Through such means the policy and financial foundations were set in place. As a consequence of this, the vulnerable capacity regarding the problem-solving ability of local health administrations was thrown into relief. In particular, this highlighted the lack of the managerial capabilities of local health administrators and their inexperience in the organizational aspects of regional and district health administration (Figure 1-2).

Figure 1-2 The Three Foundations of HSR



Source: Created by Sugishita (2006b)

1-5 Local Government Reform Programme (LGRP)

1-5-1 Transformation of Local Administrative Policies

In 1972 the Tanzanian Government did away with the local government authorities that had persisted until that time. The reasons for this included a shortage of capable administrators, improper disbursements from budgets, a lack of operation and maintenance capacity for the social infrastructure developed by the central government, a lack of managerial capacity on the part of administrators, and others. After that, from 1972 to 1984 the system shifted to one of centralized administrative authority, thereby turning into a bureaucratic, inefficient, and ineffectual system. The declining living standards of the people and soaring costs of operation and maintenance led to a deterioration in social and economic services. It was acknowledged that the morbidity and disease prevalence rates were increasing as a result of the drop in the number of people receiving health services, while literacy rates were declining along with the decrease in the number of children enrolled in primary education. In 1984 the central government set out to rebuild the local government authorities in the wake of legal reforms, and the provision of administrative services by local government authorities was resumed. However, the number of public servants had decreased substantially on account of the structural adjustment programs implemented from the 1980s to the 1990s. As such, there was a shortage of human resources, and all of a sudden improving the quality of regional public services was no longer feasible.

Decentralization by devolution (D by D) was articulated in the 1998 Policy Paper on Local Government Reform. The objectives for this were given as devolving authority related to personnel, finances, and other matters to the local government authorities, as well as rebuilding the administrative system (Table 1-1). Following this, the LGRP was officially announced in 2000. This ranked the health, education, water, agriculture, and roads sectors together as strategic pillars for restructuring of regional administration and poverty reduction. The following objectives are established within the LGRP.

- A system of local government authorities with autonomous authority[5]
- A system of local government authorities with resources (particularly financial and human resources)
- Local authorities comprised of democratically elected leaders
- Local authorities that allow for public participation in development planning and implementation
- A system which reflects regional needs
- An autonomous system which ensures transparency and accountability

Furthermore, the following matters were requested of the various local government authorities with regard to the devolution of authority to the local areas.[6]

- Establish comprehensive strategies and objectives aimed at improving public services
- Establish indicators to measure performance
- Identify causes for discrepancies in performance
- Invest strategic resources (financial, human resources) so that services benefit the local residents
- Promote democracy in the determination process

The following action policies are indicated in the Mid-term Plan and Budget 2005-2008 (MTP05-08), which serves as a specific action plan for the achievement of the items above.

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[5] Additionally, at the regional level in Tanzania regional governments which act as branch agencies of the central government have been established instead of local government authorities.

[6] PMO-RALG (2004) p. 5

- Mainstreaming of D by D
- Fiscal Empowerment
- Human Resource Empowerment
- Legal Framework
- Restructuring LGAs
- Governance
- PMO-RALG & Regional State Capacity Building

Based on the aforementioned items, the provision of various public services was transferred from the central government to the local government authorities. There were problems involved with this, such as missteps between government ministries and agencies, as well as the fact that smooth progress was not seen with the legal framework or the transfer of personnel authority. Yet regardless, the financial foundations were established within the ministries for local authorities in a manner consistent with the national development plans (PRSP, TAS, MKUKUTA, etc.). The basket fund designed to promote the LGRP serves as an example of this.

1-5-2 Decentralization of Health Services through the LGRP

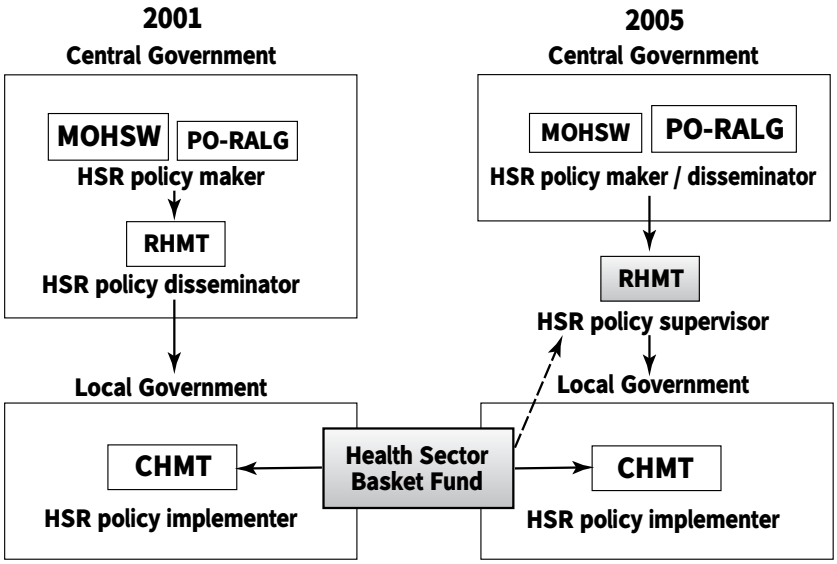
The introduction of the LGRP in 2000 defined the roles of the central and local governments: the former formulates policies and the latter provides administrative services, including the planning, implementation, and monitoring of various projects and programs. Within the health sector, the carrying out of health and medical services was transferred to the initiative of the local government authorities. Due to the devolution of authority with regard to personnel, health sector human resources were shifted from the MOHSW to the local government authorities. Furthermore, in the wake of the decentralization the division of labor among central government ministries and agencies changed as well. Local governments were required to manage local revenue sources and provide services, while the MOHSW was called upon to strengthen its capacity for technical backstopping and human resources development.

Figure 1-3 offers a comparison of the relationship diagrams from 2001 and 2005 for actors who had their roles altered as a consequence of the decentralization. Prior to decentralization, MOHSW maintained consistent responsibility for everything from policy formulation to the implementation of services, and CHMTs provided services as branch agencies of the MOHSW. After decentralization, the fact has not changed that MOHSW still formulates the policy. However, services in the local areas are provided solely by the districts, and the President's Office-Regional Administration and Local Government (PO-RALG, currently the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG)) came to bear responsibility for the supervision and backstopping of administrative management as a whole. The function of the MOHSW has changed to focus on the formulation of the policies as well as technical backstopping and support to the local authorities.

Budgetary allocations from the HSBF to the RHMT, which are part of the central government, were not planned in the institutional design from the time of the HSBF's establishment. But gradually, however, autonomous activities like the backstopping and supervisory functions of regional governments targeting district governments came to be called for. Based on this background, in 2005 it became possible for the HSBF to make contributions to the RHMT.[7]

[7] During the implementation of MHP, expenses were not actually allocated to the RHMTs for their routine visits and guidance to the various districts.

Figure 1-3 Health Sector Policy Transition during 2001-2005



Source: Sugishita (2006b)

In this manner, the MHP was created in order to promote the HSR. Accompanying the advance of local administrative reforms the role of regional governments was reconsidered. Furthermore, since the MHP's activities and mid-term evaluation onwards there have come to be calls for activities to strengthen management related to the organizational enhancement of the region as a means of converting it from a manager of the districts to a joint implementer alongside them.

Against the background of the two important reforms mentioned above, MOHSW had to accept the fact that, despite the setting in place of policy and financial foundations, this had largely not led to the provision of the health services sought by the local residents. It therefore worked out a policy of giving priority to promoting the enhancement of management capacity for regional and district health administrations. The expectation was for JICA to create a model of region-district partnerships in the Morogoro Region. Yet even though authority was transferred to the region during the project period, creating this model took time on account of the fact that the budgetary measures for regional governments were not carried out smoothly relative to those for district governments.

Box 1-1 "There's no budget..." What would you do? (Part 1)

One day I received the message, "There's no budget, so we can't attend the next working group" on my cell phone. The message was sent by a member of the Monitoring and Evaluation (M&E) Working Group (WG) which I was in charge of.

This was in the last year of the project. In consideration of autonomous development after its completion, the project requested that each district bear part of the daily subsistence allowance (cost sharing) related to the project. This came right in the middle of the M&E WG's compilation of the "District Health Management Handbooks," which served as a final tangible outcome of the project, and in which all of the group members played their part for the writing.

The WGs gathered representatives from each district and were held over a two to three day schedule on the basis of at least one each month. Therefore, we only had a few chances left to come together in order to complete the handbooks as planned by the end of the project. With each opportunity precious, the situation was such that the participation of each member sharing the work of writing for the sake of completing the tangible outcomes was indispensable.

"When considering the completion of these tangible outcomes, even though the project was covering the daily subsistence allowances, I still preferred that every member took part. This was my true feeling as the manager. At the same time, "if there was a problem with the bearing of cost between the district and CHMTs I would like them to consult with me openly as the manager." This was my true feeling, too.

When managing a project, these sorts of problems concerning daily subsistence allowances and lodging expenses occur on a daily basis. As such, I realized that the accumulation of these sorts of daily-occurring matters serves as a collection of live "lessons" on the ground in CD support projects that aim to "improve management capacity."

So, if you were asked for your judgment as an expert placed in such a situation how would you respond?

Furthermore, by what means would you expect the counterpart to deal with this?

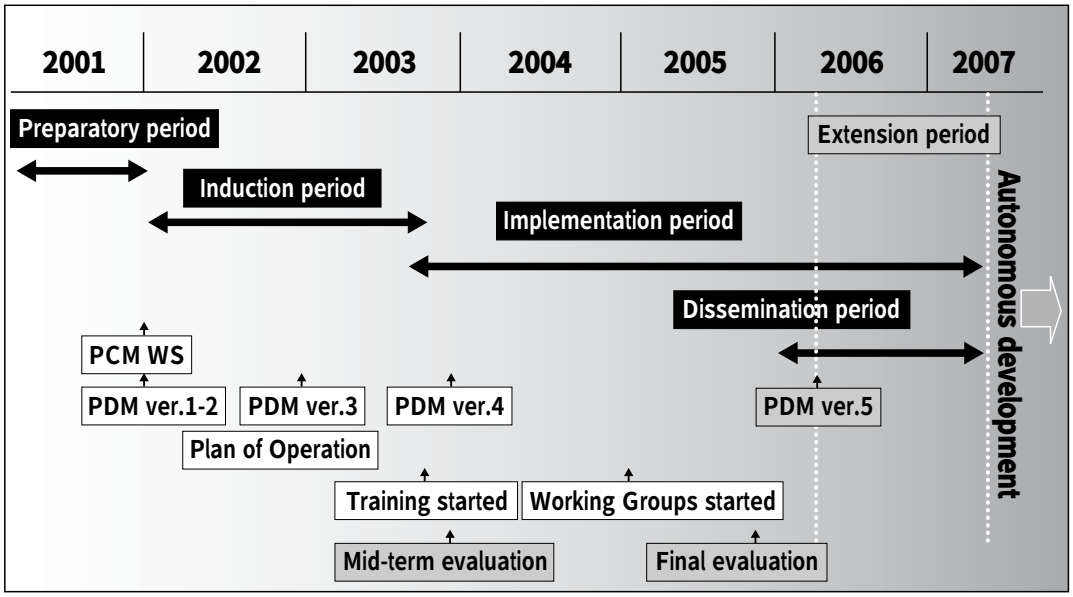
(Written by: Erika Fukushi, former MHP expert)

(Continued in Part 2)

Chapter 2 Development and Outcomes of the Project

The process of activities in MHP can be perceived as several stages of development, as illustrated in Figure 2-1.

Figure 2-1 Project Implementation Flow



Source: MHP (2006)

First, the period from 2000 to 2001 before the start of the project can be taken up as the “project formulation period.” In this period, the point of view on how the project should be formulated amidst the political and financial backdrop outlined in the previous chapter was adjusted.

Next, the stage from April 2001 to October 2003 after the initiation of the project was brought together as the “first half of the project.” For this, an analysis was conducted on the preparatory period and the introduction period in particular. This first half period corresponds to the period in which substantial project activities such as basic management training were initiated. These activities include the establishment of offices, the formulation of a project action plan, and the creation through trial and error of ver. 1.0 through ver. 3.0 of the Project Design Matrix (PDM), which is a tool for project management, and basic management training.

In October 2003, a project mid-term evaluation survey was conducted, and from this point on analysis of the “second half of the project” was carried out. This mid-term evaluation survey represented a major transitional point for the project. That is to say that upon receiving the evaluation results, the project experts and CPs worked together to review the activity contents, with the structure of the Japanese experts being reconstructed as well. In addition, activities were worked out one after another for sustainable development such as the formation of WGs. As these demonstrate, the achievement of outcomes for the project was keenly examined and it was conducted by means of strategic activities, which is considered to have enormous significance in leading to the success of the project.

Finally, the one year period from April 2006 to March 2007 is considered as the "project extension period." This was a period of systematization designed to disseminate and expand the project's outcomes and lessons to the whole of Tanzania as a management model. A variety of specialized activities were designed for the sake of this dissemination and expansion, and the contribution of activity fees from local government authorities gradually grew larger. As such, dissemination activities were carried out on the basis of the independence of the Tanzanian side in a personal, financial, and operational sense.

After such transitions and alterations the project was completed on March 31, 2007. As of April 2007, a request was submitted to JICA by the Tanzanian Government for the nationwide expansion (which would target all 21 regions) of the Regional Health Administration Capacity Building Project, a technical cooperation project utilizing the lessons of Morogoro. Ahead of this request for a new project, the Tanzanian MOHSW has already initiated activities to formulate the Health Sector Capacity Development Program along with its development partners. This project has been manifesting outcomes worthy of mention in a manner exceeding expectations with regard to sustainable development.

This chapter sets out the project activities and other aspects according to the time segments described above from project formulation through to the end of the extension period. While doing so, it also reveals the manner in which the CD of the partner country was realized through a process of trial and error at these different points in time.

2-1 Project Formulation Period: Project Formulation Based on the Counterpart's Self-reliance (August 1999 - March 2001)

MHP was formulated as a request for technical support based on the clear consciousness of the problems and ownership on the part of the Tanzanian side in the light of the progress of the two reforms of the HSR and LGRP. This is in keeping with the basic spirit of Japan's Official Development Assistance (ODA), which is to support the endogenous self-help efforts of developing countries. At the same time, it is also an important point of departure for CD projects in terms of supporting the endogenous growth of developing countries.

2-1-1 Project Formulation Led by the Tanzanian Side

Aid coordination regarding development assistance has been vigorously debated in Tanzania, which was the third country worldwide to formulate a PRSP. As of 1999 it was already promoting the policies of the HSR, and had been looking for various development partners to provide support within a framework primarily led by Tanzania itself.

During the formulation period for this project, the Chief Medical Officer (CMO) played an important role in taking up the leadership of the HSR. The formulation of the project involved close and frequent information-sharing and consultations between the CMO and the policy advisor assigned to the MOHSW as a JICA long-term expert at the time.[8] The CMO was a specialist in the health sector, having had experience serving as the Dodoma Regional Medical Officer (RMO). As such, he was fully aware of the problems of the weak management capacity of the local governments as a major impediment to effective service delivery. This was extremely important for the formulation of the project.[9] In fact, from the formulation stage the CMO requested that the Japanese side, **"Refrain from carrying out a project whereby Japanese experts merely bring something in with them, and that ends as soon as they leave."**

[8] From the interview with Hashimoto, the expert who acted as the former policy advisor of the MOHSW.
[9] Same as above.

In terms of the Japanese experts that were to be appointed, the CMO stated, **"I do not want them to just lend a hand to the health services, but rather to inform us how the region and the districts can continue to carry out their activities and services. I would like them to act as a 'catalyst.'"** As such, it was readily apparent that the CMO's expectations for the project were for "self-reliant development by the Tanzanian side."

What is more, the RMO for Morogoro Region said, "The objective should be defined as capacity building for those concerned with regional and district health through routine on-the-job Training (OJT), rather than classroom-style training via lectures. To begin with, an analysis of the present state will be necessary during the initial stages of the project in order to determine challenges and problems."[10]

In looking back to the time of the project's formulation, those in charge at JICA Headquarters were keenly aware of how strong the Tanzanian side's self-reliance regarding the project was from the preparatory study stage. Reviews of the project activity contents were promoted through the initiative of the MOHSW. The fact of the matter was that there was a strong conviction that the project would truly be able to make a profound contribution to the realization of health sector reforms.

2-1-2 Project Outline

Regarding the project site, several regions (Tanga, Pwani, Lindi, and Mtwara) were proposed as candidates at the time of the survey on project needs. But at the close of consultations with the concerned parties, the end result was that the Morogoro Region, situated 200 kilometers west of Dar es Salaam, and six districts within the region were selected as model districts in the interest of model formulation.

With the goal of improving the operational and management capacity of the RHMT and CHMTs, the project established three points as outcomes. These points were: (1) improving the health management information system; (2) sharing of experiences and information by the health managers in the region and districts; and (3) improving the planning, implementation, monitoring, and evaluation capacity for regional and district health managers (refer to Appendix 5-1 on PDM ver. 4.0 for details regarding the project outline).

The project implementation period, implementation parent organizations, implementation structure, and project formulation are as indicated below.

Implementation period	April 1, 2001 - March 31, 2007 (six years)
Implementation parent organizations	MOHSW, Morogoro Regional Government, JICA
Implementation structure	- 5 long-term Japanese experts (chief advisor, health information management, health administration management, health administration planning, activities coordinator) - 63 CPs (Morogoro Regional RHMT and six district CHMTs within Morogoro Region: Morogoro Municipal, Morogoro, Mvomero, Kilombero, Kilosa, and Ulanga) - 1 CP advisor
Project formulation	Bilateral project-type technical cooperation

[10] JICA, Medical Cooperation Department (2000)

2-2 First Half of the Project: Building Relationships of Trust through Trial and Error (April 2001 - October 2003)

Throughout the first half of the project there was a period of roughly 10 months in which the chief advisor was absent for reasons such as overlapping early returns to Japan by the chief advisor and experts. Over this period when the chief advisor was absent two long-term experts and one short-term expert were obliged to carry on with the activities.

Yet regardless, over this period trial and error was conducted in the form of laying the foundation for a network between CPs by determining and analyzing the current conditions in the region, reviewing CP-led project planning, and conducting training with the participation of every member. As such, over this period the sense of solidarity between the Japanese experts and the Tanzanian CPs was strengthened due to the mutual sense of urgency caused by the absence of the Japanese chief advisor. The sense of commitment and ownership by the Tanzanian side for the operation of the project was fostered, as were two-way relationships during this phase.

2-2-1 Laying the Foundation for Vertical and Horizontal Networks in Local Areas

In the first half of the project, the health information management expert's activities included determining the current status of medical facilities in the target region and frequently carrying out routine patrol activities for each district. Through such activities, basic data on health facilities was collected, including information like the number of health facilities and the number of health care providers. Further, the adoption of wireless devices by the health facilities to improve the means of communication related to the collection of health information was examined.

The foundation for a **horizontal network between districts** was laid through these district visits and the installation of wireless devices and such. The Ulanga District and Kilombero District both had numerous regions where the roads were underdeveloped and traffic access was difficult, due to which the transmission of health information was exceedingly slow. However, through opportunities for routine visits to local areas it became possible for adjoining districts to exchange information with one another.

In addition, **communication between the region and districts** was strengthened by having the members of the RHMT travel together. Likewise, **communication between the CHMTs and the health**

Focus Group Discussion

facilities was enhanced through the introduction of wireless devices.

Therefore, this strengthening of the information network later came to serve as a foundation for the self-reliant development of a network between district health managers and organizations (refer to "2-4-1 (2) Horizontal and Vertical Collaborations in Local Areas").

2-2-2 Project Action Plan Formulation and Modification Led by the CPs' Initiatives

Generally, in cases where indicators for project activities have not been set and when reviews are necessary, it is extremely important to hold consultations among those involved in the project and establish and reestablish PDM indicators from as early a stage as possible in order to clarify the project's outcomes and activities.

