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Annex 4 Key Informant Interviews

This annex lists persons interviewed at national level, usually in Dar es Salaam. **Those interviewed during data collection work at regional offices and district are listed in the appropriate district case study reports.**

Part One: Government of Tanzania
Ministry of Health and Social Welfare (MOHSW) Deodatus Mtasiwa, Chief Medical Officer
MOHSW Consultative Meeting With: Dr. Z. Berege, Acting Chief Medical Officer and Director of Hospital Services Dr. Faustin Njau, Head, Health Sector Reform Secretariat and coordinator of Health Sector Development Programme Mrs. Regina Kikuli – Acting Director of Planning and Policy and Budget Head Dr. G. Mliga, Director of Human Resources Dr. Kalinga, Director of Preventive Services Representative of the Social Welfare Commission
MOHSW Dr. Amos Odea Mwakilasa, Assistant Director HRD – Continuous Education
MOHSW Mr. Josibert Rubona, Head Health Information and Research Section, Planning and Policy Department
MOHSW Dr. Rowland Swai, Program Manager, National Aids Control Program
MOHSW Mr. Leonard Kikuli Acting Director Administration and Personnel
MOHSW Dr. G. Mliga, Director Human Resources
MOHSW Dr. Faustin Njau, Head, Health Sector Reform Secretariat and coordinator of Health Sector Development Program (Separate Interview)
Mrs. Mwkaluka, Assistant Director Human Resources Planning
MOHSW Jeremiah Sendoro, economist, CHF coordinator Rudovick Nduhiye, economist CHF Nema Jamu, economist CHF

MOHSW Harun Kasale, lead consultant NETTS, Health Sector Reform Secretariat Conrad Mbuya, consultant NETTS, Health Sector Reform Secretariat
MOHSW Dr. Alex M. Mwita, Program Manager National Malaria Control Program
MOHSW Anna Nswilla, District Health Services Coordinator, Health Secretary Preventive Services
MOHSW Hannock Ngonyani, Head Health Services Inspectorate Unit
MOHSW Ann Tsaba
MOHSW Richard L. Mkumbo
MOHSW Jospeph S. Muhume, Assistant Director, Pharmaceutical Services
MOHSW Petro Msigula, Head of Supplies Unit
MOHSW Ms. Helen S. Mwakipunda, Chief Accountant
MOHSW Max Mapunda
MOHSW Gradeline A. Minja, Health Economist/Administrator, Health Sector Reform Secretariat
MOHSW Jørn Kronow, Senior Financial Adviser
Joseph A. Kelya, Administrator, Health Sector Reform Secretariat
MOF Mr. S. Kibaja, Responsible for MOHSW, Budget Division
MSD Joseph Mgaya, Director
PMO-RALG Mr. A.N.M. Sayile, Project Coordinator for District Health, Rehabilitation Component
Ministry of Finance Mr. S. Kibaja, Representative of the acting Commissioner
Ministry of Finance John Mavura. C.S.A, Aid Coordination Unit and Mr. John Selemani, Aid Coordination Unit
TACAIDS Eliazary D.E. Nyagwaru, Public Institutions Response Officer
NHIF Emmanuel Humba, Director Michael Mhando, Actuary Rafael Mwamoto, Statistics and Research

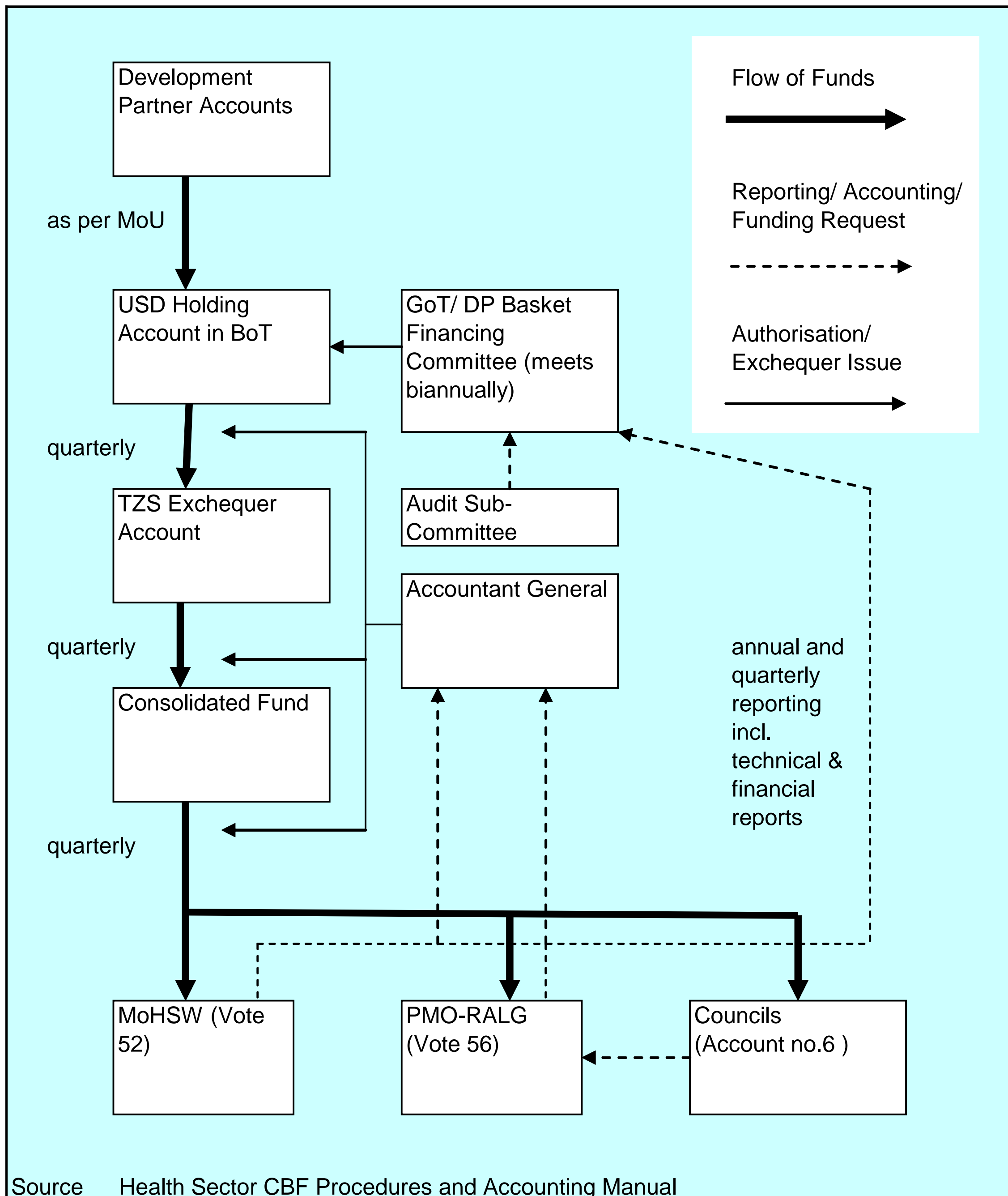
Part Two: Development Partners
Mr. Hans Raadschilders, First Secretary Local Governance, Embassy of the Kingdom of the Netherlands
UNICEF Sam Agbo, Health Officer
Royal Danish Embassy, Sanne Olsen, Counsellor (Development) Health
Danida/HSRS Anders Jeppsson, Senior Health Adviser
Danida/HSRS Sam Nyaywa, District System Strengthening Advisor
Danida/HSRS John Johansen, Hospital Management Advisor
Danida/HSRS Dr. Marlene Krag Petersen MD, MIH
World Bank Julie McLaughlin (Lead Health Specialist, Africa Region) and Dr. Emmanuel Malingalila, Health Advisor
Swiss Development Cooperation (SDC) Jacqueline Mahon, Health and Poverty Advisor, and, Nadia Isler, Program Officer
World Health Organization (WHO) Dr. Modammed Belhocine WHO Representative and Dr. Martins Ovberedjo, HRH Advisor
WHO Max Mapunda and Dr. Theopista John, MCH and Adolescent Health
JICA Naoko Nishi, Assistant Resident Representative, responsible for health and AIDS
CIDA Peggy Thorpe, Senior Health and HIV/AIDS Advisor
UNFPA – Nicola Jones, Representative, Dorothy Timu, Assistant Representative, and Rutasha Dadi, incoming Assistant Representative
Global Fund for Aids Tuberculosis and Malaria Hiltruda Temba, coordinator for the MOH (AIDS and TB, Malaria Program coordinates directly with TACAIDS)
Clinton HIV/AIDS Initiative, Dr. Yahya Ipuge, Country Director
Irish Aid, Colleen Wainwright, Development Specialist, and Kizito Mugenyi, Health Advisor
US-AID – Charles Llewellyn, Population and Health Office
Royal Netherlands Embassy, Rik Peeperkorn, First Secretary (Health)
DFID (Department for International Development), Chris Berry, Social Sector Advisor