This project was no exception. From immediately after the start of the project onward, a great many opportunities were provided to confer with the CPs in order to examine the contents of activities and establish the performance indicators. On such occasions, the principle focus was placed on creating a satisfactory action plan by applying the Project Cycle Management (PCM) method and nurturing a cooperative spirit with the CPs. It took nearly two years to complete PDM ver. 3.0. However, **by emphasizing the self-reliance of the CPs and with the experts playing the role of catalysts**, the CPs devoted a great deal of time, set their own objectives and fostered their sense of ownership and commitment regarding the activities.[11]

The CP advisor (a former RMO) described the training pertaining to project activity planning and modification as follows: "The input of long-term experts capable of teaching the PCM method is required at the outset of the project. Since it is difficult to understand the PCM method and apply it to the logical framework of the project in a single workshop, I believe that the abilities of a facilitator well-versed in such method will be especially necessary from the very beginning of the project."

2-2-3 Implementation of Full Participation-style Training

The basic training at the very beginning of the project was participated in by all CP members. This had the major advantage of fostering team work for resolving problems as an overall team by means of imparting every member of the team with a minimum understanding of basic management and instilling them with common capabilities.

However, because the CPs were engaged in medical services such as medical examinations and nursing as their routine work, the total participation training frequently caused stoppages of health and medical service functions. This fact came to be expressed as a concern of the CP side. For this reason, in the second half of the project activities and development were conducted in a manner whereby "selective training" formed the basis of the WGs (refer to 2-4-1 (1) Working Groups).

[11] From the interview with the Kilombero CHMT.

2-3 Project Transition Period: Revision on account of the Mid-term Evaluation (October 2003 - March 2004)

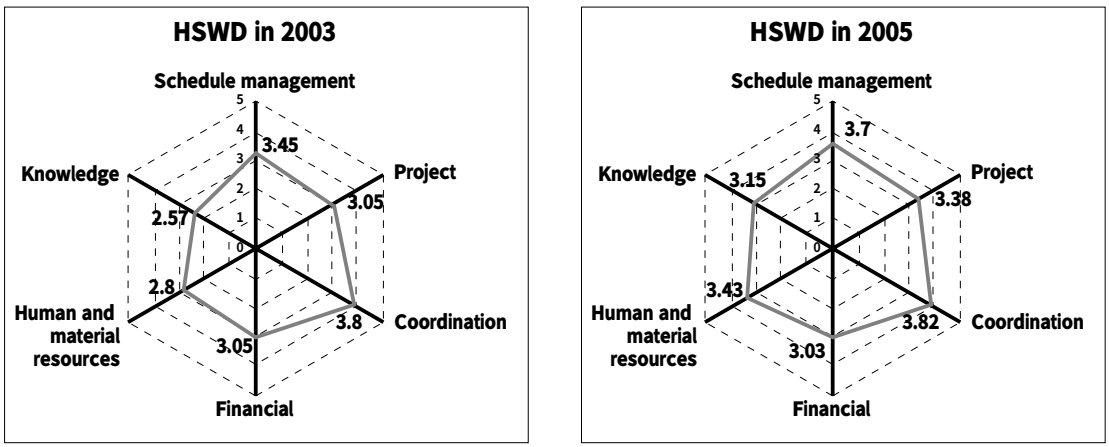
In October 2003, a mid-term evaluation was conducted which served as a review of the project. Through this mid-term evaluation the performance of the project activities up to then were evaluated and the activity contents were reviewed. There were personnel substitutions among the Japanese experts, and a specific strategy designed to obtain outcomes was clearly laid out. Taking this phase as a transitional period, this report will describe the features of this period that acted as key factors for the project's development in its second half.

2-3-1 Mid-term Evaluation

When the mid-term evaluation study team was dispatched an evaluation workshop that employed the PCM method was conducted, and the existing PDM ver. 3.0 was modified to produce PDM ver. 4.0. Moreover, the Second Joint Coordinating Committee (JCC) was held, and the study team reported that, "While delays in the project activities are foreseen, from here on it would be preferable to promote activities via greater collaboration among the concerned parties."

There were extensive debates from the very start of the project regarding the tools for measuring the improvement of management capacity, which was one of the project goals. From PDM ver. 3.0 on, the Hexagon-Spider-Web-Diagram (HSWD) which was devised between the experts and CPs was adopted. In the mid-term evaluation as well, using the HSWD the six management capacities were clearly defined as the various capacities for schedule management, project, coordination, financial, management of human and material resources, and knowledge. The results of the measurement of benchmarks through the HSWD are as follows (Figure 2-2).

Figure 2-2 Hexagon-Spider-Web-Diagram



Source: MHP (2006) p. 18

Through the introduction of the HSWD the prospects for accomplishing the project's objectives were further clarified in the mid-term evaluation. Furthermore, while there were variations in the level of understanding of the CPs regarding the project management method, the further deepening of their understanding of this method and the PDM was achieved through consultations in the mid-term evaluation. This was enormously beneficial to the operation of the project from that point on.

2-3-2 Substitution of Experts

In this manner the project went through a period of "creating trust and laying the foundations for management." As such, in the mid-term evaluation expectations rose for the achievement of outcomes oriented toward the completion of the project, particularly the achievement of visible outcomes and model creation. Following this, a detailed examination of the project's implementation structure was conducted. As a result, because of the changing role of the project, four of the five Japanese experts currently serving were substituted out and a reorganization was conducted of the new experts team "in the interest of producing outcomes." In particular, the experts for the second half of the project did not limit themselves to "interaction" meant to solely keep good relations with the other side, but drew out the others' capacity by "coming face to face" to honestly exchange ideas with one another from time to time. As a result, the input of highly specialized human resources capable of making proposals in a tangible manner was needed.

There were concerns that the activities would be held up due to the substitution of experts. However, one expert who had a grasp of the activities and the process of trial and error with the CPs up to that point, Dr. Sugishita (in charge of health administration planning), remained on-site. Following the chief advisor's return back to Japan, he took over the activities related to the chief advisor's duties, thus earning the consent of those involved. On account of the relationships of trust with the CPs that were formed by the predecessors, no significant problems were observed in the relationships of trust and communication with the CPs in spite of the nearly complete turnover of the experts. Moreover, the CPs were still actively committed, and the new expert team was able to join the project activities relatively smoothly.[12]

2-3-3 The Mid-term Evaluation and Changing the Awareness of those Involved from the Partner Country

From the mid-term evaluation onward, while faced with several problems such as the overhaul of the Japanese experts team and the construction of the resources center[13], a change came to be observed in the CPs towards adopting a more assertive attitude.

In other words, at the point where the mid-term evaluation study team reflected back over the project, having everyone involved share in the development and outcomes of activities served as an opportunity for the CPs, which had independently carried out activities, to display accountability for the outcomes of such activities. Separate from the PDM for the project, the RHMT and CHMTs each independently created their own respective PDMs. For these, a reexamination was performed on elements related to the achievement of the project, such as the activities, inputs, and external conditions for the regional and district achievement of project goals.

From the planning of to participation in project activities, the Morogoro Regional Administrative Secretary (RAS), the official responsible for the operation of the project, was changed. The CPs were compelled by this event to brief the new RAS on the project contents and build new relationships of trust between the project and the regional administration. This made the CPs recognize that little would have remained after the return home of the Japanese experts unless the CPs became able to resolve problems on their own.[14]

After the construction of the regional resources center was halted due to various circumstances, the Kilosa District renovated and reopened a resources center using its own finances. This serves as an example of a team from another district utilizing the lessons learned from the process of resolving the problems

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[12] From the interviews with experts Tsuda and Goto.

[13] Resource center held the function of assembling together health information from inside the region and widely making it available for the RHMT and general public. In addition, it also carried out WG activities and training.

[14] From the interview with expert Sugishita.

confronting them and applying them in the project. It was also acknowledged that there were numerous cases where the administrative capacity required was secured through the local network.

2-4 Second Half of the Project: Establishing a Self-reliant Health Management Structure (April 2004 - March 2006)

In the second half of the project, concrete CD outcomes emerged that represented the fact that the trial and error in the first half of the project had borne fruit. By establishing cooperative structures between the region and districts, a sense of ownership was fostered that allowed them to deal with challenges on their own. Moreover, by improving its health planning capacity, the Tanzanian side became able to budget activity expenses for the project by using the HSBF, thereby strengthening its cultivation of ownership on the financial front.

2-4-1 Establishing Collaborative Structures between the Region and Districts

(1) Working Groups (WG)

Every CP had rotated their participation in all activities for three and a half years since the project was launched. After October 2004, however, cross-district WGs were established for each outcome and they were introduced into all activities.This WG-unit strategy was aimed at stipulating outcomes and objectives and managing activities smoothly and efficiently.

As shown in Table 2-1, seven WGs were formed that were suited to the project's outcomes. Each WG was comprised of seven people (one from the RHMT and one from each of the six CHMTs were elected, respectively). Those recommended were made the WG leader, and would participate in WG projects as a district representative.

Table 2-1 Project Outcomes and the Seven Working Groups (WG)

No.	Outcomes	Working Group (WG)
Outcome 1	"Rebuilding the health information system"	- Health Management Information System (HMIS) WG - Communication (TWINS) WG - Internet Homepage WG
Outcome 2	"Sharing and restoring experience and information"	- Newsletter WG - Health Information Resource Center WG
Outcome 3	"Strengthening health problem analysis, planning, implementation, and M&E capacity"	- Operational Research (OPR) WG - Monitoring and Evaluation (M&E) WG

Moreover, "selective training" was conducted suited to the formation of the WGs. The major goal of "selective training" was not merely to arrange it so that medical facilities and offices would not cease to function. It was also meant to "foster the skills and sense of responsibility of the selected participants" for specific issues. In addition, it had its basis in the judgment that there were numerous benefits for efficiency and effectiveness, such as reducing the costs related to items such as daily meeting expenses.

The WGs did not just undergo training and carry out tasks in workshops designed to produce tangible outcomes. Instead, they would "repeat" the actual activities of the WG in the form of On-the-Job Training (OJT) at the workplace of various members. Furthermore, they were also requested to set up training plans for each WG as necessary and incorporate these into budget planning.[15]

[15] From the interview with expert Sugishita.

OPR Working Group

(2) Horizontal and Vertical Collaboration among Local Governments

In the second half of the project, the horizontal connections between districts as well as the vertical connections between the region and districts were strengthened as described below.

1) Horizontal Collaboration

In the project's first half, the situation in each district came to be commonly shared owing to the routine visits to the districts by Japanese experts (refer to 2-2-1). In addition to this foundation for the local network, in the project's second half the cross-district horizontal network was further strengthened due to the initiation of WG activities. For example, a member of the Kilombero District CHMT remarked to the effect that, "Before the MHP was conducted we were largely unaware of how health activities were carried out in other districts. But now we have the chance to collaborate with members from the CHMTs in other districts through the WG activities and can determine the state of health activities in other districts. And you can tell just from asking anybody that a shared awareness has been reached within the districts." From this statement it can be seen how horizontal collaboration was strengthened through communication between the WG members. Moreover, the holding of region-district regular joint meetings (quarterly), exchange visits between districts, and other activities have strengthened horizontal collaboration at multiple levels.

2) Vertical Collaboration

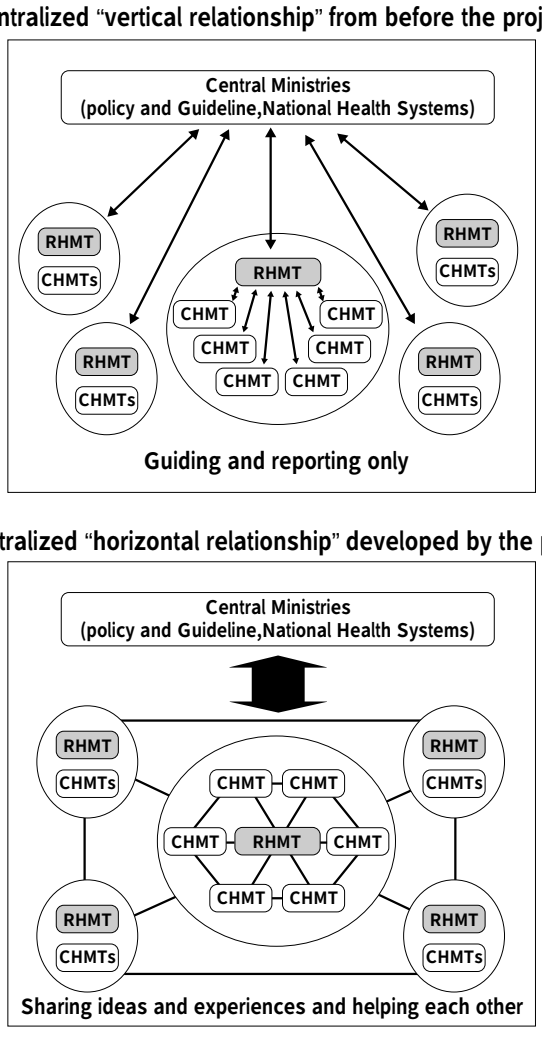
For WG activities, since RHMT members also act as constituent members of the WGs, vertical lines of each operation were expanded in a freer manner. In other words, through collaboration among the region and districts for the achievement of shared objectives, the vertical relations consisting of the formation of a network between the CHMT and RHMT teams was strengthened. The outcome that resulted from expanding their relations surpassed the "manager - subordinate" relationship.

In their keynote address at the annual international science conference sponsored by the Tanzanian National Institute for Medical Research (NIMR) held in Arusha in March 2007, the MHP's CP advisor announced the final outcomes and lessons from the project. Also at the conference, the former CMO of the MOHSW made the following remarks.

"The MHP has intensively strengthened the managerial capacity of health managers in the

Morogoro Region and districts. The conventional system was a vertically-divided, one-way administrative system in which the central government and its branch agencies of the regional governments would lead and supervise the district governments. However, a new administrative system was introduced in which district governments erected a horizontal network centered around regions. Strengthening teamwork, with the region and the districts acting as one, this also laid the foundation for a local health administration in which the region and the districts compete against and mutually help one another out in a form of friendly rivalry. This has led to the raising of an endogenous and sustainable administrative system. This is the most amazing aspect of the project, and was a groundbreaking accomplishment in a traditional and centralized Tanzania."

Figure 2-3 Vertical and Horizontal Collaboration



Fostering Team Work by Strengthening Vertical and Horizontal Collaboration

Source: MHP (2007)

(3) Utilization of and Cooperation with Local Resources

The project gave particular consideration to "the utilization of and cooperation with local resources," including latent human resources and organizations of universities, research institutions, and other sources both within and outside of the Morogoro Region in its second half. The purpose of this was to ensure continuity and for sustainable development.

This stems from a proposal from the RMO to JICA, which had been examining whether or not to dispatch short-term experts from Japan to the project site. The proposal suggested that it would be possible to utilize academic institutions capable of providing business training services on the ground. Another contributing factor was that Mzumbe University had conducted tailor-made business training jointly with the project.

The project had already collaborated with various universities, including Muhimbili University (Dar es Salaam), Mzumbe University (Morogoro Municipality, business management training), the University College of Lands and Architectural Studies (UCLAS, Dar es Salaam, GIS training), the National Institute for Medical Research (NIMR, Dar es Salaam), and Ifakara Health Research and Development Centre (IHRDC, Ifakara). These were centered around WG activities in particular, and served to erect and strengthen the on-site support structure sustaining technological development after the completion of the project.

2-4-2 Cultivating Ownership on the Financial Front

When facilitating independence and autonomous development on the partner's side, it is essential that financial ownership be ensured with regard to the budget for project activities. This project analyzed how the budget for activities like those of the WGs should be shared with the Tanzanian side, and in what manner the HSBF should be utilized as a source of revenue for this.

(1) Budgeting Activity Expenses

By paving the way for the WG activities initiated through the project and making other administrative officials and the general public aware of this as a visible outcome, these project activities gradually came to be recognized as essential health activities of Tanzania's local government authorities. In particular, the commitment of district and regional governors to WG activities increased. Contributions from district health budgets for various expenses related to the project activities (including Daily Subsistence Allowances: DSA) and the districts' own health activities (first annual meeting with workers at health facilities in the Kilombero District) became possible.

As illustrated below, it is understood that the net burden gradually increased after October 2004, which was when the WGs were formed (Table 2-2). In addition, Figure 2-4 shows how Tanzania's net burden of expenses in the final year of the project (extension period) exceeded JICA's net burden from the first and second years of the project's implementation.[16]

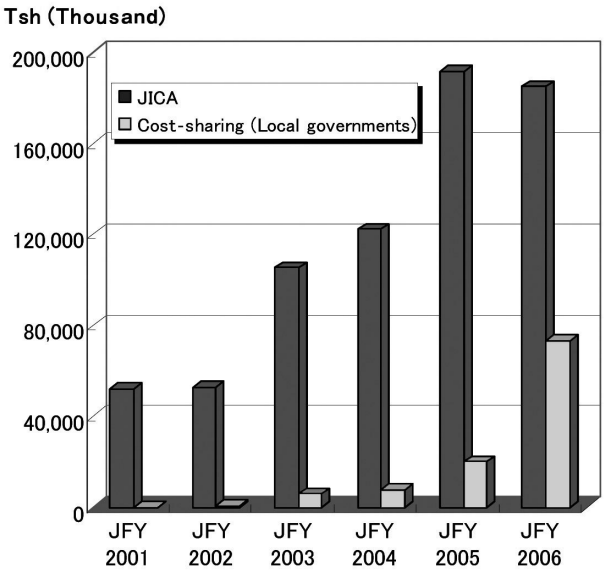
[16] There were delays in the start of expenditures, and it is believed that the actual amount of expenditures fell below the budgeted amount.

Table 2-2 Burden of Expenses Borne by the Counterparts

	Project Implementation Period					Extension period
	JFY 2001	JFY 2002	JFY 2003	JFY 2004	JFY 2005	JFY 2006
JICA	52,226,352	52,598,916	105,324,465	122,150,555	191,699,144	184,898,200
CP	0	790,610	5,860,550	7,857,550	20,000,000	73,292,160
Budget accounting (Tsh*)	52,226,352	53,389,526	111,185,015	130,008,105	211,699,144	258,190,360
CP's Burden of Expenses Rate	0%	1%	5%	6%	9%	28%

*Tsh: Tanzanian Shillings
Source: MHP (2006)

Figure 2-4 Increase in the Net Burden of Expenses Borne by the Counterpart



Source: MHP (2006)

At the district health administration level, a certain procedure had to be followed for the ongoing participation in WG activities. This process entails CHMT members first explaining the importance of WG activities to the District Medical Officer (DMO). The DMO would then explain this to the heads of various sectors within the district, such as the District Executive Director (DED) and, upon receiving approval, the expenses would then be subsidized. The project provided training and OJT on matters such as this type of financial management and activity planning, how to write proposals, and more. Owing to this, it became possible to perform such budgeting relatively smoothly. In particular, as they were forced to seek their main source of funding through the HSBF, they were not given approval for anything less than an excellent budget plan for their activities. As a result, a positive cycle gradually took shape in which their motivation to participate in activities served as the motivation for them to acquire managerial abilities. This fact is of extreme importance in terms of ensuring the continuity of the project.

In this manner, through negotiations on issues like cost sharing for project activities, a successive cycle of practice in drafting, formulating, implementing, and monitoring and evaluating the Comprehensive Council Health Plan (CCHP) was repeatedly carried out. This resulted in sound improvements to the CHMTs' capacity for formulating the CCHP, as well as the budget formation capacity of the local health administration sector.