President's Emergency Fund for AIDS Relief (PEPFAR) Tracy Carson, Country Coordinator, President's Emergency Plan for Aids Relief and Elise Jensen, MPH, Team Leader HIV/AIDS US AID, and Rebecca Martin PhD, Program Director Strategic Information and Human Capacity Development, CDC Tanzania.
GTZ – Dr. Bergis Schmidt Ehry, Sector Coordinator, Health
Part Three: Others
Aga Khan Foundation Tanzania – Nemat Hajeebhoy, Executive Officer
Ifakara Health Research and Development Centre, Paul Smithson, Resource Center Advisor
Family Health Initiative (FHI) Eric van Praag, FHI Country Director, Tanzania
Association of Private Health Facilities in Tanzania (APHFTA) – Dr. S.M.A. Hashim, Chairman and Dr. Kaushik, Secretary
Christian Social Services Commission (CSSC) Adeline I. Kimambo, MD, DPH, Director
Aga Khan Hospital Dr. Sulaiman Shahabudin, Chief Executive Officer
Research on Poverty Alleviation (REPOA) Valerie Leach, Coordinator for Policy Analysis and Masuma Mamdani, Senior Researcher
National Institute for Medical Research (NIMR) Dr. Berta Mayegga, Acting Deputy Dirctor Dr. Aziza Mwisongo, Health Systems Researcher Dr. Berta Mayegga , Acting Deputy Dire Jonathan Mcharo, Research Scientist (Demographer)
Tanzania Nurses and Midwives Council (TNMC), Mr. G Moyo, Registrar and Mrs. Joyce Safe, Chairperson
Economic and Social Research Foundation (ESRF) – Professor Hidari K.R. Amani, Executive Director and Dennis Rweyemannu, Acting Coordinator of Commissioned Studies.
Women's Dignity Project, Maggie Bangser, Director
Plan International, Dr. Louisa, Masayanyika, Country Health Advisor
AMREF Paul Waibale, Director
Muhambili University College of Health Sciences Prof. Dr. Zul Premji, Dean School of Public Health
Muhimbili University College of Health Sciences Dr. T.W. Kowhi, Head of Nursing School
Muhimbili University College of Health Sciences Dr. Olipa Ngassapa, Dean, School of Pharmacy
Part Four: Kisarawe District Reconnaissance Visit
Kisarawe District Hospital Dr. Constantine M. Kibera, Principal Assistant Medical Officer

<table>
<tr><td>Kisarawe Council Health Management Team
Ndanganya Ally, District Cold Chain Officer and HMIS Coordinator</td></tr>
<tr><td>Kisarawe Council Health Management Team
Dr. Othman Mgomi, Acting District Medical Officer (DMO)</td></tr>
<tr><td>Maneromango Health Centre
Mr. Chalo Marco, Clinical Officer in Charge</td></tr>
<tr><td>Maneromango Health Centre
Egidia Mmanda, Nurse Midwife</td></tr>
<tr><td>Maneromango Health Centre
Mrs. M. Mbelenje, Clinical Officer</td></tr>
<tr><td>Masanganya Dispensary
Mr. Mahamadu R. Joseph, Health Assistant</td></tr>
<tr><td>Masanganya Dispensary
Mrs. Fatuma Mzaka, Traditional Birth Attendant (TBA)</td></tr>
<tr><td>Masanganya Dispensary
Mrs. Sophia R. Msangule, Community Health Worker</td></tr>
<tr><td>Kigoma/Ujiji Municipal Council
Ag. Municipal Human Resources Officer
Mr. Ayubu Sebabili</td></tr>
<tr><td>Ag. Municipal Medical Officer
Dr. Abigael Kasumani</td></tr>
<tr><td>Planning Officer
Mr. Wilfred Mwita</td></tr>
<tr><td>Ag. Municipal Nursing Officer
Ms. Bernadetta Peter</td></tr>
<tr><td>Ag. Municipal Treasurer
Mr. Blantaye M. Rugagara</td></tr>
<tr><td>Maweni Regional Hospital
Health Secretary
Mr. Solomon Buganga</td></tr>
<tr><td>Accountant
Ms. Minyota</td></tr>
<tr><td>Medical Technician Pharmacist
Mr. Samson</td></tr>
<tr><td>Kigoma Rural Council
Ag. District Medical Officer
Mr. Katule</td></tr>
<tr><td>District CHF Coordinator
Mr. Mabula</td></tr>
<tr><td>Assistant District CHF Coordinator
Mr. Lusaila</td></tr>
<tr><td>Municipal Trade Officer and Ag. Municipal Director
Mr. Protase Kato</td></tr>
</table>

Annex 5 Financial Flow Model

Financial Flow Models



Annex 6 CAST Focus Group Tool

DATA COLLECTION INSTRUMENTS

ENTITY Users and non-users at Village Level

Person Category

- One group of adult men of all ages
- One group of adult women of all ages

Evaluations Tools

- Change Assessment and Scoring Tool (CAST)

The Change Assessment and Scoring Tool (CAST) is a semi-structured participatory tool, assessing a number of pre-determined issues or issues to be identified by the participants on a scale of change (5 or 3 categories) - negative change, no change, positive change.

In this CAST to be used for users at village level, on every issue listed below, villages are asked to rate the changes they have experienced since 1999 as respectively "very positive" (++), "positive" (+), "no change" (0), "negative" (-) or "very negative" (--)

Name District: ……………………..

Name Village/community: ……………………..

Nearest HF (circle): Pub disp/FBO disp/Priv disp/Pub HC/FBO HC/priv HC

Name Facilitator: ……………………..

Name Translator: …………………….

Women/men (circle): ….. (number)

	Indicators Dispensary, HC and Hospital	**----**	**--**	**0**	+	++
1	Distance to the closest HC/Dispensary and the hospital					
2	Transport facilities to the HC/Dispensary and the hospital					
3	Costs to make use of the health services					
4	Awareness of exemptions					
5	Clear indication of prices and exemptions at the HF					
6	**Cleanliness**					
7	Attitude of the staff					
8	Waiting time					
9	Availability of qualified staff					
10	Availability of laboratory tests, equipment etc. for diagnosis					
11	**Availability of drugs**					
12	Capacity to deal with malaria					
13	Capacity to support deliveries					
14	Capacity to deal with HIV/AIDS patients					
15	Possibility for women to be treated by trained female health staff					
16	Overall health situation in your community					
17	If you would be the Minister of Health, what would you change? Or what would you ask the Minister to change?					

Annex 7: District Case Study Reports

Kigoma Municipal Council, Kigoma Region

1. Overall Sector and Program Relevance

1.1. Health Sector Strategies Relevant to Council Needs and Priorities

Expressed as priority areas – the sector priorities are relevant to both disease burden (reported at the facilities level) and the institutional managerial situation faced by Kigoma Municipal Council in strengthening health services especially when seen from the perspective of the RMO, RHMT, and Regional Hospital staff. Efforts to strengthen management and operations of the regional hospital (which also serves both Kigoma Urban and Rural districts as their council hospital) could be crucial to the development of health services in those districts. In the hospitals, dispensaries and HCs visited, malaria was the overwhelming leader in diagnosed cases. HF data show that the number of malaria cases are more than all others combined.

1.2. External Support Appropriate to Council Needs and Priorities

The predominant forms of external support are support through the basket fund and support funnelled through Axios and, later, Columbia University as part of the PEPFAR programme. There have been occasional relatively large scale bilateral projects of support including infrastructure investments in the regional hospital by JICA using food-aid counterpart funds, programme support from DFID for the Adult Morbidity and Mortality Program and some targeted bilateral support from GTZ.

The bilateral support has not been long term and has largely subsided at present so it is difficult to assess its appropriateness in relation to municipal and regional priorities. Axios funding could not be found in the CCHP budget lines but there are two entries related to HIV/AIDS, funded under columns for "receipt in kind" (PMTCT for TSH 7,985,000) and for "others" (VCT for TSH 3,000,000). All in the 06/07 CCHP.

So some vertical HIV/AIDS money is mentioned in the CCHP but it is hard to say where it comes from. CHMT members interviewed were aware the CCHP should include all sources of funds but did not know if Axios and now University of Columbia contributions (from PEPFAR) had been included.

2. Progress and Achievements Under Health Sector Strategic Plans

2.1. Strengthening Council Health Services

Achievements

- Progress in strengthening council health services has mainly been in the development of the mandatory structures for planning, governance and budgeting as well as oversight, including the

CHSB, training of the CHMT, and setting up of facilities committees at the HC and dispensary level.
- A CHSB and Governing Committees at HC and Dispensary levels have been established.
- One dispensary Governing Committee is reportedly very active and had called an extraordinary meeting to question staff on unofficial charges. Apparently a sufficiently activist committee can go some way to fulfilling its broader mandate.
- Kigoma urban has undergone an O and OD (opportunities and obstacles for development) PRA planning process to identify community priorities (education and health were the two highest in that order) but the planning officer reports that this will feed into the next CCHP rather than the current one.

Constraints
- Kigoma Urban has apparently not enjoyed as much attention under the reform strategies as some other districts, even within the region.
- The CHSB is not able to fulfill its mandate given its infrequent meetings and dependence on the secretary (the DMO) for calling meetings.
- The CCHP is a planning/budgeting process which is carried out largely by the CHMT with support from the Municipal Planning Officer and one member of the RHMT. It encompasses a budget request from the Maweni regional hospital for 25% of the basket fund (but not a full hospital budget and plan) but does not reflect a bottom up process of priority selection and planning. At the very most it seems HC and dispensaries sometimes send in priorities in writing but there is no reporting back to them on how those may have influenced the final priorities in the plan.
- None of the facilities below the regional hospital level have a copy of the CCHP.
- One private dispensary proprietor clearly had no information on even the existence of the CCHP.
- While rules and, for example, bylaws are clear in written form the level of understanding at the council level is low and not consistent from one manager to the next.
- Council/CHMT staff also lack clear understanding of what can and cannot be permitted in the allocation of budgets (for example using supervision funds for something other than fuel).
- Facilities governing committees may have an impressive formal mandate but in practice they are mainly seen as bodies to administer TIKA funds when that system is fully operational.

2.2. Changing Roles of the Central Ministry

Achievements
- Staff acknowledge the flow of guidelines and templates for their functions at both the RHMT and CHMT levels as well as the provision of training opportunities.
- The recentralization of hiring and allocation of staff within MOHSW has been welcomed by senior leadership in the RAS, Municipal Director, RMO, RHMT, CHMT and HMT ranks.
- Training opportunities at the ZTC and in other places (CEDAH in Arusha for example) are seen by staff as important aspects of central support.
- The level of support from MOHSW associated with some of the vertical programs is significant (including supplies and drugs). This was noted for vaccinations, tuberculosis and leprosy, malaria and HIV/AIDS activities.

Constraints

- The RHMT is severely constrained in its functioning by lack of funds for supervisory travel to the councils. This represents a deterioration since 2004 which they related to a switch in the routing of funds for supervision from a transfer directly from MOHSW to the RMO to one through PMO-RALG to the RAS. This seems to have resulted in a big reduction in funds flows to the RHMT for supervision. Basically it seem that this has broken down.
- The CHMT is attempting to implement a significant set of reforms and initiatives while dealing with ongoing management and supervision issues. It seems that the menu of initiatives is demanding and could benefit from a pause in new initiatives while more is done by MOHSW to ensure really solid understanding of, in particular, financial innovations at the district level.

2.3. Hospital Reform

Maweni regional hospital serves as the council hospital for both Kigoma Municipal Council and Kigoma Rural Council. They each allocate 25% of their basket fund money to the hospital. The hospital comes under the authority of the CHSB for Kigoma Municipal Council.

Achievements

- Laboratory equipment and functioning of the laboratory have improved;
- Some improvements in availability and condition of equipment in other parts of the hospital;
- Some improvements in infrastructure (mostly funded by JICA in the period 2000 to 2002). There is a relatively new, separate RCH ward constructed with JICA funds (apparently food aid counterpart funds). Infrastructure and equipment improvements at the regional hospital tended to be concentrated around HIV/AIDS including new consulting rooms (4) constructed for VCT and improvements to the laboratory to allow for HIV/AIDS testing and to support prescribing of ARVs;
- Improvements in vaccination services and a subsequent decline in vaccine-preventable diseases (such as measles and rubella);
- A significant improvement in drug supplies (in the 2001-2002 period);
- There has been an influx of staff in the past year, partly from the emergency recruitment programme, which allows MOHSW to assign staff to the council (helps only in the lower cadres apparently) and partly from FBOs and Private providers;
- Some hospital staff have taken advantage of training opportunities, including at the ZTC;
- Some improvement in therapies for malaria but no noticeable decline in incidence;
- Significant improvements in the care and treatment of HIV/AIDS patients (laboratories, infrastructure, services);
- Some reported improvements and initiatives to reduce maternal. This came about partly because the RMO and head of the HMT are both specialists in obstetrics. They have emphasized life saving skills in dealing with obstetric emergencies and have put an emphasis on "focused antenatal care". Any observed decline is hospital based only and does not take account of what happens in the community as a whole.

Constraints

- There is no hospital board or governing committee at the regional hospital.
- Apparent absence of a hospital plan or regular annual report. Despite considerable searching and persistent requests, HMT (mainly the health secretary) were not able to provide a plan and

only estimates for a new budget (2007/2008). It was not possible to find a copy of a budget FY 2005 or FY 2006 to check on budget execution.
- Apart from basket funds it was not possible to check what other sources of income the hospital has, as there was no budget breakdown.
- There is no regular review of hospital performance against targets and no opportunity to meet with other regional hospitals and compare performance.
- While individual programs seem to have improved, overall hospital management and planning has not been the subject of program or project support as far as can be determined.
- The situation in human resources for the hospital is very difficult and has not improved except very recently due to the emergency recruitment programme.
- Newly trained or poorly trained clinicians often prescribe symptomatically and have not been well trained in the use of essential drugs.
- Administrative staff are not well trained, including some of the administrators responsible for keeping records and recording HMIS information.
- Both electricity and water supply at the regional hospital are intermittent. In particular, water is only available about 2 to 3 days a week.
- Sharps control was very poor at the laboratory in the regional hospital.
- Dispensary staff refer patients directly to the regional hospital rather than to HCs.

2.4. Central Support Systems

Drug Supply

Achievements

- There is a reported improvement in drug supply, especially since 2001, 2002. This report was consistent from the staff and FGD participants and with observations at the HCs and dispensaries.
- ACT provided under the malaria programme is sent outside the kit system and supplies were at least adequate.
- Reagents and equipment allowed for basic testing at the HC and dispensary level which means, for example, that malaria is mostly diagnosed through testing in the municipality and treatment with ACT is reported by staff and patients alike as very effective (especially in comparison to treatment with SP).
- The municipal council has provided funds for a "local kit" which supplements the MSD kit with some drugs not on the list in the latter.
- PMTCT is available for pregnant mothers just prior to delivery at the dispensary and HC level and ARVs are provided at the regional hospital based on testing at lower levels.

Constraints

- This council still relies on the kit system and has not had the same strong improvement in drug supply as reported in other councils.
- The contents of the kit remain constant in terms of which drugs and supplies are included and the amount provided. In the face of significantly increased populations and hence demand for more drugs, the kit simply runs out. Reports vary of the supplied drugs lasting as many as three

weeks or as few as one, but all facilities run out of key drugs and basic supplies such as syringes and needles before the kit is re-supplied.
- As in other districts there is sometimes a particularly acute shortage of reagents.

Infrastructure and Equipment

Achievements,
- Laboratory equipment is in relatively good supply, even at the HC and dispensary level.
- The regional hospital has benefited from external support in the provision of an X-ray machine, automatic film processor, and laboratory equipment. Maintenance support is available for the X-ray equipment.

Constraints
- Systematic maintenance practices are clearly lacking (although cost sharing funds are used for "minor maintenance".
- Infrastructure is generally poor in most facilities (other than two constructed in 2004 and 2005 respectively) and the municipality has not received support under the Joint Rehabilitation Fund in recent years because of diversion of funds to the education sector by the Council (which must replace those funds before accessing more resources from the Fund);
- The council has not yet qualified for a capital development grant.
- There are very severe problems of water shortages (a general municipal water supply issue) in the facilities and electricity supplies at the HC and dispensary levels are either intermittent at best or simply lacking.
- There has been very little effort or investment to capture and store rain water or to use solar or other energy sources. One exception to this has been the use of kerosene and gas run fridges for storing vaccines.
- FGD participants in a number of communities expressed a desire for adequate fencing of the HF to provide security.
- Lack of housing for staff is seen as a major constraint by FGD participants as it means that dispensaries are often not open in the evenings, not even for emergency deliveries (which most dispensary staff say they will perform).
- It was interesting to note that FGD participants also equated lack of staff housing with retention – the unwillingness for staff to stay and serve at lower level facilities.