Box 2-1 Schemes for Sustainable Training Participation

For their participation in seminars and workshops related to their work, the participants were provided with a Daily Subsistence Allowance (DSA).[17] Tanzania has advised Development Partners (DPs) to establish certain standards in paying a DSA in cases such as where its government employees take part in training. Examination of these standards is conducted among the Development Partners Groups (DPG), and agreement is reached between the Tanzanian Government and the DPs. Furthermore, official notification is provided to each DP so as to ensure that these standard amounts for payment are being observed. Yet this standard amount equates to a large amount from the point of view of the salary standards for Tanzanian government workers. Because of this, there are participants whose interest is in receiving the DSA from training and seminars in every sector, as well as cases in which people place a greater priority on receiving the DSA rather than the knowledge gained through attending the training and seminars. The dilemma of the DSA and ownership on the partner's side is a pressing issue for the DPs that conduct training and seminars. On the other hand, for those receiving the DSA the question of whether or not to take in extra income on top of their salary, which is not especially high, is a similarly compelling problem. Such maneuvering related to the DSA causes some degree of trouble for those concerned with the project on the ground in terms of creating mutual relationships of trust.

In the MHP, the Japanese experts initially used the DSA as an important incentive in order to teach the CPs that all training, including management training, is important for improving their basic managerial capacity. However, there is a limit to how many times training participants can be compelled to continuously take part in training based solely on the appeal of the DSA. On this account, it was necessary to consider the content of training that would lead to changing their consciousness so to enable them to experience the benefits of participating, even if the regional and district budgets have already been appropriated. However, accompanying the progress of the project activities, particularly the development of the WG activities, up until then the DSA had served as a major motivating factor for participation in these activities, but this gradually came to change. There was a shift towards motivation through the activities themselves, which would lead to their own capacity development and personal growth (enjoyment). A recognition had begun to take hold among local administrative officials that the outcomes from the project activities were important to the Tanzanian local government authorities. Therefore, the DSA and travel expenses came to be budgeted into district health budget plans in order to ensure continuity after the end of the project. In this manner, the budget appropriations for the DSA were able to take off as a part of the routine affairs of the Tanzanian side.

In project activities, a shared recognition was reached with the CPs to the effect that the "WGs are worthwhile and enjoyable." The various RHMT/CHMT members felt that their own managerial capacity was improving due to the WG activities. The fact that the members "came to enjoy working" and "came to perform their tasks with confidence" had a positive influence on their colleagues. In the second half of the project it became commonplace for the members to take part in training and the WGs through out-of-pocket expenses even when payments from the districts were delayed. It was no longer the case that they were attending training and performing activities in order to receive the DSA. Upon entering the second half of the project, as a result of eventually raising their own capacity, the feeling that "we can contribute to improving the quality of local health services" was shared among the RHMT/CHMTs. Furthermore, the message that with "No Commitments, Nothing Moves" had taken hold.

(2) Utilizing the Health Sector Basket Fund (HSBF)

As the preceding section indicated, the WG activities were not merely project activities, but rather were regarded as activities of the districts themselves. Because of this, a request was made by the Tanzanian side to examine working out their own activity budgets. It also became possible for project activity expenses to be allocated in district health budget planning and for the HSBF to be used as an independent revenue source for local health. While Japan is not a contributory country to the HSBF, it did make full use of the HSBF as a budget support framework in its project activities. That is to say, this demonstrated that Japan's technical cooperation could build mutual complementarity with the budget support of other development partners.

[17] In Tanzania it has become common practice to pay the DSA on the first day of training, even if there are multiple training days. Through MHP, measures were taken such as having those who did not attend the remainder of training refund the DSA after it was provided.

Furthermore, from the point of view of effectively utilizing budget support, it strengthened the financial foundations required for the provision of local health services. Yet despite this the background, a low budget implementation rate and fewer effects from budget support occurred due to the lack of appropriate budget planning and executing capacities. By aiming to enhance to the basic capacity of the CHMTs for planning, implementation, and monitoring and evaluation, the MHP raised the quality of district health budget planning and created mutual complementarity with budget support. It raised the efficiency of support to the Tanzanian health sector as a whole, for which the MHP as a process for technical cooperation received little in the way of harsh criticism. On the contrary, during a DAC assessment mission conducted in March 2003, the project was favorably assessed by the donor community in the sense that the MHP indicated how projects should be patterned in the future.

2-4-3 Manifesting Project Outcomes

WG activities are tied in to the outcomes of project activities in the sense that the outcomes of activities by the respective WGs complement each other.

(1) Outcome 1: Rebuilding the Health Information System

The Health Management Information System (HMIS) WG enhanced its system for routine visits and guidance. Doing so facilitated its collection of information on health facilities (scale, operating structure, number of doctors, number of hospital beds, geographic and positional relationship, etc.) at the regional and district levels. The HMIS WG also regularly published the Morogoro Health Abstract and achieved other such visible outcomes.

The Communication WG methodically prepared the system design for a Two-Way Information Network System (TWINS) and installed wireless devices and the like in remote medical facilities. Doing so allowed them to guarantee communication across all of the districts, collect health information, carry out a patient referral system and health education activities, and more. In particular, this had the effect of enabling them to collect health data from health facilities that are inaccessible during the rainy season, as well as providing cautionary advice on cholera and other infectious diseases via the wireless devices in a timely manner.[18]

Computer Training

[18] From the interview with the Morogoro Municipality CHMT.

(2) Outcome 2: Sharing and Restoring Experience and Information

The Resources Center WG carried out a variety of activities for the systematic management, use, and integration of the health information and materials that had previously been scattered and dispersed. In the second half of the project, district health information resources centers were established by the two local government authorities of the Kilosa District and the Morogoro Municipality through the self-help efforts of these district government. As the first such attempt in Tanzania, this drew an enormous response. Moreover, by periodically issuing newsletters, the Newsletter WG contributed to the sharing of health information between local health facilities while also being of service in health education activities in remote areas.

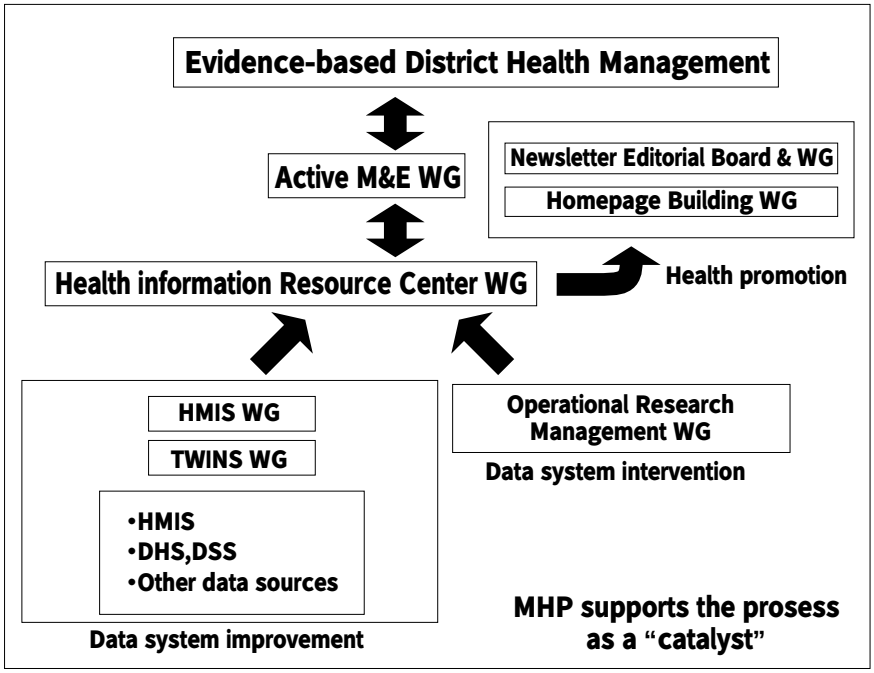
Furthermore, a number of interactive activities were also carried out, including the holding of region-district joint health meetings once every six months, the holding of regional health stakeholder meetings, and mutual study visits between districts. These activities served to strengthen the network channels between the RHMT and CHMTs, which in turn deepened their self-confidence and fostered a positive spirit of competition by promoting the sharing of information and experiences. Gradually, aspects such as voluntary cooperative activities among the districts for the resolution of problems began to be noticeable (refer to subheadings 2-4-1 (2) 1) Horizontal Collaborations and 2) Horizontal Collaboration).

(3) Outcome 3: Strengthening Health Problem Analysis, Planning, Implementation, and M&E Capacity

The Operational Research (OPR) WG made it possible for local health managers, who were CPs of the project, to carry out their own health research activities. The objective for this was to have them extract evidence from among health issues by using their research capabilities, and then to reflect this in local health planning. Such research activities in particular were developed as activities for regional and district health administrations as a whole. This was acknowledged as having fostered team work among the RHMT and CHMTs, while raising the management capacity of each of the administrations. What is more, the “Operational Research Report” and “Operational Research Management Handbook” were issued with the intention of sharing the research outcomes and methods with the MOHSW and health managers in other regions.

In the M&E WG, the members were fostered as facilitators for district health planning and activity monitoring by means such as M&E facilitator development practice and PCM training. Furthermore, primarily providing technical support for CCHP enabled health planning and appropriate budget management. In addition, it also issued the “District Health Management Handbook.” This handbook was designed to share these lessons with other health managers, and to be used as a reference for the formulation of health plans and other matters.

Figure 2-5 Synergistic Effects from the Activities of the Working Groups



Source: MHP (2006) p. 34

2-5 Extension Period through to Project Completion (April 2006 - March 2007)

During the extension period, proactive efforts were taken in order to establish project activities in the Morogoro Region in a sustainable manner. Initiatives were also taken to disseminate and expand the project's outcomes and lessons acquired over the six year period to the surrounding regions. To be precise, logistical and coordination capacity were strengthened for the sake of sustainable management, the activities of the MHP were systemized, and educational tools were developed. On top of this, the project outcomes were announced and shared, reflection of the experience from the MHP in other regions was examined, and collaboration with other development partners was explored.

2-5-1 Strengthening of Logistical and Coordination Capacity for the sake of Sustainable Management

In order to ensure an autonomous operational structure for the activities on the Tanzanian side after the completion of the project, logistics and coordination capabilities were strengthened so that those involved could continue with activities like those of the WGs on their own. In addition, training and the like was also conducted in order to ensure the continued maintenance of equipment.

To be specific, the CPs elected people to positions such as the Chairperson, Coordinator, Secretary, and so on themselves. In addition, assigning the task of completing the "WG Coordinator Guide Package" to the Tanzanian side enabled them to demonstrate independent management for WG activities. The tasks carried out by the project to date, including schedule coordination among the members, issuing official letters, and budget control, were compiled as part of this guide package.

For machinery maintenance as well, the fact that previously the maintenance and upkeep of equipment was entrusted to others was reconsidered, and training for people to manage this was conducted with the cooperation of Mzumbe University. Furthermore, a Maintenance Manual was created, and OJT was carried

out to so that the Tanzanian side was able to conduct maintenance and upkeep for all of the equipment, not just the provided equipment.

2-5-2 Systemizing MHP Activities and Experiences and Developing Educational Tools

The establishment of project activities in the Morogoro Region and their modeling and systematization for diffusion and expansion to other regions were explored by the concerned parties.

In particular, the MHP's feature of its "catalytic support" regarding the involvement of Japanese experts (described in detail in 3-2) was extracted and systemized.

Moreover, activities such as the development of educational materials and publications that compiled experiences, outcomes, and lessons from the activities were also actively carried out. Specifically, the MHP Summary Booklet, Operational Research Management Handbook, District Health Management Handbook, Morogoro Health Abstract, multimedia educational materials, and others were edited and published as tangible outcomes through the leadership of the WGs.

For example, information such as that on the concrete steps taken by the CPs, checklists that could be used immediately in the form of templates, and detailed indications of resources and agencies has been recorded in the OPR handbook, which has been made to be extremely easy to read. The names of the people who took charge of the writing are recorded in each chapter of this handbook, which allows people from other regions to inquire of the specific author directly should they have any questions.

For the CPs, the sense of accomplishment and self-confidence gained through the experience of providing these sorts of visible outcomes served as a far greater motivation than that provided by any monetary reward.

2-5-3 Demonstrating and Disseminating the Project Outcomes

The project laid the groundwork to foster the self-confidence of the CPs and for dissemination and expansion. It did this by systemizing activities and experiences and converting them into educational materials, while at the same time having the CPs themselves actively take opportunities to publicly present these to the outside world. More precisely, the project provided support so that the CPs would have the greatest possible number of opportunities to disseminate such outcomes on any occasion from domestic meetings such as stakeholders meetings and JCC, all the way to venues for international conferences.

Through such opportunities to disseminate the outcomes, the CPs can catch the attention of the health managers of other regions, top government officials, those associated with university research institutions, and others. These chances were thus beneficial in the sense that they had the potential to widen their personal networks. As a typical example, the outcomes of the project were selected for the keynote address at Tanzania's international conference on healthcare held in March 2007 immediately before the completion of the project. The outcomes were presented by the former health director for the Morogoro Region before participants from around the world. During the presentation's question and answer session, the CMO, who had played a leading role in the project, commented to the effect that, "This is one of the two most successful health projects in Tanzania." All of those concerned with the MHP felt encouraged by this.

The presentations to those outside Tanzania offered ideal opportunities in which the CPs were able to convey their leadership to the outside world. For the CPs, not only those in the upper levels, but the Front Line Health Workers (FLHWs) as well felt the significance in their having achieved such outcomes. They also carried out activities in order to extend the project outcomes to healthcare facilities (distribution of handbooks, holding seminars to disseminate research outcomes, etc.). In Tanzania, where harmony is especially prized, having one's leadership acknowledged by others is profoundly meaningful.

Presentation

2-5-4 Reflecting the Experiences from the MHP in the Health Sector in other Regions

In light of the evaluation at the end of the project, the vision of transferring the outcomes and experience of the MHP to other regions began to be earnestly explored during the project's extension period.

In particular, the activities and experience that had been systemized and made into educational materials as described above were shared with other regions, and a program of mutual visits was conducted to examine the feasibility of applying them in other regions.

An RMO, six DMOs, CP advisor, and four Japanese experts (a total of 12 people) visited the Kagera Region RHMT. There they exchanged opinions with the purpose of building horizontal and vertical collaboration in health management in local areas. Located on the west bank of Lake Victoria, the Kagera Region was the quickest region in Tanzania to introduce and implement the HSR from 1994. Furthermore, with the experience from the Testing the Health Sector Reform (completed in 2004) through the support of Danish International Development Assistance (DANIDA), the region is claimed to be the most successful within Tanzania in terms of independently developing its managerial capacity.

The Morogoro Region RMO and DMOs were spurred on by the high level of capacity of the Kagera Region's RHMT overall, and the MHP reaffirmed that the fact that, "We learned not what, but how." Furthermore, through repeatedly presenting the outcomes achieved through their own project in the Kagera Region, the RMO deepened their self-assuredness.[19] "Before coming to the Kagera Region, I thought about what the Morogoro Region could possibly have that had not yet made it to Kagera. But upon actually visiting, I feel confident in what we have accomplished so far. It is clear that Morogoro measures up to Kagera." This comment succeeded in increasing awareness of the project outcomes.

In addition, aside from the exchange visit program, the CPs from the MHP are expected to disseminate the activities from the MHP through being transferred to other regions. Before the end of the extension period, the DMO from the Morogoro District, who was a CP, was appointed as the RMO of the Mbeya Region, due to which it is anticipated that activities such as those of the WGs will begin in the Mbeya Region. Similarly, the DPO of the Kilombero District who was also a CP was appointed as the assistant director of the Coordination Bureau in PMO-LARG. It is anticipated that these persons acquainted with six

[19] Sugishita (2006d) p. 9

years of MHP experience will further strive for enhancement of the human resources of local administrations through the central government.

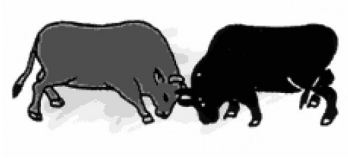
2-5-5 Exploring Collaboration with the Initiatives of other Development Partners

A project to strengthen district health management capacity (Tanzanian Essential Health Interventions Program: TEHIP) was implemented in the Morogoro District through support from Canada's International Development Research Centre (IDRC). In particular, a cascade method referral system was established. On this account, CPs from other districts visited Morogoro Region as part of their MHP activities. Training is conducted for workers at health facilities designed to teach them know-how on this cascade method, as well as budgeting within a district health activity budget plan.

What is more, in the Kilosa District the dissemination of a Community Health Fund (CHF) had been promoted through the support of the World Bank. Owing to this, different CHMTs visit the Kilosa CHMT and learn about the Kilosa District's CHF activities and procedures for initiating activities.

In this way, the CPs are not bound by which development partner they receive support from, but rather mutually learn from one another regarding health service delivery. As such, this demonstrates how having the CPs personally incorporate various donor initiatives into the CCHP as new activities and carry out budgetary allocations that are intended to strengthen the organization of the CHMTs.

Box 2-2 "There's no budget..." What is meant by coming face to face? (Part 2)



There is no right answer when it comes to management. This case can also serve as an example in terms of how it was handled at that time. But it is extremely important to gather lessons from previous precedents.

What I felt was most unfortunate about this case was that, from what I gathered from my contact with the CPs, they had made snap decisions to attend the WGs based solely on whether the districts would share the costs. "Why am I participating in this WG? What sort of impact will this have on things like the organization I belong to, the community, and other regions?" With this in mind, I shared my distress with my supervisor, but was only told that I should express enthusiasm for taking part in the WGs. In fact, there was another CP who I had a discussion with, who said, "I somehow managed to raise the DSA from my district, but there are meetings that run until immediately before I depart. Since I won't make it by using public transportation, would you let me ride together with you in the project vehicle?"

Finally, as a result of consultations with the DMO (who was this CP's boss) and for reasons such as measures against an outbreak of disease in their district and the delayed implementation of the basket fund, it was confirmed that the district could not share the DSA for this CP. Due to a reexamination of the project, priority was placed on having the CPs learn the importance of management (consultations and negotiations with bosses and supervisors, budget implementation procedures, independence), more so than the progress of tangible outcomes. Yet the conclusion was that the project would not provide the DSA for this CP. In the end, he was the only one of seven CPs slated to participate who missed the opportunity to take part. However, learning from this experience, for the next WGs the DSA was raised from the district budget without a hitch, and he was able to participate.

This was not the only case. Through honest discussions (coming face to face) concerning cost sharing with the district, I feel as if I became able to see not only the individual, but also the organizational and institutional courses. This is an aspect I never would have been able to see had the costs for the project been borne unilaterally. In the organizations that the CPs belong to (CHMTs), does frank communication exist where subordinates are able to consult with their superiors over anything? Are the district health budgets being fairly apportioned? Are the basket fund and budgets from the national government being implemented smoothly? Is the DED, who holds final decision-making authority for district budget implementation, cooperative when it comes to promoting health activities and reforms? Do the district accounting systems facilitate rapid budget implementation procedures? Moreover, does the region (RHMT) determine the circumstances in each of its districts, and is it furnished with the capacity to support the districts and achieve health objectives? And on and on, with each of these a step toward organizing and institutionalizing which is not readily apparent.

Cost sharing is only one example of project management. **A catalyst elicits the true feelings of the partner in each and every daily setting which requires management. It incorporates notions that this is all for the partners, organizations, social institutions, and for the health of the people, and then throws this back to the partner**. Perhaps things such as the self-reliant development of individual CPs and CP organizations are not particularly desired if the project is only to be used for its own convenience. The achievement of outcomes after the end of the project is not the only thing that is expected. In addition, by facing the partner country and honestly "coming face to face" while the project is ongoing-or rather, from the project formulation stage on – it is almost certainly possible to wish body and soul for true self-reliance on the part of the partner country.

(Written by: Erika Fukushi, former MHP expert)

Chapter 3 Outcomes and Challenges from a CD Perspective

This chapter will look at how the problem-solving ability of the health managers of Morogoro Region and its districts was enhanced by the project activities from a CD perspective. In 3-1 the respective outcomes at the individual level; the organizational level; and the policy, institutional, and societal levels will be articulated, and the section will conclude by analyzing CD challenges throughout the entire process. 3-2 will compile the features of and lessons from the implementation approach for MHP.