HMIS

Achievements
- Staff are knowledgable at all levels regarding HMIS and its requirements.
- Reviews of books 2, 5 and 10 at different HFs indicate HMIS data is being gathered and entered in accordance with guidelines. Books are complete and there is little or no missing data.
- HF staff report that they do use HMIS data to track both diagnosis and case loads and there is evidence of this in the materials on display.
- Staff also fill in customized (but relatively clear and simple) forms on HIV/AIDS, vaccinations, MCH and TB activities among others.
- CHMT supervision does include review of HMIS books at the HC and dispensary level, including private facilities, to make sure they are filled out on time and accurately.

Constraints

- Staff at HC and dispensary level (and the CHMT) report no feedback from either senior or central levels on the content and meaning of the data supplied.
- There is no apparent comparison of activities and results across health facilities either within or beyond the municipality.

Other

- The RMO argues that the Zonal Medical Store in Tabora does well in providing drugs to the districts in Kigoma region compared with his experience of other regions. He feels this is because the director there has worked with the region for 18 years and visits regularly.
- The entire Kigoma Municipality has a major ongoing problem with both water supply and electricity despite being located directly on the shore of lake Tanganyika (the town rises steeply from the lakeside in many areas so pumping water is an issue).
- Some private health facilities have been much more active in setting up poly SIM tanks and other containers for storing water than their public counterparts. This is a good strategy as often the water supply is intermittent rather than non-existent so water storage in tanks is effective. Public facilities sometimes have concrete tanks and SIM tanks but they are not often in good repair. More could be done to capture rainwater as well.

2.5. Human Resources Development

Achievements

- The emergency recruitment programme has had substantial impact in Kigoma, perhaps because it has a small population (120,000 or so) and is quite compact with a small number of public health facilities. In this context the numbers recruited in the past year have had a more significant impact.
- In the past, Kigoma has had a large refugee operation under UNHCR and NGO management and health workers have left the public sector to work in higher paying positions in the refugee camps. As the Burundian and Congolese refugees have begun returning home in large number, the refugee camp operations are being wound down and some staff are returning to the relative job security of the public sector.
- Most facilities visited were able to report some significant training undertaken by staff in the past two to three years to upgrade skills and most of these staff are functioning in their planned roles. Often this took advantage of the ZTC in Kigoma (which has been upgraded and strengthened in the past two years) but also included training at CEDAH in Arusha.
- In most dispensaries and HCs there is a staff complement which matches the numbers expected under the MOHSW standards. At the same time these staff are usually not at the qualification levels expected by the standards. On the other hand they are usually trained and capable of delivering most of the services expected at the HF level where they work. One dispensary even had three Clinical Officers.
- FGD participants also indicated community awareness and approval of improved levels of qualified staff, albeit not enough of them, at dispensary level.
- The council has seen an innovative approach to the problem of lack of laboratory technicians and assistants. In at least four facilities visited (FBO and public) there is no laboratory assistant on the staff complement but the labs function for basic blood, urine and

stool testing (including malaria and tuberculosis) because a "volunteer" lab assistant works part time and charges patients, usually 200 shillings per test. This provides a service which FGD participants say is good value for money. On the other hand, it means that the individual uses facility equipment and supplies (including reagents) while receiving direct payment for the tests. It should be noted that these tests would be more expensive if the patients would have to be referred to the hospital, especially if transport costs are taken into account.

Constraints

- Recruited staff must wait three months for wages to begin to be paid as they are put on the centrally controlled civil service roles. This causes some to abandon their posts.
- There is a continuing shortage of lab technicians and assistants at the HC and dispensary levels.
- Kigoma is an isolated "peripheral" location and it is difficult to get young well trained clinicians and others in the more qualified cadres to relocate there, especially in the absence of incentives.
- The Kigoma ZTC is still mainly focused on up-grading of the Rural Medical Assistants (cadre), to Clinical Officers. The institution's Principal did voice some concern that little thought and planning has been focused on the future; 'after up-grading, what's next, for the institution?'

2.6. Health Care Financing

Achievements

- In Maweni regional hospital there has been consistent collection of fees including consulting fees, charges for drugs and charges for laboratory investigations. These fees are clearly marked and the patients know what they are.
- The council is just in the preparatory stages of the CHF (called TIKA in the urban area) process. CHMT members have received support in development and sensitization on TIKA prior to its implementation. The council has passed a bylaw defining the rules for TIKA and the signing authorities for the account. The tariff has been set at 5000 shillings per year and the consultation fee for those not in possession of valid TIKA cards (one per family) will be 1000 shillings. CHMT members and dispensary and HC staff expect that TIKA will provide a more sustainable flow of finances to the facility level and will help them improve services.

Constraints

- Exemptions are not clearly posted but FGD participants are very well informed of their rights to exemptions (maybe a side effect of the sensitization process for the beginning of the TIKA).
- While the bylaws for TIKA are clear on signing authority for expenditures, staff interviewed are quite unclear on how decisions will be made to use the revenue generated by payments of contributions and who will make those decisions.
- There is a lot of work to be done in informing staff in dispensaries and HCs on the ins and outs and management of TIKA and a tremendous task in selling TIKA, especially to the very poor people who live in Ujiji (this is a bipolar town with two distinct centers, one at the railway station in Kigoma town and one in the center of the much poorer but populous Ujiji).

- The intention is that those to be "waived" or exempted due to poverty or inability to pay will be identified in advance by the ward development committees (the lowest level of local government in an urban setting) or even by street leaders and that they will prepare a list for the Municipal Directors Office each year and the families identified will be enrolled in TIKA for one year with no contribution. This process will be done each year to make sure that those who can pay will pay. As seen in other councils this process can be expected to take a significant time and is quite inflexible for either transient populations (students for example) or those who become destitute during the year. The effect of this may be denial of service to residents genuinely in need (it certainly is occurring in Same).
- When NHIF revenues were discussed with HC and dispensary staff they claim that NHIF members never take services at their level but go straight to the regional hospital.
- In the current set up of dispensaries and HCs , staff do not handle any money (at least not officially). For all the in-charges met the prospect of handling and being accountable for fairly significant amounts of cash seems a daunting prospect and one that they are not adequately prepared for.

2.7. Public Private Partnerships

Achievements

- Secondment of a nurse to the Kigoma Baptist hospital;
- Temporary assignment of a clinical officer to the same hospital;
- Allocation of 10% of the basket fund to the Kigoma Baptist Hospital
- Service by the clinical officer in charge of the Baptist hospital and the proprietor of a private health center on the Council Health Services Board

Constraints

- The recent increase in the salary (and training opportunities) of health workers in the public sector has had a real impact on FBO and private facilities in the district as they are not able to raise salaries to competitive levels if they are significantly dependent on fees for their income. All FBO and private facilities visited gave evidence of significant numbers of staff moving to the public sector (including the CHMT and the regional hospital). Salaries for nurse midwives in the public system are now at more than double equivalent salaries in the FBO and private facilities. If Kigoma region public health workers receive further incentives for service in peripheral areas this problem will be made even more difficult for non-government facilities.
- The Baptist hospital is reduced to employing all but a handful of staff part time and may not be able to continue operation for more than a few more months despite its rather superior infrastructure and equipment. The coming of TIKA may mean that the Baptist Hospital regains some of the patients it has lost to the public system as it attempts to operate almost solely from fee revenues.
- Private providers in particular complain about the attitude of staff at Maweni regional hospital when they refer patients there. They report that patients are told they should not go to the private facilities because "those people know nothing". Both private facilities visited are operated by retired public sector health staff (including a retired RMO).
- Private facilities have not been accredited (or inspected) by NHIF.
- Private facilities requested greater access to training opportunities available to staff of public health facilities.

In summary, beyond the CHSB level and two secondments to the Kigoma Baptist Hospital (but no granting of salaries as is done in some other districts), there is very little evidence of any policy of working closely with FBO and private service providers in Kigoma. Indeed, continuing strengthening of public facilities may represent a threat to non-government service providers.

2.8. HIV/AIDS

Achievements

- There is a visible presence of HIV/AIDS programming at all levels in the health system characterized by improved laboratory and testing facilities, dedicated rooms (newly built at the regional hospital) for VCT and incorporation of PMTCT into RCH activities.
- Staff and male and female FGD participants agree that care and treatment of HIV/AIDS patients has considerably improved.
- Supplies of ARVs at the regional hospital are rated good and stock outs of ARVs do not occur (according to staff and verified in HMIS and in visual inspections).