3-1 The Capacity Development Process and Project Outcomes

Table 3-1 separates the frame of reference for perceiving capacity into three categories: individual, organizational, and institutional and social systems. It also illustrates the form of capacity for these three categories, as well as things like tools and opportunities for expressing capacity.

Knowledge, skills, commitment and approach, soundness, and awareness were what served as indicators for the strengthening of **individual** capacity. The degree to which capacity was strengthened was understood through how these measures had changed compared to before the capacity was enhanced. Next, **organizational** capacity was judged by factors like personal assets, physical assets, and intellectual property, as well as the organizational configuration by which these three assets were utilized. The degree to which capacity was strengthened was assessed through how the elements needed for the achievement of certain objectives were enhanced, including the decision making process and management system, as well as the organizational culture and structure. The extent to which the capacity for **institutional and social systems** was strengthened was understood through its effect on the environment needed for the individual and organizational levels to demonstrate their capacity (enabling environment). It was also judged based on whether the decision making processes and systems, as well as their frameworks, in relation to the formulation and implementation of policies and strategies that surpass single organizations had an impact on specific structures and policies.

Table 3-1 Means of Perceiving Capacity and its Expression

Levels of capacity	Key capacity features to be developed	Elements on which the capacity is based at the three levels
Individual	The will and ability to set objecives and achieve them using one's own knowledge and skills	Knowledge, skills, will/stance, health, awareness
Organization	The decision-making processes and management systems, organizational culture, and frameworks required to achieve a specific objective.	Human assets (capacities of individuals comprising organizations)
		Physical assets (facilities, equipment, materials, raw materials) and capital
		Intellectual assets (organizational strategy, management and business know-how, manuals, statistical information, production technology, survey and research reports, household precepts, etc.)
		Form of organizations that can optimally utilize assets (human, intellectual, physical), management methods (flat organizations, TQS (total quality control), KM (knowledge management), personnel systems, etc.)
		Leadership
Institution Society	The environment and conditions necessary for demonstrating capabilities at the individual or organizational level, and the decision-making processes, and systems and frameworks necessary for the formation/implementation of policies and strategies that are over and above an individual organization.	Capacities of individuals or organizations comprising a society
		Formal institutions (laws, policies, decrees/ordinances, membership rules, etc.)
		Informal institutions (customs, norms)
		Social capital, social infrastructure

Source: JICA, Aid Approach Task Force (2004) p. 10

3-1-1 Outcomes at the Individual Level

Firstly, the project outcomes at the level of individual capacity improvement will be analyzed. In the first half of the project, basic capacity for management was fostered through training for all of the members of the RHMT/CHMTs and by selective training. Furthermore, various individual skills were acquired and amassed by means of repeatedly conducting capacity strengthening for daily activities.[20] These include computer operating skills, presentation ability, and coordination abilities (holding regular meetings, transmitting information to workers at the health facilities, etc.). (Refer to 2-2-3)

In the second half of the project through to the extension period, there was a drastic increase in the opportunities to present the outcomes owing to the process of generating outcomes through WGs and strengthening horizontal and vertical collaboration. The individual capacity previously fostered was further tested and imparted as the ability to deal with organizational challenges in a constructive manner. For example, one of the Morogoro Municipality CHMT members stated, "Through the MHP, health activities (= my work) has now become a lot of fun." The capabilities of the Regional Administrative Secretary (RAS) and Acting Regional Administrative Secretary (Ag RAS), as well as that of the RHMT/CHMTs members soundly improved. This led to them to building their self-confidence, with the CPs even exhibiting changes in their countenance and attitudes. (Refer to 2-5-3)

Local health managers became capable of carrying out administrative acts such as examinations, planning, and drafting through their own ability (fostering individual capacity). The self-confidence of

[20] From the interview with all of the RHTM/CHMTs.

individuals in their own abilities and their motivation were fostered, and the organizational response capabilities of regional and district health management teams were strengthened to allow them to exhibit still greater management ability at the individual level (strengthening of organizational capacity). The creation of a proactive, horizontal network between districts was initiated with the objectives of conducting cooperation and sharing burdens (developing systematic capacity). As such, the presumption is that the foundation has been laid for endogenous and active local health systems.

As a catalyst spurring on change in Tanzania's district health managers, the project provided the opportunity to transition to CPs, as well as the means to do so in a competent sense. This originated out of a critical analysis of the conventional top-down type of management structure, in which administrative acts are carried out through instructions from the central government, such as MOHSW. This took the political background of the health sector reforms and the financial background characterized by the introduction of the basket fund through aid coordination as its foundations. In this sense, the role played by CD can be thought of as supporting the endogenous growth of developing countries by using what is termed development assistance as an agent for change.

3-1-2 Outcomes at the Organizational Level

(1) Outcomes of the Organizational Capacity Improvement

The organizational strengthening for the Morogoro RHMT/CHMTs was conducted through the individual acquirement of basic managerial capacity. This was then accumulated as organizational ability among the group activities of the WG, which brought this individual ability together. The achievement of various outcomes which extended beyond solely that of individual capacity was achieved successively by means of the organizational ability which collectively brought together this individual capacity. Such outcomes include an information transmission system utilizing wireless devices, the publication of a health information abstract, the regular publication of a newsletter, the opening of a resource center, the implementation of operational research (OPR), the creation of various manuals and handbooks, and more.

As an example, on August 18, 2006 the MHP received a letter from the MOHSW in relation to the publication of the Morogoro Health Abstract 2005/06. The letter read, "The Morogoro Region is the first region in Tanzania to publish a health abstract, and this abstract is the first health abstract within the country to rise to the level expected by the MOHSW."

Furthermore, NIMR praised the performance of the local OPR study report, which was also the first in Tanzania, when evaluating the activities of the MHP. The institute commented that its outcomes had contributed to improving the organizational capacity of the local health administration sector as a whole.[21] (Refer to 2-4-3 (1)-(3))

(2) Significance of Support from the Region

The former CMO of MOHSW emphasized the fact that, "The project contributed to strengthening the organizational capacity of the district health systems in the Morogoro Region. This in turn allowed the region and districts to break out of the mold of vertically-segmented administration and resolve the health problems besetting the community as a single "team."

As a part of the central government (MOHSW), the RHMTs principle duty had traditionally been to operate and manage regional hospitals. However, since 1999 they have additionally been furnished with the function of providing on-site guidance and management support for district health administration. As such, their fundamental duties have come to be surveying the incidence of and prevalence rates for diseases,

[21] From the interview with NIMR (Dr. Kitua).

which differ for each district within the region. They then provide technical guidance and administrative monitoring so that the districts can provide appropriate health services.

In the MHP, the RHMT and CHMTs worked together to put the WG activities into practice. This led to the strengthening of the region's monitoring ability, as well as its capacity to provide guidance and advice to the various districts. At the same time, the region was able to share information related to monitoring and evaluation standards for district health activities with the CHMTs, which allowed for highly transparent monitoring and evaluations. (Refer to 2-4-1 (2) 2))

(3) Horizontal Collaboration between Districts

Concurrent with the aforementioned vertical collaboration, the health administrative officials of each district conducted activities as a single WG transcending the district framework. The fact that this led to strengthening horizontal collaborative relations between district administrative officials is a result that deserves special mention. This horizontal network serves as a significant asset in the sense that it enabled daily exchanges of information, fostered a competitive spirit for health services, and strengthened the referral system. (Refer to 2-4-1 (2) 1))

3-1-3 Outcomes at the Policy, Institutional, and Social Levels

(1) Contribution to the Millennium Development Goals

The contribution to the Millennium Development Goals (MDGs) in the Morogoro Region has been incredible. As the following figure illustrates, the region is expected to achieve the target figures for two of the goals in the MDGs by 2015. These include the fourth goal to "Reduce Child Mortality," which encompasses the Infant Mortality Rate (IMR) and the under five mortality rate (U5MR), and similarly the fifth goal to "Improve Maternal Health," which includes the Maternal Mortality Rate (MMR). In reality, there are a variety of different elements involved that serve as factors in this. Yet it is conjectured that the capacity strengthening of health officials through the MHP had an impact which extended all the way down to improving the capacity of workers at health facilities for providing services, thereby acting as a facilitating factor.

Figure 3-1 Infant Mortality Rate and Under Five Mortality Rate in the Morogoro Region

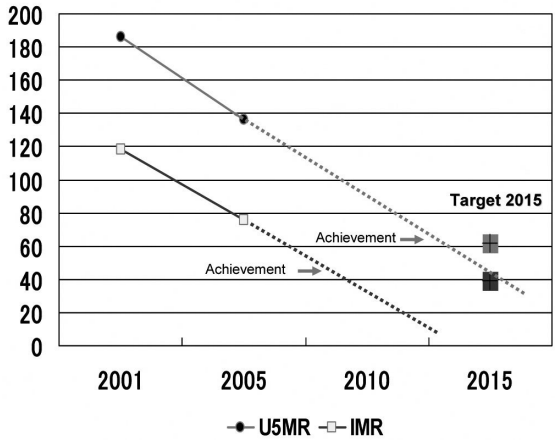
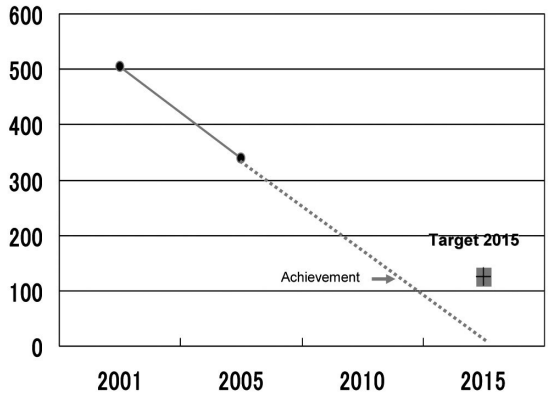


Figure 3-2 Maternal Mortality Rate in the Morogoro Region



(2) Consistency with Policy

In the health sector evaluation and study reports from 2003, 2005, and 2006, emphasis is laid on the "vulnerability of the capacity of local administrative officials and the necessity of strengthening this." As can be seen from this, the objective of enhancing local health management aimed for by the MHP was a project which was highly consistent policy-wise in its conformity to the HSR and LGRP. Owing to this, compared with the capacity strengthening projects of other development partners, this project was designed to remove the bottlenecks that were absorbing the nation's resources. This could be considered the reason for its success in accomplishing the project objectives in a relatively short period of time. (Refer to 2-4-3 (1)-(3))

From the perspective of fostering human resources in the health sector as well, the project clearly laid out the competency required for the members making up the regional and district health administration teams, as well as the methods for fostering these capabilities. In this regard, the MHP could be called a success in that it offered a single policy proposal to allow the Tanzanian Government to draft ongoing training plans for the people engaged in the health sector.

(3) Utilizing the Health SWAp

In the MHP, the districts did not rely solely on the JICA project budget in order to carry out health activities. They also made requests via their own budget planning for financial resources from the Tanzania health sector SWAp mechanism of HSBF, executing such budget planning with accountability through their own monitoring and management. This is a result worthy of special mention from the perspective of the project's autonomous development. (Refer to 2-4-2)

The chairman of the Health Development Partners Group (Health DPG) has indicated their inclination to examine further increasing the capital of the HSBF. This would be done in a similar fashion for the Morogoro Region and other regions in the future, and to the extent that local government authorities could establish their own personal accountability.[22]

In other words, improving the capacity of health administrative officials and the development of the health SWAp through MHP has been recognized as exhibiting synergistic effects. This contributes to the essential process whereby the project outcomes are set in place as institutional norms for the Tanzanian health sector.

[22] From the interviews with the former and current chairmen of the Health DPG

3-1-4 Challenges from a CD Perspective

(1) Consistency with the Comprehensive Development Programs of Local Governments

The WG activities that were established through the project are important in that, after the end of the project, they are still being budgeted for and implemented as fundamental duties as part of health activities.

In Tanzania, comprehensive development programs are created at the district level via decentralization by devolution (D by D). It is essential that such programs continue to be expanded as local comprehensive development projects by means of conducting budget coordination with other sectors. When this is done, the Regional Planning Officer and District Planning Officer (RPO/DPO) play a central role as coordinators between the other sectors.

The MHP drew these planning officers into the project activities and improved their capacity for formulating the health sector comprehensive budget plans of the CCHP. Furthermore, it not only brought in planners from the region and districts, but also involved regional and district governors and administrative officials as needed in aiming for coordination across sectors in local areas. It also contributed to improving comprehensive administrative capacity in order to appropriately allocate limited resources among the local government authorities. These efforts are considered to have been immensely meaningful.

(2) Challenges for the Implementation Structure regarding Future Local Health Administration Services

Based on the outcomes of and lessons from the MHP, hereafter it will be necessary to reexamine the administrative environment in greater detail. This reexamination must correspond to the policy, instructional, and social systems, and is designed to expand the strengthening of managerial capacity out to other areas in Tanzania.

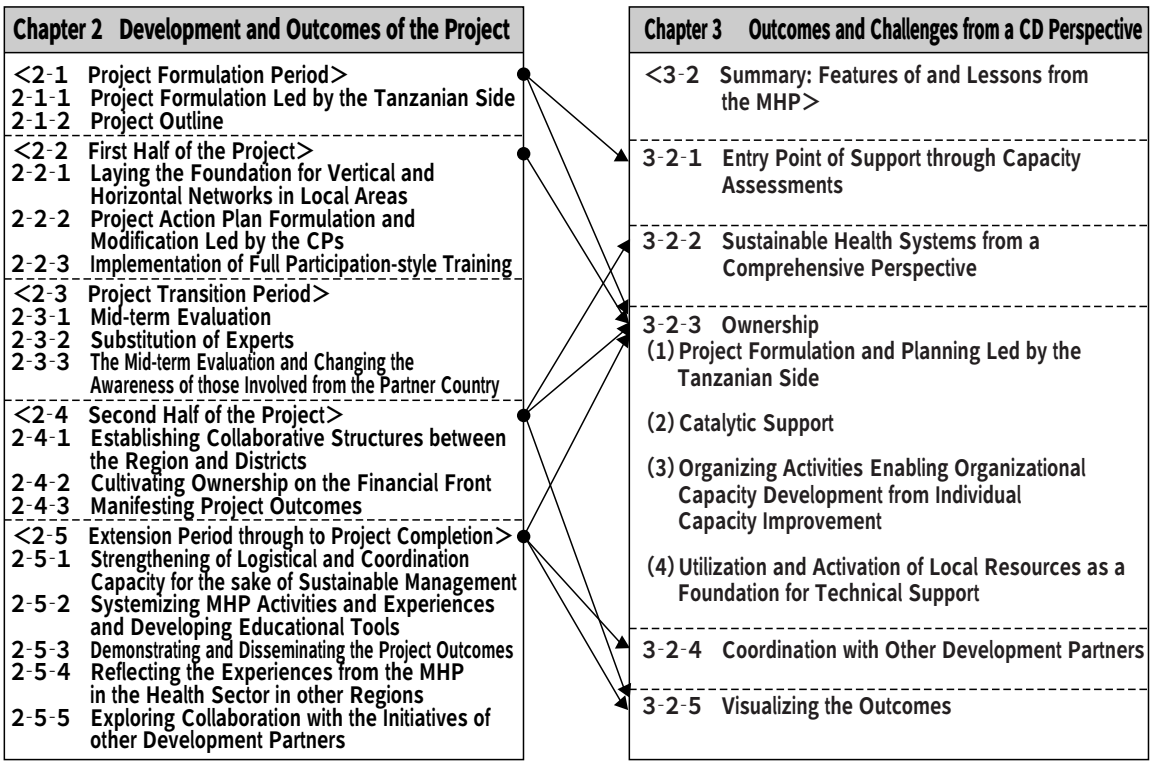
As indicated in 1-5-2, due to the decentralization by devolution process, when it comes to local health administration health activities they must be implemented based on Comprehensive Council Health Plans (CCHP) by means of the budgets from local authority ministries. The HSBF is a sector fund that works as a mechanism to provide allocations to the districts from the local authority ministries. In this manner, for the future it is envisioned that the MOHSW will play a supporting role on the technical front, while the local government will take the lead in providing services and administrative management when it comes to local health administration services.

The improvements in the capacity of local governments have progressed rapidly as a result of the abundant support that was provided, including the MHP, SWAp, and others. Yet at the same time, the development of institutions and the strengthening of managerial capacity for regional health administration are not yet complete, with this serving as a bottleneck for the promotion of decentralization by devolution.

The Tanzanian Government has petitioned JICA for technical support for the nationwide expansion of the strengthening of capacity for regional health administration, which acts as a bottleneck for the development of the entire health system. This would be done by utilizing the experiences of and lessons from the MHP. For its part, the Tanzanian MOHSW does not just have expectations for the strengthening of capacity of regional governments as seen from the central government's point of view. Rather, there are also significant expectations for the creation of modalities and a mechanism for regional health administration that are desired from the districts' point of view, such as those fostered by the MHP. The formulation of projects is currently in progress in order to allow the Tanzanian government and development partners to continue working together to support this type of mechanism.

3-2 Summary: Features of and Lessons from the MHP

While Chapter 2 traced the time sequence for the MHP activities, this chapter will once again pull together its features and lessons.



3-2-1 Entry Point of Support through Capacity Assessments [Chapter 1, 2-1]

The reason the initiatives of the MHP had such an impact is due to the fact that an appropriate entry point for cooperation was stipulated based on the policy environment for the formulation of the project. This policy environment refers to the development strategies, health sector reforms, and decentralization by devolution in Tanzania, which were described in Chapter 1.

Due to the health sector reforms and decentralization by devolution, the RHMT/CHMTs have been called upon to further enhance local health activities. The RHMT/CHMTs are gradually expanding their sphere of activities in order to achieve the objectives of the MDGs, which the international community is focused on, as well as the MKUKUTA and Health Sector Strategic Plan (HSSP) formulated by the central government. Throughout which they must formulate, implement, and conduct monitoring and evaluations of the CCHP according to the needs of the communities that are faced with the actual problems. In order to preserve consistency between the needs of both parties, the RHMT/CHMTs are being called upon to extract actual health problems as “evidence” and attach the priority to problem solving.

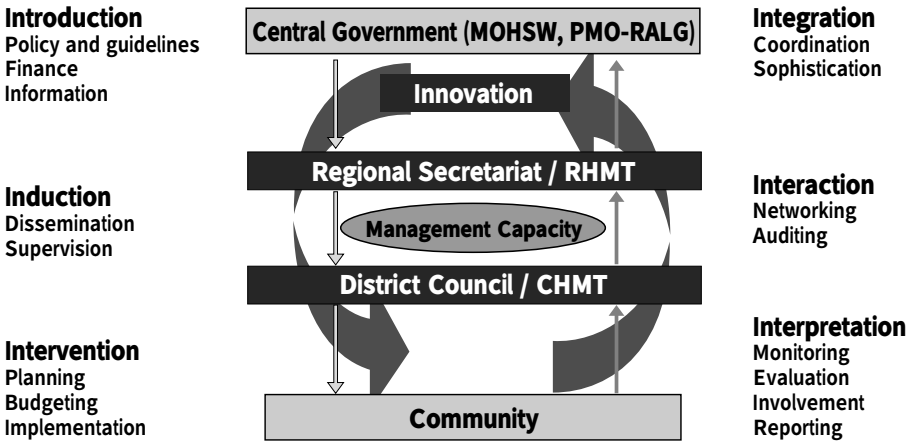
In light of this situation, for the MHP this entry point was discovered to be in improving the districts’ capacity for budget/activity planning and service implementation. This was done by means of strengthening the region’s technical support capacity in order to enhance managerial capacity for the local health sector, which was acting as a bottleneck. In addition, by thoroughly carrying out “evidence-based planning and implementation” the project was developed as a trusted local health administration model through decentralization by devolution.

Moreover, for the case of the MHP vigorous and persistent exchanges of opinions and debates were conducted over the area to be selected and the project contents. These were carried out around the time of the needs study, and were performed by the MOHSW as well as other development partners.[23] During the project formulation stage, suitable attention should be focused on adjustment between the concerned parties in order to determine the entry point for support.