Constraints

- At the HC and dispensary level at least, VCT services are much more likely to be used by women than men. Each new female patient in RCH and maternity outpatient activities is offered VCT. A review of several reports on HIV/AIDS activities in different dispensaries showed that women undergo testing on a ratio as high as 400 women to less than 30 men.

3. Access, Service Quality and Outcomes

Achievements

- FGD participants point to the construction of new facilities as one factor in improving access (reducing distances travelled and costs);
- Others point to the advent of an improved supply of drugs at the dispensary level as an improvement in access. In the early part of the evaluation period they were diagnosed at the dispensaries and HC but since drugs were virtually non-existent at that level they were given prescriptions to be filled at either Maweni hospital or in private pharmacies. Thus, improved drugs availability is seen as a positive change to access.
- Staff are reportedly (by community members) available during working hours at the HF, a significant change from the earlier years of the evaluation period (a change which they ascribe to the 2002-2004 period). This is seen as improving access to services.
- FGD participants noted improvements in quality, due to improved working hours of staff, the availability of simple tests (for a fee) for malaria, tuberculosis and pregnancy, an improvement in the attitude of staff and improved supplies of drugs.

Constraints and Barriers

- Increased demand for services as a result of rising population and inward migration has meant that waiting times at many facilities are worsening or at least not improving (a number of dispensaries have records showing they treat 70 to 100 patients per day).
- Reduced drug supplies later in the month as a result of the kit running out;
- Transport costs;

- Unavailability of staff at dispensary level after hours and at night (due to lack of staff housing in or close to the dispensaries).

4. Development Partnership

4.1. Direct Project Funding

The most visible clearly externally supported project/programme operating currently is the support to HIV/AIDS programming by first AXIOS and now Columbia University under PEPFAR to HIV/AIDS infrastructure (buildings, supplies and equipment) as well as TA and supplementing the salaries of health workers involved in after hours work in CTCs and in CVT centers.

The most visible bilaterally supported project or programme in Kigoma municipality was the Adult Morbidity and Mortality Project (AMMP) supported in the past by DFID and apparently to be re-instated with the Ifakara Research Centre as the implementing agency. Another direct project funding agency, JICA, provided support to creation of infrastructure (RCH clinic at regional hospital as well as several wards) in the early part of the evaluation period. In addition, GTZ and the Netherlands have provided support to the regional hospital and other donors have supported the ZTC.

Kigoma Urban receives GFATM support but this support is not visible (in terms of where funding is applied and budgeted) to the CHMT members. The support of GFATM seems to be felt at the municipal level through the workings of national programmes on Tuberculosis and Leprosy, Malaria and HIV/AIDS. In that sense it is integrated into national programs.

4.2. Development Partner Harmonization and Alignment

There is little evidence of any effort to coordinate DP operational requirements at the municipality level. On the other hand, extra reporting requirements for some DP supported programmes such as NACP and NMDCP do not seem onerous and the forms used to monitor them (outside HMIS) have been kept fairly simple. Nonetheless they represent an additional demand on a staff struggling with the administrative and operational requirements of the services they provide.

4.3. Aid Modalities

While direct evidence on the relative benefits of different aid modalities is hard to find, RMO, RHMT, and CHMT interviews place significant importance on the independence and reliability of the basket fund as a source of reliable and impartial financing of municipal health activities. In this sense they find it more reliable than the block grant for health and much less susceptible to re-allocation than the council's other sources of funding.

4.4. Monitoring and Evaluation

This is mainly done through HMIS and through a set of additional reporting forms required to support programs in HIV/AIDS, Tuberculosis and Leprosy, Immunizations and to some extent, MCH activities.

4.5. Technical Assistance

Other than Axios and Columbia University working in support of HIV/AIDS programming there is little or no external TA in the health sector evident in Kigoma.

4.6. Trends in Aid Modalities and Structures for Cooperation and Dialogue

See above on aid modalities.

4.7. Participation by Civil Society in Goal Setting and Planning

There is very little involvement of civil society in goal setting and planning.

4.8. Burden on Time of Staff

This is difficult to gauge but other than the planning requirements of the CCHP and perhaps the reporting around vertical programmes such as PEPFAR there does not seem to be a major burden put on staff by external projects. If anything this burden has reportedly been reduced over time as projects have been completed or absorbed into national programs.

Structure of Teams and Boards

Regional Health Management Team:

Core Members
Regional Medical Officer RMO
Regional Nursing Officer RNO
Regional Health Officer RHO
Regional Health Secretary RHS
Regional Laboratory Technician RLT
Regional Pharmacist
Regional Dental Officer

Of these seven core members only the RNO is female

Co-opted Members (up to seven allowed)
Regional Reproductive Health Coordinator RRCH
Regional Cold Chain Coordinator RCCH
Regional Aids Coordinator RAC

Only the RRCH is a woman.

Council Health Management Team

Core Members

Acting Municipal Medical Officer
Municipal Nursing Officer
Municipal Health Officer
District Laboratory Officer
Health Secretary
District Pharmacist (vacant)

Co-opted Members

Tuberculosis and Leprosy Coordinator
District Cold Chain Officer
District Aids Coordinator
Malaria Focal Point
District Reproductive and Child Health Coordinator
District School Health Officer (vacant)

5 female (DNO, Acting DMO, Malaria Focal Point, District School Health Coordinator and District Reproductive Health Coordinator) and 7 male members.

Persons Interviewed: Kigoma Region / Kigoma Ujiji Urban Council

Ernest KB Nkonyozi	Municipal Health Officer
Proiase Nato	Acting Municipal Director (equivalent to DED)
Wilfred Mwita	Planning Officer, Kigoma/Ujiji Municipal Council
_______________	Acting Regional Administrative Secretary and Regional Medical Officer

Regional Health Management Team:

Dr. Modesta Missana	Medical Officer in Charge, Maweni Regional Hospital and Acting RMO
William Maganga	Acting Hospital Matron
Silas A. Kassanga	Acting Regional Cold Chain Officer
Dr. Fadhil O Kibaya	Regional Dental Officer
Abenja Paul	Regional Lab Technologist
Kiza A. Kiseka	Regional Pharmacist
Anatolia Yabba	Regional Pharmacist
Solomoni Buganga	Regional Health Officer
Majaliwa R. Mabula	Acting Regional Health Officer

Maweni Regional Hospital Management Team

James Kasembo	Radiographer in Charge
Masaka Samson	Pharmacist in Charge
Jonathan Magogwa	Eye Department in Charge

Stephen Sugumvya	WDI in Charge
Doscar Ndayanse	Assistant Matron
William Maganga	Acting Hospital Matron
Dr. M. Leonides	Surgery in Charge
Dr. M Resalituke	Medical in Charge
Dr. Sollo, Cs.	PMO

Council Health Management Team

Dr. A. Kasumani	Acting Municipal Medical Officer
Mr. E. Russota	District Aids Coordinator
Mr. M.K. Ntemiseni	Acting Health Secretary
Mr. F. Mputa	Acting District Cold Chain Officer
Mr. Felix Bigg	DTLC
Ms. B. Petter	District Nursing Officer
Mr. S Salumnu	Laboratory Assistant
Mr. E.K.B. Nkonyonzi	Municipal Health Officer

Council Health Services Board

Salome Kaumini	Community Representative
N.J. Rubasha	Member (Baptist Hospital)
Dr. F.S. Rwebanagila	Member (Private Health Center)
Omary A. Ndimuligo	Member
Dr. A. Kasumini	Secretary (Acting Municipal Medical Officer)
Ruth Kabeza	Member

Ujiji Health Center Management Team (Government)

Dr. Albian Inyasi	Medical Officer in Charge
Pili S. Ndugulile	Public Health Nurse B
Neema Mwangoka	Clinical Officer in Charge
Japhet Z. Musiba	Patron

Upendo Dispensary (Private)

Mr. Luiza	Clinical Officer in Charge

International Health Center (Private)

F.S. Rwebangira	Proprietor

Kigoma Baptist Hospital Management Team (FBO)

Dr. M.J. Rubasha	Medical Director
Tiracy Guntave	Acting Laboratory Technician
Mrs. G. Nkonyozi	Public Health Nurse B
M.Y. Gibogo	Assistant Medical Officer
Michael Bazaniye	Financial Manager

Masasi Council, Mtwara Region

1 Overall Sector and Program Relevance

1.1 Health Sector Strategies Relevant to Council Needs and Priorities

The health sector strategies are relevant to council needs and priorities and contribute to achieving the MDG and MKUKUTA health sector goals and targets. Strengthening of council health services since 1999 has led to a significant refocus from the central to the council level, which has empowered the councils to address their health needs. New diseases like HIV/AIDS and new strains of malaria are being tackled, especially through foreign-funded support. Despite the progress in some areas, there are significant constraints. The council and regional hospitals have been neglected during the reform process. The role of the RHMT is not well understood and thus not effectively utilized. Masasi council and Mtwara region are considered hardship posts, but there are no incentive packages to attract health workers to remote areas; as a result, the whole region is severely understaffed. Basket funds are not released in a timely manner and the budgeted amount is not available. CHF started early but has almost come to a complete halt.