3-2-2 Sustainable Health Systems from a Comprehensive Perspective [Chapter 1, 2-4-1 (2), 2-4-2, 3, 2-5]

Based on the capacity assessment from the situational analysis mentioned above, Figure 3-3 is an image of the health system that comprehensively illustrates the manner in which the central, regional, and district governments, as well as the community are related to one another regarding the MHP.

Figure 3-3 Sustainable Health System



Source: Sugishita (2006c)

The ascending arrow on the left illustrates the process whereby the CHMT, which perceives the needs of the community and uses this as evidence, incorporates activities into CCHP while also offering up materials to the region and central government (MOHSW and PMO-RALG) in order to effect policy changes. The descending arrow on the left indicates that health-related policies and guidelines (policy making conforming to needs is required) formulated by the central government descend down to the regional governments. The regional governments provide supervision to ensure that the district governments have properly interpreted the policies, while the district governments provide health services to their communities that matches the guidelines.

It is important that both systems, those that draw out the needs from the bottom up and those that provide services from the top down, interplay and function as a sequence of systems. As a result, this ensures development whereby local health administration services can reach the residents in an appropriate manner.

Thus, the MHP was **positioned in between these bottom up and top down approaches. Targeting regions and districts that were acting as bottlenecks, it fostered health administration management with the goal of organizational enhancement.** As a result, the district health administrative team

[23] From the interview with former policy advisor Hashimoto.

accurately determined the health needs of the community, and it became possible to formulate this as a district health planning and budgeting operation. At the same time, these activities led to the creation of a sustainable health system by means of the acquisition of a sector basket fund positioned from the top within the health SWAp.

By positioning the initiatives of the MHP within such holistic health systems, its alignment with health sector reforms was adjusted. As a result, it came to serve as a move for the formulation of national health sector CD strategies as indicated in 2-5-5.

3-2-3 Ownership

By what means was ownership by the Tanzanian side fostered? The answer to this is thought to lie in the **attitudinal factors** between the parties of Japan and Tanzania for the project formation and planning, and the **strategic factors** which went so far as to "set up a system in which the RHMT/CHMTs worked to address health problems within the region as a team."[24] Going into specifics, project formulation and planning led by the Tanzanian side and the catalytic support of Japanese experts will be described regarding the former, while for the latter the formation of project activities and the utilization and activation of local resources will be discussed.

(1) Project Formulation and Planning Led by the Tanzanian Side [2-1-1, 2-2-2]

During the MHP's project formulation stage the CMO played a central role in clearly grasping an awareness of the need to strengthen the management foundations for local health administration along with the JICA Tanzania Office. As such, this case was created in a manner that utilized ownership by the Tanzanian side to the utmost extent.

Furthermore, in the first half of the MHP the CPs were personally made aware of the project's objectives by attempting to have them engage in project activity plan drafting and modification in a participatory manner. The fact of them personally getting involved in developing the project was a motivating factor behind dramatic outcomes being produced in the project's second half.

(2) Catalytic Support [Chapter 2]

The MHP adopted **"catalytic support"** as its support modality in order to foster the ownership of the Tanzanian side.

The MHP Japanese experts carried out activities in consideration of the following points for the implementation of catalytic support.

- Valuing an attitude of thinking and learning together with the CPs
- Trusting in and developing the latent potential of the CPs (for example, fostering basic management capacities such as leadership, team work, communication ability, etc.)
- Providing continuous support for the process of reflecting skills learned through training in regular duties

The Japanese experts emphasized an attitude of **thinking together with the CPs and learning from one another.** This was designed to enable the RHMT/CHMTs to implement health activities independently and actively at the local level without having to wait for instructions from the central government. Expert Sugishita explains, "It is necessary to motivate those on the ground and to have the ability to think from the field **(field capacity)** in order to conduct catalytic support. This requires not only **'knowledge and**

[24] From the interview with the former CMO.

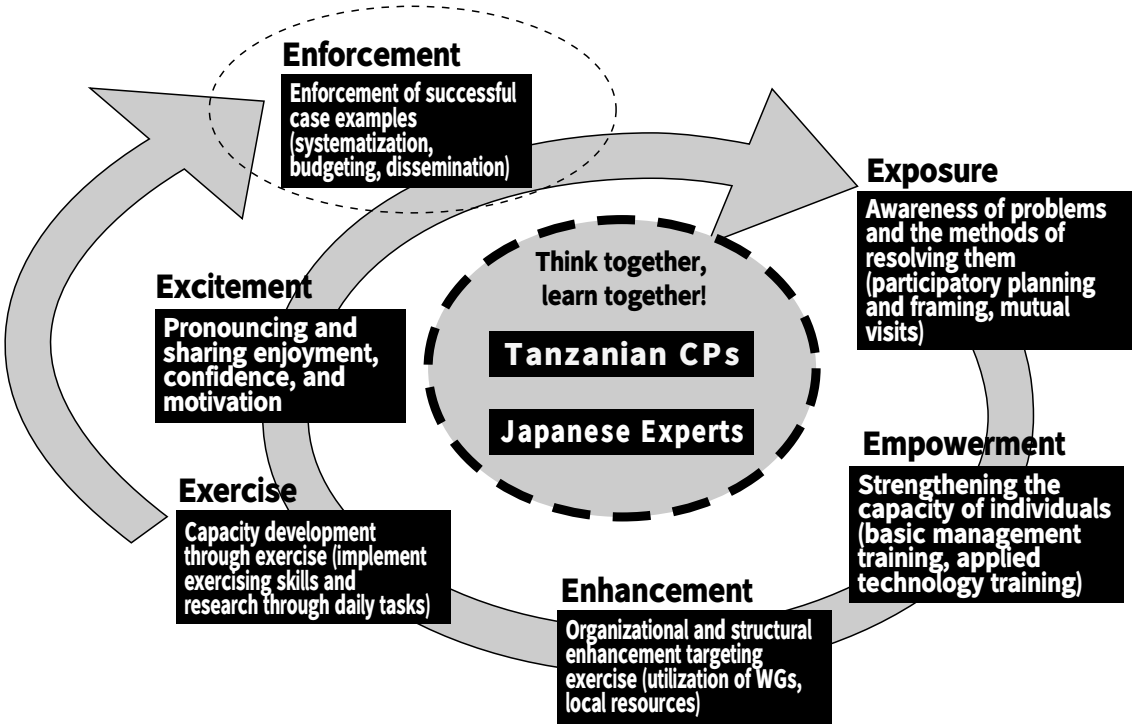
experience,' but also health administration management consisting of comprehensive **'technical ability'** as well as just enough **'personal magnetism'** to get the partner moving." Moreover, Fukushi, another Japanese expert, said, "In the CP growth process there are a great many things that must be overcome and numerous areas where you can't get progress simply with a cosmetic or superficial response. This requires the resolve to honestly 'come face to face' with issues rather than just superficial 'interacting.'"

Therefore, through genuine interaction CPs imbued with leadership capabilities were fostered. Along with this, teamwork was created among the CHMTs as well as the WGs, which were formed for each health issue. It can be said that these facts comprise the quintessence of catalytic support.

This posture of acting as catalysts also serves to explain the importance of the presence of the Japanese experts as foreigners. To the Tanzanians, the Japanese experts were foreigners who would return home at some point. It was precisely because they served as "catalysts" for a limited period that they were at times able to carry out an intermediary role between the various stakeholders, occasionally propose ideas from a different point of view, and "interact" by thinking together and learning from one another. Through such efforts support was provided for the self-reliant initiatives for Tanzania taken by the Tanzanians themselves.

Figure 3-4 below denotes this catalytic support in a more systematic manner, expressing this concept by means of the **5Es (Exposure, Empowerment, Enhancement, Exercise, and Excitement).**

Figure 3-4 Catalytic Support (5Es) and 1E (Enforcement)



Source: Created by the authors from the MHP (2007) p. 25.

The first step is **Exposure**, which is designed to make the CPs recognize problems on their own and take up these challenges. Drafting plans in a participatory manner through trial and error served as exposure which fostered ownership on the part of the CPs towards the activities they would continue to address themselves.

The **Empowerment** stage aims for capacity enhancement at the individual level, such as by basic management training.

When conducting **Enhancement** to put the outcomes of individual capacity enhancement into practice, attention is paid to forming WGs and establishing a structure designed to take organizational responses. Furthermore, the utilization of local resources is conducive to the development of sustainable activities.

By means of **Exercise** underneath such a structure, one becomes conscious of the duties of one's own organization, and examinations begin to be made into independently working out a budget that is separate from project expenses.

Thereupon, by independently acquiring learning from this exercise, the work is improved and visible outcomes begin to appear, through which **Excitement** is created. This represents a self-reinforcing system and process whereby the CPs are instilled with self-confidence which they mutually share among themselves, by means of which they begin receiving exposure to still more challenges.

The above describes the 5Es, but the MHP goes further by adding the new E of **Enforcement**, which is designed to make the outcomes resulting from such support sustainable. As is written in 2-4-3 (4) and 2-5 on the initiatives in the extension period, changes occurred in order to organize the experiences from the MHP and develop them into policy and institutional frameworks. The purpose of this was to turn the initiatives of the MHP into a model that was sustainable and would be disseminated out to other areas. Comprehensive ownership on the partner's side was fostered through this CD process.

The 5E process also thinks highly of the ownership on the partner's side, and is consequently time consuming and largely non-apparent at the outset. However, CD is realized by having this process of trial and error by the CPs serve as a foundation for them to resolve challenges on their own.

The Regional Nursing Officer (RNO) expressed and evaluated catalytic support in the following manner.

"**Catalytic support means providing close support together for forward-looking change.** In this not only must the Japanese experts act as catalysts, but the regions must act as catalysts for the districts, and the districts must be catalysts for health facilities. As a representative of the region, I would like to personally continue to provide ongoing support for the districts through this."

A staff member of the Morogoro Municipality CHMT described the effects from catalytic support in the following manner.

"Following the occurrence of a chemical reaction, a catalyst essentially remains unchanged. Yet I know that the **Japanese experts as 'catalysts' themselves changed** through our project. They learned about issues like cultural differences in the procedure and protocol for administrative duties in Tanzania and recognized our respective division of roles. As this was occurring, through a tug-of-war of sorts we stimulated each other, grew, cooperated, and built relationships of trust."

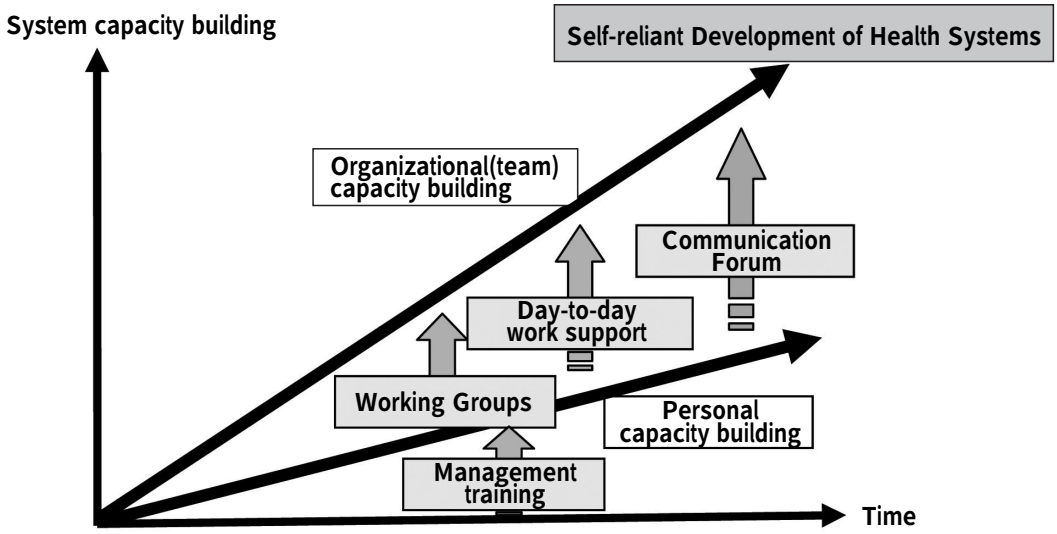
(3) Organizing Activities Enabling Organizational Capacity Development from Individual Capacity Improvement [2-4-1 (1), 2-2-3]

For the fostering of ownership, not only an attitude like that described above, but also strategic aspects of activities that are meant to change specific behaviors of the CPs are essential.

Figure 3-5 offers a graphic illustration of the organization of four activities that serve as capacity development models conducive to organizational capacity development from individual capacity improvement. These are understood to be time-oriented development: (1) basic applied management training; (2) working groups (WGs); (3) practical applications for day-to-day work; and (4) providing opportunities to share information.

To begin with, after working to "improve managerial capacity" by training every member, "WGs" were

Figure 3-5 Capacity Development Model



Source: Sugishita (2006c)

formed for each health challenge by selected leaders, and activities designed to determine tasks were initiated. Then "applied management training" was carried out for the members belonging to the WGs, after which the WG members would pass on the abilities that they had personally acquired to the team. These would be reflected throughout "day-to-day work," and the teams would carry out problem solving as a whole. In this way the strengthening of organizational capacity was facilitated. What is more, the WGs themselves were expected to act as a team for the achievement of visible outcomes, with a mechanism created for all of the stakeholders to "share information" through opportunities to present these outcomes.

Training for every member related to basic management contributes to the development of individual capacity. On the other hand, by clarifying where the responsibility for leadership lies in response to each group's mission, the WG activities strengthened their ownership as members of an organization, rather than the capacity of scattered individuals. This contributed significantly to improving the capacity of the overall organization. The "applied management training" was given a different character from the training for every member in the sense that it was implemented in a manner that was responsive to the mission for each individual for selected members. (Refer to Box 3-1)

By putting the capacity acquired through management training and the WGs to practice in day-to-day work, such capacity took hold among the RHMT/CHMTs, which thereby developed their organizational response capabilities. Furthermore, such experiences and lessons serve as outcomes which offer encouragement to a wide range of concerned parties, both domestically in Tanzania and internationally. These have been disseminated via mutual visits to other regions and organizations, presentations at international conferences, exhibitions of the tangible outcomes, and other such opportunities.

(4) Utilization and Activation of Local Resources as a Foundation for Technical Support [2-4-1 (3), 2-4-2]

Financial backing from independent revenue sources is important for the self-reliant planning and execution of health activities. As was mentioned in 2-4-2, this project promoted cost sharing of the expenses for project activities with the district governments in consideration of the sustainable development of the activities after the end of the project. The health sector basket fund that was allocated to the districts

Box 3-1 Separate Use of Training Methods According to Objective

The MHP had 63 "official CPs," which is a large number compared to other projects. Providing training targeting every CP would have taken up considerable time (scheduling) and cost a great deal of money. It is necessary to fit elements like the time, participants, and contents into the framework for training while constantly thinking, "Will the anticipated outcomes be worth the investment?" When it comes to training methods, the most suitable method according to the objective must be selected on the basis of their respective advantages and disadvantages from the diagram below.

Comparison of Training for Every Member and Selective Training in the MHP

	Example of actual training	Advantages	Disadvantages	Points of consideration
Training for every member (concerted participation from members of the same team) (27 participants + 36 people = 63 people total)	OPR basic training, etc.	Improves the basic abilities of every member **Enables problem solving (group work) of each team** Team building	Offices would be short-handed High cost of training	A single training period is under 5 days Training conducted over 2 sessions (3 teams + 4 teams)
Training for every member (phased participation by members of the same team) (63 people total)	PC skills, etc.	Improves the basic abilities of every member **Offices can operate**	Members of the same team unable to discuss amongst themselves during training High cost of training	Training participation periods (out of 2-3 sessions) adjusted because of individual schedules
Selective training (Around 14-20 people)	ORP upper level training, etc.	Training on advanced subjects for those responsible for the teams **Fosters sense of responsibility of the participants towards challenges** 10 day training possible from a budgeting / schedule standpoint	Persons targeted limited to only some of the responsible parties	Requires multiple lectures and scrupulous planning and coordination Requires DSA for weekend that falls in the middle

Source: Created by expert Fukushi, June 2007.

under the SWAp was actively used as an independent source of revenue for the districts. An important factor in the background to this promotion was that a sense of financial commitment for project activities was developed in the CPs themselves through their management of the WGs and the like, with this being conducive to ensuring independent sources of revenue.

Furthermore, as described in 2-4-1 (3), the facilitation of activities and collaborations with local resources like universities, research institutions, and NGOs is thought to be highly sustainable in a cost and technological sense as well. The purpose of this is to enable ongoing technical support on the ground with regards to the holding of basic and applied management training. When formulating the project, discovering technical local resources within a certain range adjacent to the project area at the earliest stage possible (until immediately after the commencement of activities at the very latest) is an extremely important task. For the future, Tanzania will disseminate and expand this model for the strengthening of local health administration management out to the entire country on its own. When this is done, it is

anticipated that these local resources will be able to act as catalysts for the strengthening of individual and organizational capacity.

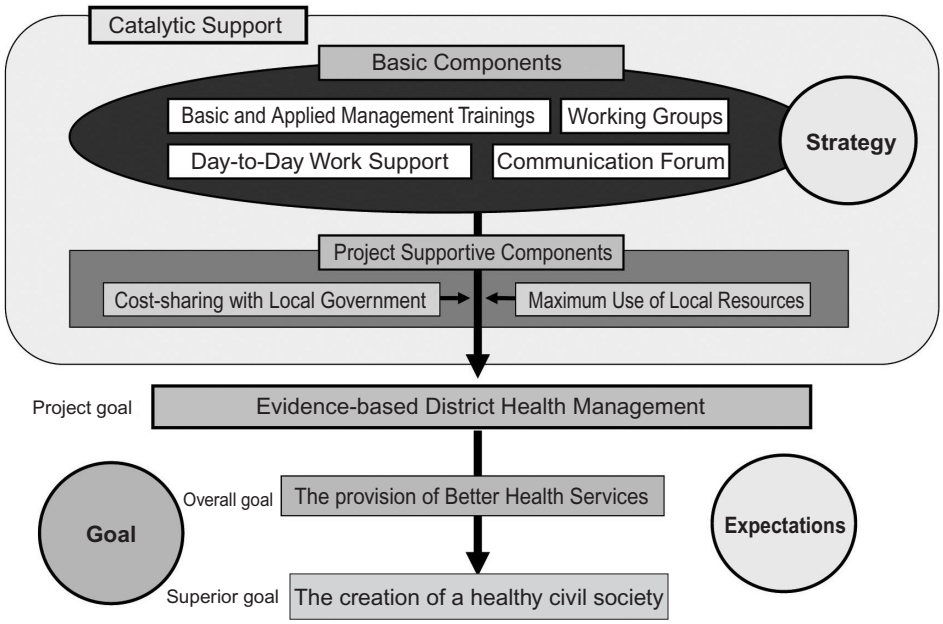
The "CP's capacity to utilize and manage local resources" is as important as accessing them. For the second round of OPR management in the MHP, the Morogoro municipality CHMT searched for and found a university lecturer on its own and commissioned the lecturer to provide consulting for just the necessary areas at a low price. Budget support-type assistance takes the position that "work that you cannot do yourselves should be consigned to a local consultant for a fee." The MHP, on the other hand, aimed to "impart the CPs with the ability to handle issues on their own with the use of a local consultant" (sustainable pay-per-performance system). The MHP's success will demonstrate the significance of the technical cooperation in this project as well as the validity of complementarity with budget support.

Figure 3-6 brings together the aforementioned factors that contributed to the fostering of ownership on the partner's side based on catalytic support. This includes the configuration of activities for realizing CD, as well as providing the supporting foundation from local costs and resources used to carry out these activities in a sustainable manner.

The former RAS from the Morogoro Region described this CD process in the following way.

"CD is like building a house. When building the foundations for the house you spend an enormous amount of time and money, and you start to feel like you just squandered your money. But when the house is finished, you realize that even though you can't see the foundations, it's extremely important to have them for the house to stand firm."