1.2 External Support Appropriate to Council Needs and Priorities

Masasi is a large recipient of external support, not only in the form of basket funds but also direct foreign technical assistance. The Tanzanian German Program to Support Health (TGPSH) is active in Masasi and Mtwara region and provides both technical and financial support. There are various technical advisors of the German Development Service like a medical doctor working in the Masasi council hospital and a health management advisor in Mtwara. The District Health Improvement Project – a cooperation between MOHSW, KfW and German Development Service – provides financial support, e.g. through the construction of health infrastructure like water supply, sewage, electricity, storm drainages and staff housing. The Elizabeth Glaser Pediatric AIDS Foundation provides PMTCT support in Mtwara region. The Clinton HIV/AIDS Initiative provides care and treatment for people living with HIV/AIDS and is establishing care and treatment clinics in Masasi council hospital as well as in other health facilities. There are also Peace Corps Volunteers. For example, in Chiungutwa village the Peace Corps Volunteer is attached to the local school and works in HIV/AIDS awareness-raising.

Basket funding is considered appropriate to council needs because it is aligned with council (and national) priorities and facilitates joint planning and implementation (between government funded activities and foreign funds). However, Masasi has constraints with its basket funds as they are not released in a timely manner, the budget is not transparent and the approval for expenditure is nebulous and raises power conflicts between local government and health civil servants.

Other external funding, especially that related to HIV/AIDS, is appropriate in that it addresses the council's needs to deal with this disease, in which it has little experience. The issue here is that many of these activities are not part of the normal government planning procedure and require their own planning procedures, financial reporting and M&E. Some support like the building of a zonal blood bank in Mtwara by the US Centers for Disease Control is questionable as the construction and its maintenance are very expensive. Currently recruitment of 30 staff is underway at the national level and

salaries are subsidized by CDC. The problem with the blood bank is that the infrastructure to provide blood to the Zone is not in place.

2 Progress and Achievements Under Health Sector Strategic Plans

2.1 Strengthening Council Health Services

Achievements

- There are some illnesses that have been significantly reduced in number, e.g. cases of anemia (in under fives), malnutrition and measles;
- Access for women to health services has improved, e.g. increased access to family planning methods, ANC services, and more hospital deliveries;
- The community is increasingly becoming aware of patients' rights;
- The process of decentralization has taken place to a large extent. Structures are in place (CHMT, RHMT, CHSB, etc.) and are minimally functional in that regular meetings take place; however, the interplay between the various structures needs to be strengthened and come alive in that all contribute towards a decentralized district planning and its implementation;
- A CHSB has been officially established in 2005. It does not have its own financing and as a result, it is restricted in carrying out its work;
- Masasi Council Hospital has a Hospital Management Team;
- Since 1999, when the basket fund was introduced, the district has more funds for health;
- Many health facilities have been renovated and upgraded. The district hospital infrastructure has been renovated and staff housing is being built with donor support.

Constraints

- Decentralization has progressed, but to a lesser extent than expected because the health workers in Mtwara region and Masasi council strongly question the authority of local government over the health sector, both technically and administratively;
- The CHSB is dissatisfied with the fact that its work is limited to Board meetings. They depend on the Council for funding and logistical support, which they do not get. The Council does not put a high priority on the CHSB, as they do not consider its members as equals and treat them neglectfully. The Secretary (DMO) points out that there is not enough money for sitting allowances and thus the CHSB does not meet quarterly;
- CHSB stated that the Masasi council hospital has too few staff, too few drugs and too many maternal deaths;
- CHSB raises issues with the CHMT, but they do not represent the Village Health Committees or the Health Facility Committees, which constitutes a problem;
- There is no Governing Committee for Masasi council hospital;
- There is a need for increased supervision and support by the CHMT, especially of peripheral HFs. CHMT does not supervise HF monthly as it should;
- The local community is not involved in CCHP planning;
- No HF has running water and only 5 HC have solar panels to provide electricity;
- All HFs have severe staff shortages;
- Some HC have an ambulance. Recently all were called to council headquarters and that is where they are now located. Villagers complain that transportation is very costly. Except

pregnant women and under fives all are expected to pay for ambulance services, if they are available at all. Ambulances are often used for campaigns and other council activities;
- Preparing the CCHPs takes around 6 weeks; it is too strict in demanding details, especially on expenses; it seems that every year the activities of the previous year are just recopied; no feedback on progress achieved last year is given; there is no insight into the finances by the participants; and, most activities of the CCHP are not being implemented, the main argument being that the money is not available.

2.2 Changing Roles of the Central Ministry

Achievements
- Overall indication is that it has been effective, in that central MOHSW no longer has a direct role in implementation of council health activities. The district is now better able to address issues in accordance with their own set priorities. In the past the MOHSW would take top-down decisions about what should be implemented in Masasi, whether it was appropriate or not;
- MOHSW issues directives/policies on new issues, e.g. new malaria treatment;
- There is a reduced number of traditional healers operating in the council as a (direct) result of the national awareness creation by MOHSW.

Constraints
- The RHMT lacks the funding/support to carry out their supervisory, coordination and advisory tasks (RHMT does not get the funds it requests in its annual budget). Councils do not call upon the RHMT, when they need their services;
- The RHMT structure, i.e. the position of regional personnel/bodies vis-à-vis the overall government structure in relation to other ministries such as Public Service and Ministry of Education, is not clear;
- The RHMT believes that in resource poor regions like Mtwara decentralization is good in theory but not in practice. As the RHMT is not being empowered with resources and authority it cannot function as an arm of the Central MOHSW. It is caught between two ministries, where each is not sure where its demarcation is, the result being catastrophic;
- The RHMT feels that the old system of centralization was better in reaching the very poor. It just needed strengthening;
- The RHMT does not approve of the clustering system at both RAS and council levels. Too often health is not given the priority that they think it should get. For example the social services cluster has two vehicles and if the RAS decides that education activities are more important than immunization, then the immunization activities suffer;
- The RHMT staff resent the fact that their positions are not officially recognized. For example, the Regional Pharmacist is simply recognized as a pharmacist in the civil service cadre;
- The DMO earns more than the RMO, is recognized by MoPS and is not obliged to accept advice from the RMO. In addition, the RMO is also not ‘the boss’ of the Regional Hospital anymore; the MO in-charge is. All this leads to bitterness among the RHMT.

2.3 Hospital Reform

Achievements

- The council hospital has an ambulance. However, the fact that it is under control of the District Transport Officer occasionally presents access challenges;
- Council hospital financing has improved due to the following sources of funding: basket fund, local grant, cost-sharing, NHIF, CHF, and direct donor funds (see 1.2);
- Although staffing is a problem, of late some unqualified staff was hired and some nurses are upgrading their skills to clinical officer level;
- The triage system was introduced in the council hospital.

Constraints

- The referral system is not working well. Many cases that could have been seen at lower HF levels are seen directly at the council hospital level. There is no referral hospital, as the regional hospital in Mtwara does not fulfill this role;
- There are no medical officers at the council hospital;
- Council hospital has a severe water problem. The two wells and recently constructed tank are inadequate;
- The council hospital does not have electricity 24 hours a day. The recently purchased generator is not functional yet. When there is no electricity, no water can be pumped;
- The regional and council hospitals both have incinerators, which were built under a WHO initiative; however, they were poorly constructed with limited functionality;
- There is no Hospital Governing Committee;
- HMIS of district and regional hospitals is poor;
- Many complain about hospital staff's attitude (rude language and disrespectful behavior).

2.4 Central Support Systems

Drug Supply

Achievements

- The indent system was introduced during 2002-2004.
- The Zonal MSD is very positive about the indent system.
- Cost-sharing allows for local (independent) purchase of drugs – with approval from the DED's office, as it is signatory to the account from which such purchases are made.