Figure3-6 Process for Strengthening Capacity that Enables Autonomous Development



Source: Sugishita (2006c)

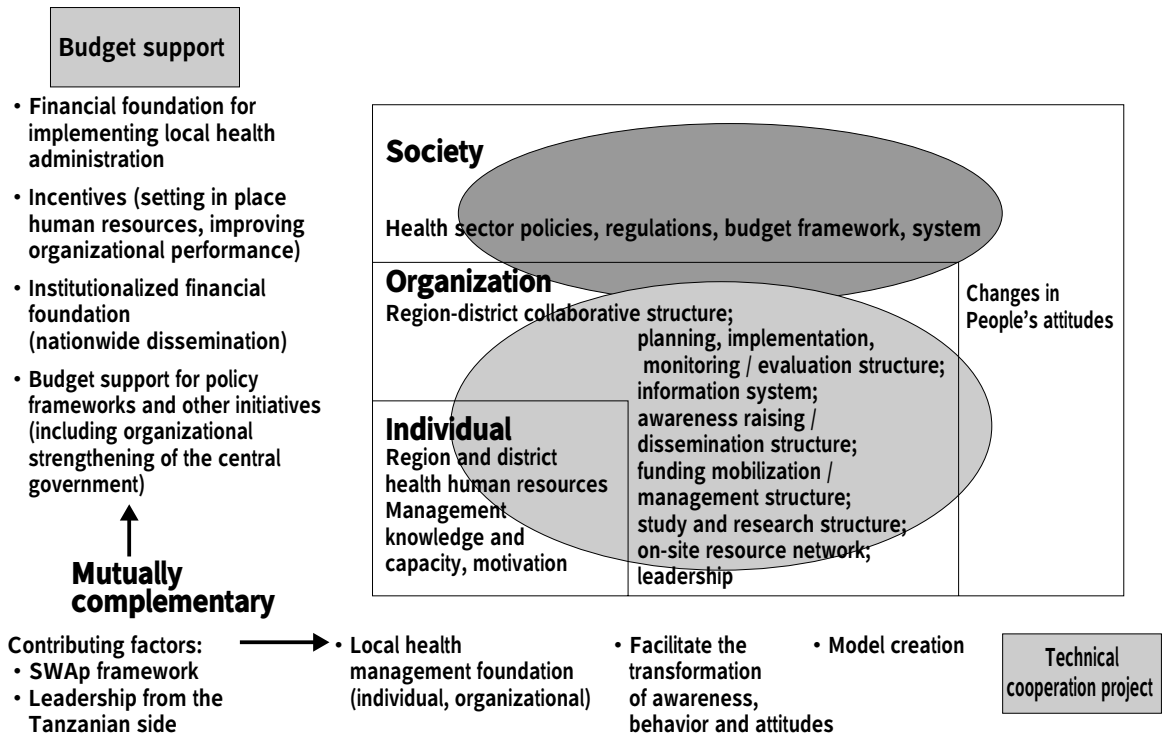
3-2-4 Coordination with Other Development Partners [2-5-5]

The positioning of the MHP's initiatives within the entire health system has been described previously. As was mentioned, the fact that comprehensive CD support could not be implemented solely through support by JICA alone had been recognized by not only the project experts, but also those on the Tanzanian side. For this reason the contents of the request by Tanzania, which is a country in which aid coordination is advanced, were altered. The request changed from a stand alone-style project approach to project-type assistance that provides support through mutually supplementing other assistance modalities, such as budget support-type assistance based on a programme based approach.

In the case of the MHP, the goal was to position technical cooperation from the policy background of the health sector reforms, and also to acquire the expenses for the WG activities based on CP ownership from the sector basket fund. In terms of these two points, the MHP could be labeled as technical cooperation that produced development outcomes through mutually complementing other modalities in a manner consistent with the health sector program of Tanzania as a whole.

Figure 3-7 illustrates the complementarity between MHP, which is a technical cooperation project, and budget support regarding Tanzania's health administration CD. This illustrates the fact that the foundation for the budget framework was laid through budget support, the foundation for local health management was established through a technical cooperation project, and that a model was created.

Figure 3-7 Complementarity between JICA's Technical Cooperation Projects and General Budget Support



Source: Miwa (2007)

3-2-5 Visualizing the Outcomes [2-3-1, 2-5-2, 2-5-3]

(1) Setting Indicators to Measure the Outcomes

As can be understood from the characteristics above, it is important to visualize the outcomes to the extent possible and express them both internally and externally. This is essential in working to position the project outcomes in a comprehensive manner and institutionalizing them with the support and understanding of the concerned parties.

For the MHP, self-diagnoses were performed for the management capacity of the CHMTs through six indicators (schedule management, project management, coordination ability, finances, management of human and material resources, and knowledge) by means of the HSWD. This was designed to visualize the improvement of management capacity, which was considered to be difficult to measure qualitatively, in an easy to understand manner in the form of quantitative indicators.

This HWSD is characterized by "an evaluation by oneself, for oneself." Having the CPs hold numerous consultations among those concerned with the project and establish monitoring indicators in line with the actual conditions themselves was immensely important in terms of fostering ownership. In other words, not stopping at monitoring that simply collected indicators, but rather conducting activities like the holding of emergency meetings and working out countermeasures by the CPs based upon fluctuations in the indicators resulted in autonomous activities. In this sense, creating independence for the establishment of indicators was exceptionally important in terms of the development of management.

(2) Creating Opportunities to Present the Outcomes

In the MHP, the CPs were able to actively express the fact that they felt a sense of achievement from accomplishing outcomes, as well as self-confidence in their own abilities. This was achieved by setting up venues for them to express this, including stakeholder conferences, donor conferences, public health forums, and international conferences. It has been indicated that consciously creating such opportunities is thought to have resulted in promoting endogeneity in the form of "backing up the CPs as catalysts." Furthermore, "acknowledgment from a wide range of actors" also represents an important element in the self-reliant development from the perspective of comprehensiveness.

Simultaneously, providing the CPs with opportunities to present the outcomes on their own also led to the establishment of local networks with central government officials, health and medical facilities, responsible parties among other development partners, and more. It also had the effect of expanding the foundation for support. With this serving as the motive behind various stakeholders acknowledging the CP's capacity, it became possible to secure the resources to support the self-reliant development of the project in a more comprehensive context.

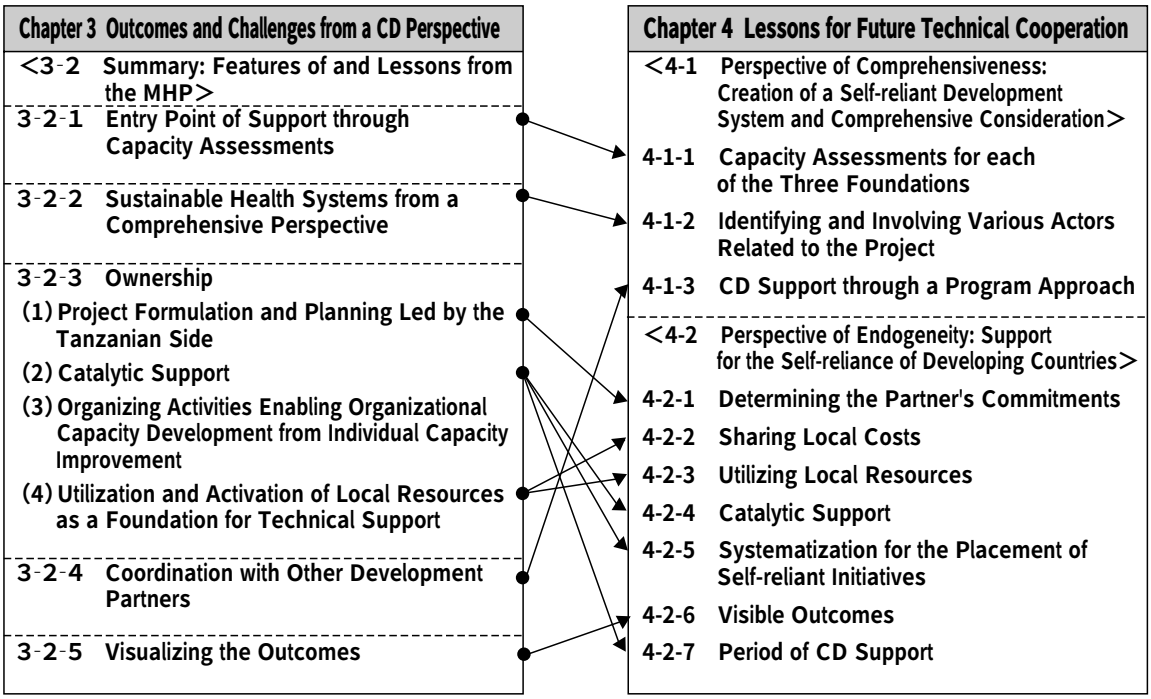
In this manner, the fact that the CPs consciously worked to create opportunities for others to assess the outcomes of their activities is considered to be important for a CD project from the perspective of both endogeneity and comprehensiveness. What is more, monitoring and evaluation, comments, and more were provided by monitoring and evaluation teams, and related embassy officials from Japan and visitors from other projects. Such activities are felt to have been effective in actively providing encouragement to the CPs from the Japanese experts, since they served as opportunities to revise activities and to present the outcomes of these activities.

(3) Publishing Tangible Outcomes

For MHP, goals were set by framing the outcomes from activities by the WGs as visible outcomes such as “publications.” The names of the CPs themselves were listed in these publications as the authors, which was an effective incentive as a reward for the CPs’ hard work. In addition, these publications could be picked up and referred to at any time, and were thereby immensely gratifying in that they strengthened the CPs’ self-confidence and allowed them to contribute to their teams the use of these publications (Morogoro Municipality CHMT member). Moreover, producing publications was persuasive with respect to upper-level officials such as the DED and made it easy to request the expenses for CPs to participate in WG meetings (WG member). As such examples show, the creation of publications was an effective means of fostering self-reliant development through visible, concrete outcomes designed to win the understanding and cooperation of the related parties over to the project activities.

Chapter 4 Lessons for Future Technical Cooperation

This chapter will conclude by bringing together items that can be generalized from the lessons of the MHP to serve as lessons for the implementation structures of other projects. This will be from the perspective of CD, and will precisely identify the viewpoints of comprehensiveness and endogeneity.



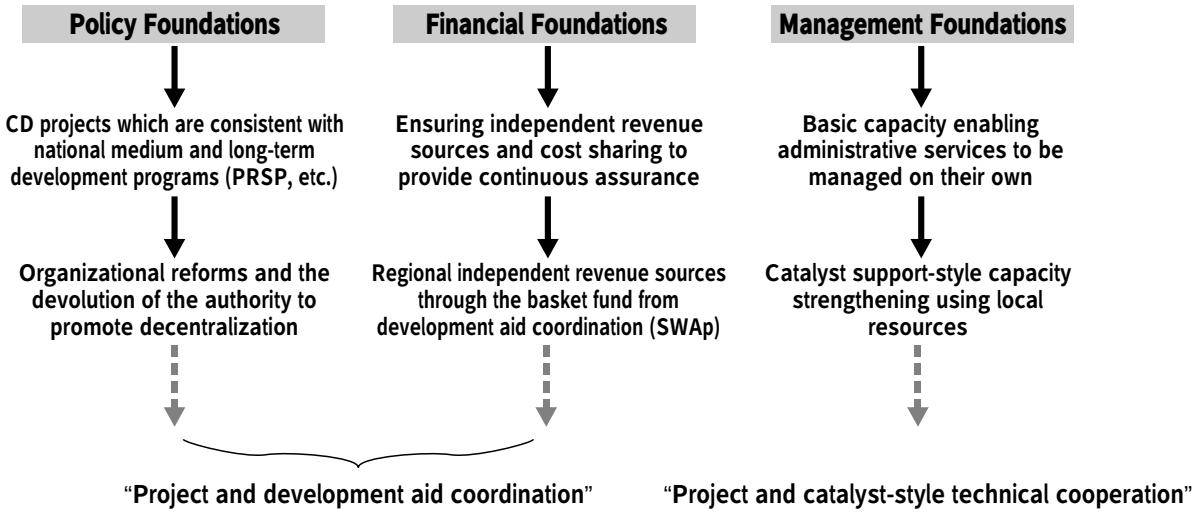
4-1 Perspective of Comprehensiveness: Creation of a Self-reliant Development System and Comprehensive Consideration

A persistent prerequisite of the technical cooperation implemented by JICA is that it creates systems that can be sustained by the partner country. Therefore, after first assessing the overall picture of the health system, support was provided to areas that were acting as bottlenecks, with this serving as the basis for a self-reliant development system. On this account, it is necessary to carry out project cooperation while aiming for collaboration and cooperation with other development partners and related organizations. This is to be done on the basis of the political background and with consideration for a comprehensive system.

4-1-1 Capacity Assessments for each of the Three Foundations [3-2-1]

As was made clear via the three foundations for the health sector reform in 1-4-2, self-reliant development requires the three pillars of policy, financial, and management aspects. The government of the developing country and development partners should share a development vision and increase development effectiveness through complementarity with fields that other development partners focus on and specialize in and fields in which Japan has technical cooperation experience.

Figure4-1 Three Foundations of the Tanzanian Health Sector



Source: Sugishita (2006a) p. 117

Figure 4-1 illustrates what methods are sought for each of the respective three foundations supporting the sector reforms. It can be understood from this figure that, to bolster the policy and financial foundations requires strengthening of the partner country's policies and budget support to back this up. Consequently, there must also be coordination between the government and development partners, as well as amongst development partners themselves. In terms of the foundations for management in local government, it has been deemed necessary to strengthen capacity that enables the organizations and individuals from the partner country to independently carry out projects on the basis of these policy and financial foundations. It is in this area that the catalytic support of the MHP made its contribution.

When implementing CD support, it is necessary to consider a development vision after assessing the capacity on the ground in terms of the three foundations, and with a comprehensive outlook.

The government of the partner country, other development partners, those involved with the implementation of similar projects, and other such persons should be involved and hold dialogues together. This should take place at each stage where part of the project framework is determined, such as at the time of the request survey, during project formulation, and at the ex-ante evaluation. As this is being done, it is extremely important that capacity assessments of the partner country be conducted carefully and reliably.

Table 4-1 is a model that arranges the viewpoints which are necessary when conducting capacity assessments. This table provides a viewpoint for capacity assessment in terms of the degree to which those concerned at the central and local levels are furnished with the three foundations for the sector reforms mentioned in the previous section.

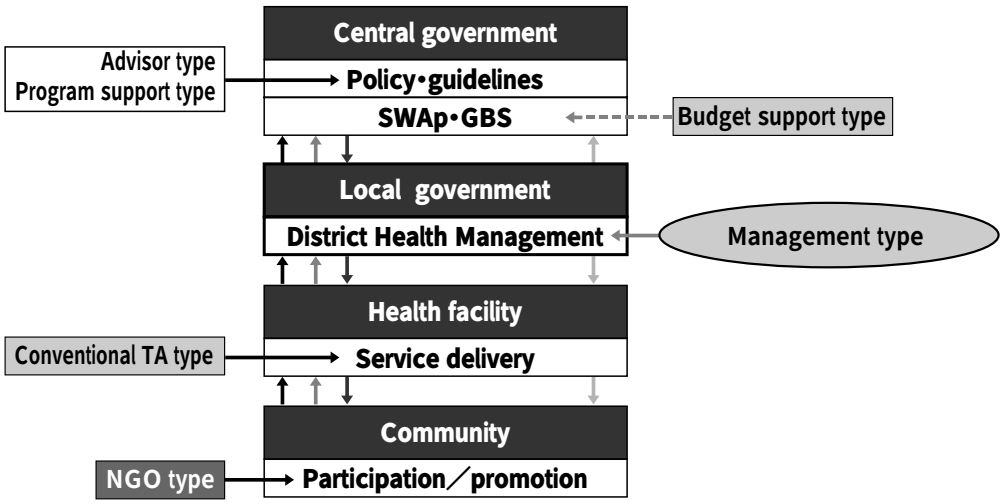
Table 4-1 Capacity Assessment Perspectives (Example)

		Policy foundations	Financial foundations	Human resources (management foundations)
Central government	Directing ministries / agencies			
	Implementing agencies			
Local government				
Cooperation target				

Source: JICA, Institute for International Cooperation (2007) p. 73

This can be thought of as the format for a new assistance approach that is based on such capacity assessments. As shown in Figure 4-2 below, this approach combines the functions and roles of program support cooperation such as policy advisors and budget support to the central government, which mainly sets in place policies and institutions; with administrative management improvement support like that of the MHP for local governments, which provide administrative services in local areas.

Figure 4-2 New Assistance Approach Based on the Local Health Administration System



Source: Data from expert Sugishita

4-1-2 Identifying and Involving Various Actors Related to the Project [3-2-2]

The previous section described the necessity of conducting capacity assessments of the partner country's related agencies for each of the three foundations. Upon receiving the outcomes from this, it is also necessary to ascertain bottlenecks and accurately narrow down the entry point for support. At the same time, it is also essential to broadly determine not only the targets of support, but also related actors from the three foundations, and to involve them in the aforementioned initiatives at the implementation stage. This is indispensable for the establishment of a self-reliant system.

With regard to technical cooperation, there are numerous cases of support for the improvement of service delivery for different sectors. In such cases, the sector ministry offices, local administration such as with the MHP, and direct service delivery points, such as hospitals, can be thought of as the cooperation partners. Supporting the improvement of technical and managerial capacity to enable these organizations to independently provide service delivery can primarily be seen as a means of fully utilizing the unique qualities of JICA projects.

However, the policy and financial foundations are deemed necessary for the sake of enabling the targeted organizations to continue delivering sustainable services even after the end of the technical cooperation. Yet that does not necessarily imply that the direct counterparts of a JICA project will have an influence on such foundations. Rather, it will be the planning departments of their organizations, central government ministries and agencies, or supervisory ministries and agencies. What is important is how to devise a mechanism that gives consideration to how the project outcomes are to be positioned in the policy and financial foundations. This is to be achieved from the perspective of actors who are deeply involved with the foundations of the given field even if technical cooperation directly strengthens the management foundations. It should be carried out by means of sharing the project goals, issues, and outcomes with such

actors starting from the project formulation and implementation stages.

The role of foreign experts is to act as intermediaries for mutual understanding between the direct CPs and the actors involved in policy making and financing as well as to directly appeal to such actors on some occasions.

In this manner, each actor playing a role in these three foundations should be effectively involved. Doing so facilitates the organizational capacity strengthening of administrative services and the institutional improvement regarding the SWAp as the two wheels of the same cart, while also leading to CD effects over the medium and long term.

4-1-3 CD Support through a Program Approach [3-2-4]

In order to allow for synergistic effects between organizational strengthening and institutional improvement, it is not feasible to consider CD support through technical cooperation alone. Instead, technical cooperation projects must be formulated and implemented in harmony with programme based approach of the partner country.

More specifically, the capacity of the related agencies (central / local) of the partner country should be determined for each of the three foundations listed in the previous section. It is then necessary to strive for broad-based coordination and cooperation with the government of the partner country and other development partners over the issue of how cooperation should be implemented to strengthen these different foundations.

When examining the formation of technical cooperation, it is necessary to demonstrate the validity of the project with respect to the policy foundations of the partner country in particular, as well as to clearly stipulate how it will strengthen the management foundations. During project implementation, factors related to the financial foundations should be jointly examined and appeals made to key persons as needed, with a view to sustainability after the completion of the project. There is also benefit in having an impact on the improvement of the policy and financial foundations by actively transmitting the outcomes of and lessons from the strengthening of the management foundations.

4-2 Perspective of Endogeneity: Support for the Self-reliance of Developing Countries

In order to support the CD of the partner country, it is necessary to think about mechanisms designed to successfully foster ownership on the part of the partner country throughout the support process. This section will give a step by step account of the process for such autonomous mechanisms based on the lessons of the MHP.