Constraints

- There are all round complaints about the indent system, which has slowed down the procurement and distribution process. Orders are made through DMO's Office who collates for all HF's and then places an order to Central MSD. Central MSD then does the packing, the filled order then being sent to the Zonal Store. Problems arise from the fact that Central MSD does not inform the Zonal Store on what is missing, which means that by the time the facility receives it, it has been recorded as a 'filled delivery', the process of redress taking a great deal of time, during which the health facility has to go without those drugs.

- Health facilities only get 2 – 3 supplies per year, instead of being regularly supplied on a quarterly basis; this creates planning problems. They are told that drugs are on the way and thus do not make a local independent procurement in order to minimize the use of their meagre resources; however, these drugs often do not appear. Many lower level health facilities in Masasi reported that the last time they were supplied was 5 months ago.
- The 2005 *Evaluation of drug availability in Masasi District and ways of improvement through CHF* reported the following findings. Delays in drug ordering on the district side and delays in delivery on the side of MSD cause serious out-of-stock situations in the HF. The practice by MSD of supplying other goods than ordered was highly criticized, because drugs not needed were piling up in the HF and the insufficient financial deposits at MSD level were exhausted fast. As the training on the indent system was apparently not sufficient, many health workers faced great difficulties in calculating their needs by using information provided in the different registers and the HMIS. In addition, adapting the needs to seasonal fluctuations in patient numbers, fluctuations due to other reasons and response to outbreaks of diseases was experienced as a big challenge. Reportedly only 25% of the commodities were always available and 25% were out-of-stock for longer than a month.

Infrastructure and Equipment
Achievements

- All HF visited were clean.
- JICA has supported remote HFs with the acquisition of radios for communication a few years ago. As the radios cannot be maintained, the system is not functional anymore.
- IT is being introduced at the hospital level. The Mtwara regional hospital has an IT room, which is now occupied by the CHAI Advisor. The Masasi district hospital recently received Internet access.

Constraints

- Water is a problem in most HFs in Masasi. Health workers spend much time in collecting water.
- Electricity (24 hours per day) is not available in Masasi. The District Hospital has power shortages (its new generator has no starter), which means that some emergency operations are carried out with torches and mobile phone lights. Five HCs have a solar panel to run the refrigerator, etc. which was only provided at the beginning of 2007.
- Equipment and its maintenance have been sub-optimal. The donor supported zonal workshop for hospital equipment should improve maintenance.
- The laboratories of the hospitals seem to often be out of reagents, etc and thus not functional.
- Neither the hospitals nor the new safe blood center have an ambulance (yet). Ambulances are attached to some health centers, but somehow do not seem to function as planned (as villagers complained of lack of transport).

Other

- The DED's office seems to be developing its own information management system, which is planned to integrate all district level information – health, education, works (local government infrastructure), vehicles, etc. It is not clear as to whether this is being done in

consultation with the various sectors or how it would harmonize with the centrally sanctioned MIS systems; this is being supported by JICA through TA.

HMIS/MTUHA

Achievements

- The staff of the health centers and dispensaries fill in the HMIS forms and actually seem to have a greater degree of commitment and willingness to fill in HMIS forms than hospital staff.

Constraints

- The HMIS (multiple forms) were reported at all levels to be burdensome to fill.
- Most facilities report that the level of HMIS-feedback is very low. This also applies to the feedback to higher level facilities from MOHSW.
- The huge amount of time (and information) required by the HMIS forms coupled with the minimal feedback may be one of the contributory factors to the limited use of the data for planning purposes.
- The burdensome nature of the HMIS system, along with the limited commitment to using it properly, brings into question the validity of the data therein.
- HMIS books are not supplied on time, which means that facilities cannot maintain a consistent record.
- Data collection, verification, analysis and sharing is very poor – essentially the HMIS system is 'collecting for the sake of collecting'.

2.5 Human Resources for Health

Human resources (for health) are considered as the number one constraint and priority to address throughout the district.

Achievements

- There has been some hiring of new staff in the council, but it does not match the needs, neither in numbers nor in qualification. Where a Laboratory Technician is needed, a Laboratory Assistant is hired. Numerous Nursing Aides have been deployed, where qualified nursing staff are needed. However, staffing levels should be looked at in light of the standards of the HF and their utilization rate.
- It was noticeable that in many HFs young Lab Assistants were hired to run the laboratory. Simple testing was possible.
- Some staff like nurses are upgrading themselves by visiting the Clinical Officers & Nurse Training Institutes near the District Hospital.
- Data on Personnel Management Information System is available.
- The Emergency Hiring Plan was applied in Mtwara region; however, only one staff out of the 4 who were hired has stayed.
- The RMO and DMO do "local" recruiting in that they look for, identify and try to convince people to come and stay. DMO coaches new staff on why they should stay in Masasi.
- Recruitment in the health sector was re-centralized due to the lack of district capacity/the inability to manage the process (advertise, capacity to interview high-level personnel, etc).
- Staff of health centers and dispensaries are few and have many limitations; however, they are doing a great job, given the circumstances. They seem to be very dedicated and are part of the community they live in.

Constraints

- Staffing needs are determined centrally and do not match actual needs. National staffing guidelines are not useful.
- Masasi district hospital has about 50% of its positions filled and this human resource crisis has been chronic.
- There are no job descriptions for most staff.
- Zonal Training Centre has suffered severe neglect. Their great potential to play a key role in HRH development in the region and zone to improve the quality of staff is unfulfilled.
- There is a 'skills-mix' distortion at all levels. Despite the critical shortage of medical doctors, many are drawn into administrative posts. This results in further loss of technical capacity.
- Planning of human resources with respect to utilization does not seem to be a focus. The district and regional hospitals have only a 40 – 50% occupancy rate, which is much lower than that found in the FBO hospital.
- There is foreign funded staff in the district (under CHAI and the Mkapa Foundation). They are reported to be getting a substantially higher salary than their government colleagues, which has created 'bad feelings'.
- There are no set, documented/official staff attraction and/or staff retention strategies in place.
- Staff at FBO-run health facilities is leaving in streams. They leave for the following reasons: 1. Government salaries are of late much higher (except in some HFs like Ndanda Hospital); 2. Government employees work less; 3. Government employees have less supervision; 4. Government jobs are more secure (it is very difficult to fire a public servant); 5. Government offers a training scheme, which privates do not. Also government staff goes more on workshops and has time to have a second job on the side. The sister in-charge of Lupaso Health Center has even fired two staff this month, as she cannot afford paying their salaries anymore. All FBO-run HFs we visited in Masasi are very concerned about the financial viability of their HF and are worried that they may have to close down or decrease their services significantly in the near future.
- It is difficult to attract health workers to remote areas, if they are not provided with staff housing.
- Government should be stricter in enforcing that staff stays in remote areas once they have been assigned that job.

2.6 Health Care Financing

Basket funds

Achievements

- There has been an increase in the level of funding at district level and the district health team has a greater say in how to spend its funds.

Constraints

- There is a degree of concern that funds that may well have been intended for the health sector are being used for non-health activities. Most interviewed sources indicated that

100% of the (budgeted) funds arrive in the district; however, there is no transparency about utilization and disbursement of these funds.
- The staff at lower level facilities did not know of CCHP or the existence/availability of basket funds.
- Funding, when it does arrive, is often late, which negatively impacts implementation according to plan.
- Basket funds should be available for running costs but never seem to be available, e.g. the German Development Service vehicle never has fuel for outreach services, funds budgeted for supervision are not available, the starter for the brand new generator of the district hospital has not been bought in the last year.

User fees
Achievements
- User fees are clearly indicated at the district hospital (not exemptions).
- User fees collected by the district hospital are used to purchase drugs and equipment as well as for maintenance and repair.
- User fees have enhanced facility's ability to run/sustain their services, as well as to make improvements, as deemed necessary – small renovations, small purchases (drugs), security, etc.
- Under 5 and pregnant women are exempted from user fees, meaning that these services are greatly used.

Constraints
- The level of access for the majority of adults has decreased as they are too poor to pay the user fees. This has been noted by some health facility staff to be one of the major reasons for a decrease in facility utilization.

CHF
Achievements
- CHF started in 2001, Masasi being one of the first districts to introduce it. CHF monies (at the time) were from cashew producers, who were deducting it from the sales of 'members', who did not know this and who were only given cards in 2005. Later it was very well resourced when it received the matching grants.

Constraints
- In 2005, when the Council Health Services Board was put in place, the existing investment from the past was utilized upon requests posted by the health facilities, which were not necessarily what the community perceived to be their priorities – infrastructure, etc. When it came to renewal, on the basis of cards (now existing), many community members did not do so, as they viewed CHF to have no direct advantages and to give no direct benefit to them.