4-2-1 Determining the Partner's Commitments [3-2-3]

As seen in 2-1-1 and 2-2-2, starting from the project formulation stage the network needed for strategic project formulation should be expanded, information should be collected from all sides, and appeals should be made to the partner country. On top of this, it is crucial to obtain commitment to the project in the form of the self-reliant initiatives of the CPs from the government of the partner country themselves. This should be achieved by formulating the project in a manner that is consistent with the important policies of the partner country.

It is important to specifically clarify the extent to which the partner side is willing to make commitments in a policy, financial, and personnel sense to the project from the project formulation stage. If this cannot be elicited from them satisfactorily, then it is necessary to resolve to go so far as suspending the

cooperation. To do so, based on the commitments of both the developing country and the development partner side, it is necessary to clarify the commitment in terms of the extent to which responsibility is upheld in achieving implementation. In this sense, an attitude of “coming face to face” with each other is essential from the project formulation stage onward.

4-2-2 Sharing Local Costs [3-2-3 (4)]

Local cost sharing for project operations is extremely important in terms of ensuring the endogenous initiatives of the partner country. However, it is no simple a matter for developing countries that are essentially lacking the funds to bear such financial costs.

For this very reason, cost sharing will not be achieved easily; this is something that should be examined from the project formulation and implementation stages over a medium- to long-term time frame. When implementing this, it goes without saying that the project should be positioned on the basis of the policy foundations of the partner country. It is also necessary to call attention to the significance of activities and their outcomes that are sufficient to convince the developing countries to bear the financial costs.

When it comes to pressing the partner country into accepting a burden in the form of cost sharing, there are always extremely intense debates that occur on the ground. However, only after the awareness of the CPs themselves has been transformed and there have been visible changes in performance is the development partner side able to adopt a firm posture.

4-2-3 Utilizing Local Resources [3-2-3 (4)]

The dispatch of experts capable of providing full support is not necessarily guaranteed for every JICA project. On the other hand, since every JICA cooperation project has an exit point, it is necessary to create a cooperative structure in order to achieve optimal outcomes over the medium and long term within the range of the limited resources of the partner country.

In this sense, it is of the utmost importance to seek out the potential for creating a sustainable technical cooperation structure, rather than dispatching short-term experts from Japan. This is to be done by discovering and actively utilizing technical local resources such as universities and NGOs.

Local resources are more knowledgeable than the foreign experts are when it comes to on-site problems, meaning that they are able to provide technology and information that is suited to the actual site. Another important point is that local resources could intertwine with the technology of foreign resources based on catalytic support. Doing so contributes to the growth of the local resources themselves. By such means, the foreign technology is relativized by the local resources, which makes it possible to provide ideal technical cooperation suited to the local context.

Utilizing local resources in such a manner positions them within the ongoing initiatives of the partner country. The expectation is that this will serve as a mechanism designed to constantly strengthen capacity following the end of the project.

4-2-4 Catalytic Support [3-2-3 (2)]

As was seen with the “catalytic support” described in 3-2-3 (2), the project was not meant to substitute for direct services. Rather, it was meant to support self-reliant management in order to continuously implement services attuned to local needs. In this sense, the project experts acted as catalysts and adopted an attitude of thinking and learning with the CPs. They played the role of eliciting the latent potential of the CPs by means of offering exposure and providing information, as well as forming connections with stakeholders and external resources so as to allow the CPs to carry out activities themselves. Through this

process, not only the counterpart side, but also those on the development partner side who were the catalysts personally changed and grew. This is believed to have exhibited synergistic effects for both parties, while also promoting the development of the project.

4-2-5 Systematization for the Placement of Self-reliant Initiatives [3-2-3 (2)]

Starting during the project implementation period, it is essential to **systematize the project outcomes from a policy-wise institutional point of view, and also to give rise to a cycle of strengthening self organization.** The purpose of this is to set in place initiatives from the project as independent efforts of the partner country after the end of cooperation from JICA.

The systematization of initiatives from the project was seen during the second half and the extension period of the MHP. However, there was a tendency to downplay cases of this where consideration was given solely to strengthening the capacity of the CPs, which had been made the target of direct support. Yet the initiatives of the project were consistently meant as a pilot endeavor. If this were to be used as a basis for convertion into self-reliant initiatives by the partner country and expanded nationwide, then the task of systematization would have been necessary during the project implementation period so as to have an impact on the policy and financial foundations.

In other words, the Tanzanians held the follow-up work for creating a structure in Tanzania in high regard until the very end, and supported the attitude behind such initiatives.

4-2-6 Visible Outcomes [3-2-5]

As was described in 4-1-2, in order to elicit the self-reliant of a wide range of people from the partner country it is necessary to appeal to not only the project CPs, but also a diverse array of actors related to the three foundations. In order to do this, the outcomes of the project must be expressed in a visible manner, as was mentioned in 3-2-5.

For this reason, notice should be paid to the attempts to convert outcomes which were qualitative and believed to be difficult to see visually into indicators, such as with the HSWD in the MHP. At the same time, it is useful to have opportunities to draw attention to challenges for the outcomes of and ongoing initiatives for the project CPs to improve their own capacity through points of contact with various actors.

Within the project, these activities and outcomes were embodied as “tangible outcomes” in the form of handbooks and information abstracts through the working group tasks by the counterpart. In addition, it is also important to publish these visible outcomes and arrange internal and external opportunities to present the outcomes as a way of conducting effective transmission and dissemination, as well as to strengthen the motivation of the CPs themselves.

4-2-7 Period of CD Support [3-2-3 (2)]

CD for developing countries requires medium- to long-term initiatives, but for how long and to what degree should the development partners provide support for CD?

When considering the program orientation for the partner country, the development partners should similarly consider support based on a medium- to long-term outlook. However, this is not necessarily the same as implementing CD support projects over a long time period. In the event that CD demonstrates the enhancement of the self-reliant problem-solving abilities of the partner country, then consideration must be given to somehow transitioning to self-reliant initiatives by the partner country without support, on the premise that CD support from the development partners has a definite end point.

Speaking from the lessons of the MHP, it is necessary to conduct project formulation, implementation, and monitoring and evaluation that take the budget cycle of the partner country into account for CD support

projects. When considering cycling through the PDCA (Plan-Do-Check-Action) cycle in combination with the budget cycle, it is necessary to go through it at least three times or so in order to utilize the reflections on the outcomes seen the first time through the budget cycle. When this is done, the project will most likely extend from around three to five years.[25] Actions that hint at the possibility of unnecessarily long support and subsequent support produce a predisposition towards dependence and reliance on the side of the CPs. Conversely, attention must be paid to ensuring that an irreparable negative legacy does not come about. Once catalytic support has been ignited for the first time it is no longer needed later on. It is important to furnish the ability and the organizational foundation for the flame to continue burning throughout the cooperation period, to secure fuel for it, and to arrange the environment so that a large wind does not blow it off course. This is CD that aims for autonomous development, and health systems development that traces a loop of self organizational strengthening.

[25] From the interview with Mr.Moriya, the former party in charge at the local office.

Appendix 1 Field Study Schedule

	Date	Day	Activities	Place of Stay
1	3 Feb	Sat	Tokyo 19:50 to Dubai 06:05 (JL1317)	
2	4 Feb	Sun	Dubai 10:00 to Dar es Salaam 14:35 (EK725) 16:00 Meeting with Ms. Nishi (JICA Tanzania Office) at airport	DSM
3	5 Feb	Mon	10:00 Visit to JICA Office: Interview with Mr. Makino (Deputy RR) 11:00 Mr. Yokobayashi (EOJ) 16:00 Mr. Oikawa (Local government sector, JICA Tanzania)	DSM
4	6 Feb	Tue	09:00 Group Interview with Sector Coordination Division, PMO-RALG at DSM, Mr. Msingi (Director, Sector Coordination), Asst Director Mrs. Kibatala, Mr. Sugimoto (Local government advisor, JICA Expert) 11:00 Mr. Ishijima (Health sector advisor, JICA Expert) 12:00 Dr. N. Mbuya (Consultant, NETTS) 16:30 Mr. Obata (RR, JICA TZ)	DSM
5	7 Feb	Wed	09:30 Dr. Kitua (Director, National Institute for Medical Research: NIMR) 14:20 Ms. Nishi (Health sector, JICA TZ) 15:20 Mr. Koga (Agriculture and Water sectors, JICA TZ)	DSM
6	8 Feb	Thu	DSM to Morogoro (3h) 10:30 Meeting with MHP experts, Ms. Fukushi (CA) 11:30 Mr. Goto (Health Information Management Expert, MHP) 13:00 Courtesy call and Interview with Ag. RAS (RAS at Osaka training) 15:30 Mvomero CHMT 16:30 Courtesy call and Interview with RMO 18:00 Ms. Tsuda (Health Administration Management Expert, MHP)	Morogoro
7	9 Feb	Fri	08:00 Dr. Fupi (CP Advisor, Former RMO) Morogoro to Kilosa (1.5h) 12:20 Kilosa CHMT (Ag. DMO and DNO), Visit to Kilosa Health Information Resource Center, Health Facility	Kilosa
8	10 Feb	Sat	Kilosa to Kilombero (3h), 14:00 Interview with Mr. Urassa (Coordinator, Ifakara Health Research and Development Centre: IHRDC)	Ifakara
9	11 Feb	Sun	Kilombero to Ulanga (4h)	Mahenge
10	12 Feb	Mon	09:00 Ag. DMO/CHMT and Co-opted members, Ulanga to Kilombero (3h)	Ifakara
11	13 Feb	Tue	08:30 Kilombero DED/ 15:00 Ag. DMO/CHMT, Visit to health facilities, Kilombero to Morogoro (2-3h)	Morogoro
12	14 Feb	Wed	Morogoro to Arusha (8.5h)	Arusha
13	15 Feb	Thu	10:00 Interview with Mr. Upunda (Executive Director of REACH-Policy Initiative, East African Community, Former CMO) 12:00 Mr. Lendita (Senior Lecturer, Centre for Educational Development in Health Arusha: CEDHA)	Arusha
14	16 Feb	Fri	Arusha to Tanga (6h), 13:30 Courtesy call and interview with Mr. Chikira (Tanga RAS, Former Morogoro RAS)	Tanga
15	17 Feb	Sat	10:30 TGSHP (RHS Tanga), Tanga to Morogoro (4h)	Morogoro
16	18 Feb	Sun	10:00 Interview with Mr. Kikula (Mzumbe University)	Morogoro
17	19 Feb	Mon	09:00 Interview with Municipal Director/ 09:30 MMOH/ CHMT, Visit to health facilities, (Coordinated by Dr. Mtey (MMOH)) 14:00 Morogoro Rural DED/ 14:30 DMO/ CHMT, Visit to health facilities, Meeting with MHP (Coordinated by new DMO)	Morogoro
18	20 Feb	Tue	11:30 Mid-report meeting with JICA Tanzania Office & Dr. Sugishita & Ms. Fukushi, Interviews with GTZ, WB etc.	DSM
19	21 Feb	Wed	Interview with GTZ (TGPSH at Muhimbili University) DSM to Morogoro	Morogoro
20	22 Feb	Thu	09:00 Visit to Mvomero health facilities	Morogoro
21	23 Feb	Fri	Municipal CHMT, Morogoro CHMT, RHMT	Morogoro
22	24 Feb	Sat	Preparation for JCC presentation and summary report	Morogoro
23	25 Feb	Sun	Preparation for JCC presentation and summary report	Morogoro
24	26 Feb	Mon	Preparation for JCC presentation and summary report	Morogoro
25	27 Feb	Tue	Preparation for JCC presentation and summary report	Morogoro
26	28 Feb	Wed	Joint Coordinating Committee (Evaluation Meeting) (Representative of EOJ and MOHSW shall attend), Morogoro to DSM (3h)	DSM
27	1 Mar	Thu	AM: Report to JICA Office Dar es Salaam 16:30 to Dubai 22:55 (EK726)	
28	2 Mar	Fri	Dubai 02:50 to Tokyo 19:40 (JL1316)	

Appendix 2 List of Interviewees in Japan

1. JICA Headquarters

Ms. Naoko UEDA	Team Director, Infectious Disease Control Team, Human Development Department/ Former Project Planning in charge
Mr. Taro KIKUCHI	Assistant Resident Representative, JICA Zambia Officer / Former Project Planning in charge
Mr. Ikuo TAKIZAWA	Chief, Health Administration Team, Human Development Department

2. Advisory Committee

Dr. Ichiro OKUBO	Professor, Department of Health Care Policy and Management, University of Tsukuba
Dr. Yasuhide NAKAMURA	Professor, Department of Medicine, University of Osaka

3. JICA Tanzania Office

Mr. Hiroyuki TAKADA	JICA Tsukuba International Center / Former Assistant Resident Representative, JICA Tanzania Officer
Mr. Takahiro MORIYA	JICA Okinawa International Center / Former Assistant Resident Representative, JICA Tanzania Officer
Ms. Kazuko HASHIMOTO	Former Health Policy Advisor to MOHSW (Health Cooperation Plan)

4. MHP Japanese Experts

Dr. Tomohiko SUGISHITA	Senior Advisor / Former MHP Chief Advisor
Mr. Katsuya SUZUKI	Former Project Coordinator

5. Ministry of Health, Labour and Welfare

Dr. Kiyomichi FUJISAKI	Director, Food Security Department / Former Director of Medical Cooperation Department, JICA HQ

6. Morogoro Regional Administrative Secretariat

Mr. Godfrey Ngaleya	Regional Administrative Secretary

Appendix 3 List of Interviewees in Tanzania

1. East African Community

Dr. G. L. Upunda	Executive Director, REACH Initiative / Former CMO, MOHSW

2. Ministry of Health and Social Welfare

Ms. E. Mwakalukwa	Assistant Director, Human Resource Planning Division

3. Prime Minister's Office- Regional Administration and Local Government

Mr. Richard Musingi	Director, Sector Coordination Division
Ms. Miriam Kibatala	Assistant Director, Sector Coordination Division / Former DPLO Kilombero

4. Morogoro Health Project

Dr. Ferdinand Fupi	Counterpart Advisor/ Former RMO

5. Tanga Regional Administrative Secretariat

Mr. Paul Chikira	RAS Tanga / Former Morogoro RAS

6. Morogoro Regional Administrative Secretariat

Mr. Grayson W. Kikwesha	Assistant Administrative Secretary, Management Support Services

7. Morogoro Regional Health Management Team

Dr. M. Massi	Regional Medical Officer/MHP Project Manager
Mr. John C.D. Mankambila	Regional Health Secretary
Ms. Anna Gutapaka	Regional Nursing Officer
Mr. Allen Malisa	Regional Pharmacist
Ms. Margareth Wapalila	Regional Reproductive and Child Health Coordinator
Mr. Jackson Minja	Regional Cold Chain Officer

8. Morogoro Municipal Council Health Management Team (CHMT)

Dr. Godfrey J. B. Mtey	Municipal Medical Officer
Mr. A. M. Mbelwa	Municipal Health Secretary
Mr. W. N. P. Lema	Municipal Health Officer
Ms. Mary C. Nzowa	Municipal Nursing Officer
Dr. Daphroso Nhanga	Municipal Dental Officer
Ms. Martha Kikwale	Municipal Pharmacist
Mr. Bonaventusa Moshi	District AIDS Coordinator
Mr. Rogatus Mbena	Municipal Clinical Officer

9. Morogoro District CHMT

Ms. Sarah P. Hussein	District Health Secretary
Dr. Ngalula W. A.	District Dental Officer

Ms. Zainabu Y. Mfaume	District Laboratory Technologist
Mr. Makame Ally	District Health Officer
Mr. Joseph Lifa	Clinical Officer

10. Mvomero District CHMT

Dr. N. P. Chiduo	District Medical Officer
Dr. Mbena Omari	District Dental Officer
Mr. Jumanne Teggo	District Nursing Officer
Ms. Bahati Mgogo	District Laboratory Technologist
Ms. Agnes Mbio	District Mental Health Coordinator
Mr. Jairo E. Jayambo	Health Officer

11. Mvomero Health Facilities

Mr. Amos Migire	Clinical Officer- Mgeta Health Centre
Ms. Hajija Mbwambo	Clinical Officer- Mlali Dispensary

12. Kilosa District CHMT

Mr. J. Msigala	Ag. DMO
Mr. A. Mkunda	DNO

13. Kilombero District Council

Mrs. Rehema Madenge	District Executive Director
Mr. Samuwel W. Msomba	Clinical Officer- Msolwa B Dispensary
Mr. Wilson Gyunda	Clinical Officer- Kidatu Dispensary

14. Kilombero District CHMT

Mr. Godfrey Ndauka	Ag. DMO
Dr. George M. Kassige	District Onchocerciasis Coordinator
Ms. Ester Nhyagiri	District Nursing Officer
Ms. Leah Mpombo	Ag. Mental Health Coordinator
Mr. Mbonja Kasembwa	District Health Officer
Ms. Grace Lubomba	District Reproductive and Child Health
Mr. Niindaely Mallugu	District Cold Chain Officer

15. Kilombero Health Facilities

Mr. Samuwel W. Msomba	Clinical Officer- Msolwa B Dispensary
Mr. Wilson Gyunda	Clinical Officer- Kidatu Dispensary

16. Ulanga District CHMT and co-opted members

Dr. Rangi	Ag. DMO
Dr. Modestus Rupia	Ag. District Dental Officer
Mr. Thabiti Kibika	District TB and Leprosy Coordinator (DTLC)
Ms. Patricia Haule	Nursing Officer in charge
Ms. Phoibe Sumari	District Laboratory Technologist
Mr. Jonathan Chitalula	District AIDS Coordinator

Ms. Mary Mawala	District Malaria Focal Person
Mr. Alfred Kilimba	Ag. District Onchocerciasis Coordinator
Ms. Calmerina Kauredira	Ag. District Reproductive and Child Health

17. Other Stakeholders

Dr. Andrew Kitua	Director General, National Institute of Medical Research (NIMR)
Mr. Jaraj Kikula	Senior Lecturer, Business Manager Directorate of Strategic Business Development, Mzumbe University
Mr. W. Lendita	Senior Lecturer, Centre of Educational Development in Health, Arusha (CEDHA)
Mr. H. Urassa	Coordinator, Ifakara Health Research and Development Centre (IFHRDC)
Dr. Conrad Mbuya	Consultant, National Expansion of TEHIP Tools and Strategies (CIDA)
Mr. Pascal Kanyinyi	Tanga Regional Health Secretary, (Tanga Tanzania German Programme to Support Health by GTZ)

18. JICA Tanzania Office

Mr. Toshihiro OBATA	Resident Representative
Mr. Koji MAKINO	Deputy Director General
Ms. Naoko NISHI	Assistant Resident Representative
Mr. Takeshi OIKAWA	Assistant Resident Representative
Mr. Daigo KOGA	Assistant Resident Representative
Mr. Hisahiro ISHIJIMA	Health Policy Advisory to MOHSW
Dr. Akira SUGIMOTO	Local Government Reform Advisor to PMO-RALG

19. Embassy of Japan

Mr. Naoki YOKOBAYASHI	First Secretary, Economic Cooperation Department

20. MHP Japanese Experts

Ms. Erika FUKUSHI	Chief Advisor / Health Administration Planning
Mr. Nobuyuki GOTO	Health Information Management
Ms. Mari TSUDA	Health Administration Management

21. Health Sector Donors

Ms. Julie McLaughlin	Lead Health Specialist, World Bank, Co-Chairperson of Water Sector
Ms. Jacqueline Mahon	Regional Health Advisor, Swiss Agency for Development and Cooperation (SDC), Co-Chairperson of Water Sector
Dr. Bergis Schmidt-Ehry	Program Coordinator (DSM), Tanzania German Programme to Support Health (GTZ)

Appendix 4 Questionnaire

1. Interview questions for the concerned parties on the Japanese side

Common questions:

(1) How long were you involved with the MHP and what duties / activities were you in charge of?
(2) What were the activities that characterized the MHP?
(3) Was there smooth communication between the Japanese experts and CPs for the MHP?
(4) What were the lessons from the MHP project as a whole (or the period you were involved with) for other projects (weaknesses or points of improvement)?
(5) After the Japanese experts returned home, could someone else be considered to have acted as a catalyst?
(6) What sort of development do you think is possible regarding the expansion of a CD model similar to that of MHP to other regions?

Management by Headquarters (including those in charge at the time)

1) During the project formulation stage, what points received particular consideration in terms of management by Headquarters?
2) What points received particular consideration in relation to the promotion of activities after the start of the project?
3) In terms of the activities related to the project, was there smooth communication between JICA Headquarters, the domestic support council, the local office, and the project office?
4) How were the outcomes of the project activities shared with other divisions?

JICA Tanzania Office (including those in charge at the time)

1) During the project formulation stage, what points received particular consideration in terms of management by the local office?
2) What points received particular consideration in relation to the promotion of activities after the start of the project?
3) In terms of the activities related to the project, was there smooth communication between JICA Headquarters, the domestic support council, the local office, and the project office?
4) What sort of debate was conducted through donor coordination in terms of general financial support and basket funds for each sector?
5) What sort of cooperative structure exists relating to aid coordination with the embassy? (ODA task force, etc.)

MHP Experts (including the former experts)

1) Was there smooth communication among the experts?
2) After the substitution with the former experts, was there a smooth transition into activities?
3) What points received particular consideration from the team of experts?
4) Can autonomous development of the MHP's activities be expected after the experts return home?

Japanese Embassy in Tanzania

1) Roughly how frequently was communication conducted between the JICA office and the embassy?
2) If communication was smooth what were the reasons for this?
3) How do the other donors think about the role of the policy advisor from when the project was formulated?

2. Interview questions for the concerned parties on the Tanzania side

Common questions:

(1) How long were you involved with the MHP and what duties / activities were you in charge of?
(2) What were the activities that characterized the MHP?
(3) Was there smooth communication between the Japanese experts and CPs for the MHP?
(4) What were the lessons from the MHP project as a whole (or the period you were involved with) for other projects (weaknesses or points of improvement)?
(5) Could it be claimed that the capacity of the RHMT/CHMTs improved? (individual, organizational)
(6) After the Japanese experts returned home, could someone else be considered to have acted as a catalyst?
(7) What sort of development do you think is possible regarding the expansion of a CD model similar to that of MHP to other regions?

Ministry of Health and Social Welfare (MOHSW)

1) Did the MOHSW have any initiatives regarding the project design?
2) Why was emphasis placed on the CD of the RHMT in the MHP?
3) Feedback from the region to the central government is thought of as being weak, are there any measures to counter this?
4) What do you think about the demarcation for the Zonal Training Centre by the NIMR and MOHSW?
5) What do you think about Japan's project technical support? Is it effective?

Prime Minister's Office-Regional Administration and Local Government (PMO-RALG)

1) What benefits and issues were there with the sector basket fund?
2) Is Japan's project technical support acceptable when it comes to pilot-type projects like the MHP?

Regional Administrative Secretariat/Secretary (RAS)

1) Did ownership by the CP take shape? If it did in what manner was it formed?
2) Feedback from the region to the central government is thought of as being weak, are there any measures to counter this?
3) Can autonomous development of the MHP's activities be expected after the experts return home?
4) Can the continuous guarantee of things like funds for the activities of the RHMT be expected?
5) What do you think about Japan's project technical support? What parts do you consider to have been good and what should be improved?

Regional Health Management Team (RHMT)

1) Can autonomous development of the MHP's activities be expected after the experts return home?
2) What do you think about Japan's project technical support? What parts do you consider to have been good and what should be improved?

Council Health Management Team (CHMTs)

1) Can autonomous development of the MHP's activities be expected after the experts return home?
2) Is there the possibility of cooperation with health administration activities continuing on after the completion of the project?
3) What do you think about Japan's project technical support? What parts do you consider to have been good and what should be improved?

Local Resource Agencies (IHRDC, Mzumbe University, CEDHA)

1) Can autonomous development of the MHP's activities be expected after the experts return home?
2) Is there the possibility of cooperation with health administration activities continuing on after the completion of the project?

Other donors (TGPSH by GTZ, NETTS by CIDA, World Bank, DANIDA joint evaluation)

1) Is Japan's project technical support acceptable when it comes to pilot-type projects like the MHP?
2) For the joint evaluation, is there consistency with the trends in the health sector for the future and Phase II (draft)?

Appendix 5 Project Design Matrix

1. PDM ver. 4.0

Project Name: The Project for Strengthening of District Health Services in Morogoro Region
Duration: April 1, 2001 - March 31, 2006
Target Area: Morogoro Region

Target Group: RHMT/CHMTs of Morogoro Region

Ver. 4.0
Date: November 9, 2003

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal Quality of health services in Morogoro Region is improved.	Client's and community satisfaction of health services is improved.	Mini survey reports (Client exit interview/Community Dialogue) .	
Project Purpose Managerial capability of RHMT and CHMTs in Morogoro Region is improved under the consensus of Health Sector Reform (HSR) and Local Self Government Reform (LGR).	The average scores of Hexagon-Spider-Web-Diagram (HSWD) are improved for all RHMT and CHMTs from 2003 scores to 4.5 by the end of 2005.	Participatory qualitative assessment by joint internal and external comprehensive evaluation.	- All reforms (Health Sector Reform, Local Government Reform etc.) are implemented harmoniously. - Other components of Health Sector Reform are implemented accordingly.
Outputs: 1. HMIS (Health Management Information System) is improved.	1-1 Rate of collecting, processing and utilizing quality HMIS data on time is increased by the end of 2005.	District Processing File	- Condition of human resources at all levels does not worsen. - Co-ordination among vertical programs do not worsen.
2. Experience and Health Information among CHMTs, RHMT and other regions are adequately shared.	2-1 Rate of dissemination of health information and skills within RHMT/CHMTs and other regions is increased by the end of 2005.	Official report Minutes of disseminated /shared activities Working schedule/working plan of resource centre Register book of information resource centres	
3. Planning, implementation, monitoring and evaluation by CHMTs and RHMT are improved.	3-1 The number of improved evidence-based plans is increased by the end of 2005. 3-2 The implementation rate of the planned activities is improved by the end of 2005.	Annual CCHPs Progress report	
Activities:	**Inputs:**		
1-1 Equip with computer equipment 1-2 Train RHMT/CHMTs for computer skills. 1-3 Train RHMT/CHMTs for data collection, processing, storage and use. 1-4 Train RHMT/CHMTs for "on the job training skills of health workers" for data collection. 1-5 Establish mechanism for distribution/feedback system for HMIS data. 1-6 Structure communication network system. 1-7 Equip communication gears. 1-8 Link to other radios. 1-9 Train RHMT/CHMTs for communication skills.	TANZANIA: Allocation of Tanzanian Counterparts Running expenses necessary for the implementation of the Project Provision of necessary facilities Other measures defined in R/D of March 2001	JAPAN: Dispatch of Long and Short term experts Acceptance of Tanzanian Trainees in Japan Provision of Machinery and Equipment Other measures defined in R/D of March 2001	- Other donors continue to support the health sector. - Appropriate HMIS tools are available. - Present Health Policy remains unchanged. - Other developing partners continue supporting RHMT/CHMTs - Trained RHMT/CHMTs continue to work - Political climate remains.
2-1 Establish mechanism for information dissemination. 2-2 Train RHMT/CHMTs for information dissemination skills. 2-3 Publish news letter for health services. 2-4 Conduct exchange visits, study visits and workshops. 2-5 Conduct RHMT/CHMTs' regular joint meeting			

2-6 Equip materials for information resource centre. 2-7 Train RHMT/CHMTs for management skills of information resource centre. 2-8 Promote utilization of information resource centre. 2-9 Establish mechanism for schedule management 2-10 Establish mechanism for take over the job. 2-11 Develop, rectify and share the work-plan for RHMT/CHMTs.			
3-1 Training RHMT/CHMTs on planning, monitoring, and evaluation skills. 3-2 Train RHMT/CHMTs for operational research methodology. 3-3 Improve monitoring and evaluation tools for annual plan implementation. 3-4 RHMT/CHMTs develop jointly annual plan for monitoring and evaluation. 3-5 RHMT participate in CHMTs planning session regularly. 3-6 Conduct exit questionnaires to clients/patients.			**Preconditions:** - Sufficient financial resources for monitoring visit are available (e.g. fuel). - RHMT and CHMTs can spend their time adequately for the implementation of the Project.

Abbreviations:
CCHPs: Comprehensive Council Health Plans
CHMTs: Council Health Management Teams
HMIS: Health Management Information System
HSR: Health Sector Reform
LGR: Local Government Reform
RHMT: Regional Health Management Team

2. PDM ver. 5.0

Project Name: The Project for Strengthening of District Health Services in Morogoro Region

Target Group: Regional Health Management Team (RHMT), Council Health Management Team (CHMTs), Hospital Management Team (HMTs) and selected Workers (FLHWs) of Morogoro Region

Ver. 5.0
Date: 17th March, 2006

Duration: April 1, 2006 - March 31, 2007
Target Area: Morogoro Region

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal Quality of health services in Morogoro region is improved.	Constructive opinions from the health facility users is increased for the improvement of quality health services during and after the Project execution.	RHMT Management Supervision Report	
Project Purpose Health management skills of the target groups are improved in a self-reliant and sustainable manner.	P-1 Average of total scores of Hexagon-Spider-Web-Diagram in Sep. 2005 (3.42) is improved to the average score of 4.00 in Feb. 2007. P-2 Average of total scores of ISSC is improved during the extension period.	HSWD Workshop Results ISSC Reports	(Central Government) - All reforms (Health Sector Reform, Local Government Reform etc.) are implemented timely and smoothly. - New government (elected in Dec. 2005) sustains the government policy along with the previous regime.
Outputs: 1. Health information systems with reporting and feedback are improved effectively and efficiently.	1-1 MHA is produced regularly and timely. (MHA 2005 is produced by June 2006 by using Year 2005 HMIS Data / ISSC Data. And MHA 2006 is produced by February 2007 by using Year 2006 HMIS Data / ISSC Data). 1-2 Rate of HFs among all the HFs, which utilize Morogoro Health Database Guidelines for the data management of MHA2006, is increased during the extension period. (The Guidelines include information gathering, analyzing and feedback in HMIS process.)	Morogoro Health Abstract (MHA) Questionnaire to Health Facilities (HFs)	(Central Government and other development partners) - Government guidance and commitment for project activities (HMIS, Operational Research etc.) remains as the same orientation. - Newly adopted health policy and guidelines do not interfere the MHP outputs. - Ministry of Health and Social Welfares monitors the Project progress. - Ministry of Health and Social Welfares is willing to take over the Project achievements. - Prime Minister's Office Regional Administration and Local Government monitors the Project progress. - Prime Minister's Office Regional Administration and Local Government is willing to take over the Project achievements. - Health Sector Basket Fund run by development partners is effectively financed, budgeted and disbursed for the smooth execution of CCHPs.
2. Accessibility to health information is improved.	2-1 Monthly cumulative number of IRC users is increased during the extension period. 2-2 Number of submitted articles for Newsletters is increased from the first issue until the last issue of the extension period.	IRC visitor record Record of Editorial Board meetings	
3. Planning, monitoring and evaluation for evidence-based health management by CHMTs and RHMT are improved.	3-1 Number of direct interventions in CCHPs based on the OPR results is increased from the first to the second OPR execution. 3-2 Number of CHMTs, which utilize "M&E Handbook for District Health Management," is increased during the extension period.	CCHP 2005/2006, 2006/2007, 2007/2008 Questionnaire to CHMTs	
4. Project achievements are consolidated and assimilated in RHMT/CHMTs and disseminated to various stakeholders and beneficiaries.	4-1 Number of visual outputs produced by the Project activities is increased since the project commencement in April 2001. 4-2 Number of occasions with stakeholders to disseminate the Project achievements and lessons learnt is increased during the extension period.	Visual outputs Records or memorandums of the meetings	
5. Project logistic and coordination management is developed in a self-reliant and sustainable manner.	Number of working groups among seven MHP working groups, which are able to conduct meetings in an autonomous manner, is increased during the extension period.	Record of logistic and coordination management checklist.	
Activities: 1-1 HMIS, TWINS and MHP Homepage Working Group (WG) members conduct WG meetings regularly and autonomously. 1-2 HMIS WG members develop database for Integrated Supportive Supervision Checklist (ISSC).	**Inputs:** TANZANIA: Allocation of Tanzanian Counterparts Running expenses necessary for the implementation	JAPAN: Dispatch of Long term experts	(Local Government) - District Councils uptake the Project outputs in their future budget plans.

1-3 HMIS WG members revise the format of ISSC according to the development of database. 1-4 RHMT/CHMTs members produce "Morogoro Health Abstract (MHA)" annually supported by health mapping. 1-5 RHMT/CHMTs members provide feedback of customized MHA to Frontline Health Workers (FLHWs). 1-6 TWINS WG members conduct supervision for FLHWs to utilize communication gears on the purpose of regular HMIS reporting. 1-7 MHP Homepage WG members revise MHP Homepage regularly.	of the Project Cost-sharing with District Councils for the Project activities Provision of necessary facilities Other measures defined in R/D of March 2006	Acceptance of Tanzanian Trainees in Japan Running expenses necessary for the implementation of the Project activities Other measures defined in R/D of March 2006	- Cost-sharing with District Councils for the Project activities is sufficiently executed. - District Councils ensure the smooth financing for the MHP activities. - Trained members of RHMT/CHMTs are willing to disseminate their lessons learnt to HMT, FLHWs and other stakeholders. - HMTs and FLHWs are ready to uptake the management trainings done by RHMT/CHMTs. - RMO/DMOs offices allocate enough time for MHP activities. - RMO/DMOs arrange human resources for the implementation of MHP activities by regarding not to disturb their CCHP activities. (Central Government and other development partners) - Government guidance and commitment for project activities (HMIS, Operational Research etc.) remains as the same orientation. - Newly adopted health interventions do not interfere the MHP activities. - MOHSW and other implementation agencies do not disturb the MHP activities by the schedule overlap and confusion from their sudden notice and execution.
2-1 Information Resource Center (IRC) Working Group (WG) members conduct WG meetings quarterly and autonomously. 2-2 RHMT/CHMTs secure the premises and solicit funds for IRC management. 2-3 RHMT/CHMTs manage IRC for provision of user services. 2-4 RHMT/CHMTs develop networks for health information resource mobilization. 2-5 Editorial Board (EB) members operate the autonomous EB funding system. 2-6 EB members produce Newsletters and other IEC materials.			
3-1 Operational Research (OPR) and M&E Working Group (WG) members conduct WG meetings regularly and autonomously. 3-2 MHP conducts trainings for RHMT/CHMTs in planning, monitoring and evaluation skills. 3-3 RHMT/CHMTs conduct OPR on their priority health issues. 3-4 RHMT/CHMTs develop post-research action plans based on OPR results and integrate them into CCHP. 3-5 M&E WG members develop and compile M&E tools. 3-6 RHMT/CHMTs monitor and evaluate the activities and objectives in CCHP.			**Preconditions:** - Government policy and guidelines remain as long as the same orientation. - Political environment for financial allocation of district health services including Health Sector Basket Fund remains in the same guidance. - Tanzania counterpart members remain as many as in numbers, which should not disturb the teamwork of RHMT/CHMTs. - Sufficient financial resources for monitoring visit are available (e.g. personnel, fuel). - RHMT and CHMTs manage to allocate personnel and tasks for the smooth implementation of the Project activities. - Economic and social stability continue during the Project period.
4-1 RMO/DMOs coordinate all the Working Groups to produce optimal achievements by collaborative efforts. 4-2 RHMT/CHMTs produces "Annual Health Sector Work plan in Morogoro region." 4-3 RHMT/CHMTs conduct Joint RHMT/CHMTs Meeting biannually and Morogoro Health Stakeholder Conference annually. 4-4 RHMT conducts management supervision to CHMTs quarterly. 4-5 RMO/DMOs conduct project dissemination visits to other regions and districts. 4-6. RHMT/CHMTs members exhibit project achievements in various technical meetings and conferences. 4-7 RHMT/CHMTs disseminate project achievements and lessons by using IEC materials.			
5-1 RHMT/CHMTs strengthen project logistics and coordination handed over to RHMT/CHMTs by On-the-Job methods. 5-2 RHMT/CHMTs conduct Workshop for logistics and coordination. 5-3 RHMT/CHMTs compile logistics and coordination Manual. 5-4 RHMT/CHMTs ensure maintenance and repair of handed over equipments in their workplaces.			

Abbreviations: CCHPs: Comprehensive Council Health Plans
CHMTs: Council Health Management Teams
DMO: District Medical Officer
EB: Editorial Board
FLHWs: Frontline Health Workers
HMIS: Health Management Information System
HMT: Hospital Management Team
IRC: Information Resource Center
ISSC: Integrated Supportive Supervision Checklist
MHA: Morogoro Health Abstract
MHP: Morogoro Health Project
MOHSW: Ministry of Health and Social Welfare
OPR: Operational Research
PMO-RALG: Prime Minister's Office Regional Administration and Local Government
R/D: Record of Discussions
RHMT: Regional Health Management Team
RMO: Regional Medical Officer
WG: Working Group

Abbreviations

Term	Explanation
CCHP	Comprehensive Council Health Plan
CCM	Chama Cha Mapinduzi (Revolutionary Party)
CD	Capacity Development
CHF	Community Health Fund
CHMT	Council Health Management Team
CMO	Chief Medical Officer
CP	Counterpart
DANIDA	Danish International Development Assistance
DED	District Executive Director
DHS	District Health Secretary
DMO	District Medical Officer
DNO	District Nursing Officer
DPG	Development Partners Group
DPLO	District Planning Officer
DPO	District Planning Officer
DSA	Daily Subsistence Allowance
EAC	East African Community
FY	Fiscal Year
FLHW	Front Line Health Worker
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HMIS	Health Management Information System
HSBF	Health Sector Basket Fund
HSR	Health Sector Reform
HSSP	Health Sector Strategic Plan
HSWD	Hexagon-Spider-Web-Diagram
IDRC	International Development Research Centre (Canada)
IHRDC	Ifakara Health Research and Development Centre
IMR	Infant Mortality Rate
IRC	Information Resource Center
JCC	Joint Coordinating Committee
JICA	Japan International Cooperation Agency
LGA	Local Government Authority
LGRP	Local Government Reform Programme
M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MHP	Morogoro Health Project
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (NSGRP in Swahili)
MMR	Maternal Mortality Rate
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium-Term Expenditure Framework
NETTS	National Expansion of TEHIP Tools and Strategies
NGO	Non- Governmental Organization
NIMR	National Institute for Medical Research
NPES	National Poverty Eradication Strategy
NSGRP	National Strategy for Growth and Reduction of Poverty
ODA	Official Development Assistance
OECD/DAC	Organization for Economic Cooperation and Development / Development Assistance Committee
OJT	On-the-Job Training
OPR	Operational Research
PCM	Project Cycle Management

Term	Explanation
PDM	Project Design Matrix
PMO-RALG	Prime Minister's Office-Regional Administration and Local Government
PO-RALG	President's Office-Regional Administration and Local Government
PRBS	Poverty Reduction Budget Support
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
RAS	Regional Administrative Secretariat/Secretary
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RNO	Regional Nursing Officer
RLT	Regional Laboratory Technologist
RPO	Regional Planning Officer
SADC	Southern African Development Community
SWAp	Sector-Wide Approach
TAS	Tanzania Assistance Strategy
TEHIP	Tanzania Essential Health Interventions Project (IDRC)
TGPSH	Tanzania German Program to Support Health
TSH	Tanzanian Shillings
TWINS	Two-Way Information Network System
UNDP	United Nations Development Programme
WG	Working Group

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