Foreign grants
Achievements
- Masasi receives much foreign assistance in various forms: 1. Technical Assistance through staff – DED through TGPSH, CHAI, JICA; 2. Infrastructure rehabilitation - DHIP (KfW support) through TGPSH, CDC through PEPFAR; 3. Non-governmental funding – EGPAF, Basic Needs; 4. Volunteers - Peace Corps.

Capital Development Funds
Constraints

- The Council Authorities see it as a constraint that a major part of this funding is not released to the council health sector.
- The CHMT has difficulties to administer all the funds available and implement the planned activities as it is overworked and there are grave misunderstandings about the use of this fund.

Other

- The Rapid Funding Envelope has given some support to CSOs, that can request for funding, e.g. Ndanda Hospital CTC Centre.
- The Regional Facilitating Agency implements activities with funds through TACAIDS.

2.7 Public Private Partnerships

Achievements

- There was little or no relationship between the MOHSW and the FBO for many decades. Now that the FBOs are facing a crisis due to their reduced external funding (but maintained delivery-demand from the population), the circumstances have forced the FBOs to approach the MOHSW for assistance.
- Although there is some support, this is still limited to the 10-15% of basket funds that are required to go to the FBO according to the CCHP guidelines. In Masasi only Ndanda Hospital as a Voluntary Agency Hospital is entitled to receive this share of the basket fund. First line health facilities depend on the good will of the district to be allocated some funding, which is only provided to a very limited extend.
- The MOHSW assists the FBOs to some extent, e.g. provision of vaccines, drugs like DOTS treatment, refrigerators, generally provided by VPs.
- The PPP Steering Committee started this year (2007) and has met once so far.

Constraints

- MOHSW does not have the capacity to take over all former FBO work.
- The FBO and private-for-profit sector is low on the priority list for financial support, as the MOHSW itself does not have sufficient funds and staff. Nevertheless, some FBOs (e.g. Lupaso HC) think that the DMO is very understanding, and that if he e.g. would have drugs, he would send them to Lupaso.
- Integration of planning and implementation of priorities is minimal, especially as far as the CCHP is concerned.
- In the case of Masasi, the RMO does not have the authority to increase the level of support to the CSOs as he would wish.

2.8 HIV/AIDS

Achievements

- PMTCT introduced through EGPAF.
- CTC introduced through CHAI.
- VCT centers have opened.

- Awareness on HIV/AIDS has been raised.

Constraints

- The collaboration between DACC and CHAC is not optimal.
- Blood bank built by CDC is not yet functional and it is questionable if it ever will be able to supply the southern zone with safe blood.

3 Access, Service Quality and Outcomes

Achievements

- Regarding equity to basic health services, there is a linkage between providing free services to under 5's and pregnant women and them having access to such services.
- A slight improvement in the drug supply encourages clients to use health facilities more frequently as shortage of drugs is a great limiting factor to access to care.
- Staff is available during working hours.
- Due to awareness-raising, villagers are using traditional healers less than before.
- Positive health outcomes are the drastic reduction in measles, cholera outbreaks, and malnutrition.
- Positive developments are the better treatment of malaria cases and the increased use of ANC services.

Constraints

- Population growth without the equivalent growth in new health facilities has decreased access to services and increased waiting time.
- Equity within the health system itself is poor. There are disparities between higher and lower levels of health services. At lower levels all receive (have access to) the same services (dispensary, health center). At higher levels (hospital), the rich have a greater degree of access to services, as they live in the district headquarters or have more money to pay for transport and health services (official and unofficial costs).
- Staff complained that user fees for all except under 5's and pregnant women have resulted in a barrier to health care for men.
- CHF is not functioning well, meaning that few families use the services offered at the health facilities.
- Bad attitude of staff in hospitals prevents patients from going there unless it is absolutely necessary.
- The malfunctioning of the ambulance system presents an obstacle for many to reach health facilities in case of emergency.
- Emergence of HIV/AIDS and the come-back of TB are taking up a lot of resources, leaving less for other diseases.

4 Development Partnership

4.1 Direct Project Funding

Development Partners

- Development partners provide basket funding, which has increased the levels of financing within the sector. The district can now better manage its health services by setting its priorities and implementing them.
- Development partners in Masasi like TGPSH and JICA have provided technical staff to work at both district and regional levels. In theory they should alleviate the human resource crisis somewhat; although this was never explicitly mentioned by MOHSW staff and is not intended by the supporting organizations. For example, the TGPSH physician works at the Masasi district hospital as a medical advisor, who should build capacities in his colleagues; however, he has difficulties not to be merely seen as one more doctor. The TGPSH hospital equipment expert assists with the maintenance and repair of HF equipment in Mtwara region. The TGSHP Health Management Advisor assists the districts in preparing their CCHP, etc.
- There has been a direct contribution to infrastructure through TGPSH by rehabilitating HF and staff quarters.

GHI (e.g. CHAI and CDC through PEPFAR)

- The GHIs have provided staff at district level to work on HIV/AIDS related issues. CHAI has introduced the CTC and Center for Disease Control built a blood bank at the regional hospital to provide safe blood in the region.

Civil Society (e.g. EGPAF)

- Introduced PMTCT to Masasi.

4.2 Development Partner Harmonization and Alignment

Development Partners

- DPs like TGPSH try to harmonize and align their operational requirements to those of the government. TGPSH supports the health sector reform at central level, local TA are involved in the preparation and implementation of CCHP, and do not require extra M & E systems.

GHI

- CHAI has its own planning process with different dates for submitting annual plans; they distort salary scales; they have their own priorities, i.e. AIDS care and treatment, and do not support the health sector in a holistic and integrated manner.

Civil society

- CSOs like EGPAF have their own way of operationalizing their work. For example EGPAF requested interested HFs to submit letters of intent. The ones that looked promising were accepted to go to the next round of proposal writing, which is done in Dar es Salaam at the EGPAF office. Three staff (District RCH Coordinator as well as two others who will primarily deal with PMTCT), who are invited to come to Dar es Salaam, get much

assistance on how to write a detailed and technical PMTCT report that will meet US Government requirements.

4.3 Aid Modalities

Development Partners

- Tend to operate by providing basket funds and Technical Advisors.

GHI

- Tend to operate by providing funds which are managed by hired staff.

Civil society

- EGPAF does not participate in the CCHP process. They request the staff they trained in proposal-writing to put their activities in the CCHP (EGPAF funds are external) and ensure that the basket funds/block grants/Global Fund eventually take over the costs of running and expanding PMTCT sites, because EGPAF will stop funding them at some point in the future. EGPAF requires that the district open a separate sub-grant bank account to transfer EGPAF money to Masasi.

4.4 Monitoring and Evaluation

Development Partners

- Development partners like TGPSH do not require from the district that they do a separate M&E.

EGPAF

- EGPAF has hired a Data Entry Clerk at district level under government hospital terms to only collect HIV/AIDS care and treatment data. This is required as the staff working on PMTCT and care and treatment do not have the time/capacity to do so. The US Government requires the collection of this data to continue its funding; thus EGPAF pays for it separately.

4.5 Technical Assistance

- Planning and implementation (modalities) of TA is planned at 'headquarters' level. Whatever is done at district level is within the prescribed parameters, so there is no real input into this aspect, by either the district or district based TA Advisor.

4.6 Trends in Aid Modalities and Structures for Cooperation and Dialogue

- From the perspective of the district and the region, it is difficult to answer this question on behalf of the government. There is the underlying sentiment that the government is not fully in the driver's seat and thus cannot take many decisions on its own. Feelings/ impressions regarding the dynamics are "when there is dire need, aid is willingly accepted and also much

appreciated; however, there are realities about who is ultimately in control". As the districts and region are under-resourced, they cannot afford to reject any type of aid.

- Theoretically basket and other funding mechanisms should lead to positive outcomes.
- There are some outcomes that cannot be regarded as positive by the district staff. For example, CHAI and EGPAF staff are paid much higher salaries, have better offices ("EGPAF PMTCT offices are modern and high-tech, while the clinic right next to it has nothing to run its theatre"), have much project money, etc., which is creating imbalances within the system that are not healthy. They do not strengthen the system per se, which is necessary. Another example of this is the blood bank built in Mtwara by CDC. The idea of the blood bank is good, but the very expensive building was constructed in a luxurious way with marble from India, wooden doors from Dubai and floor tiles from Italy; however, considering the pattern of health care problems in the Region, it is difficult to understand why such huge amounts of funds are raised for tackling a comparatively minor problem of increased blood safety, especially because most hospitals do not have electricity to keep the blood, and the infrastructure will not allow delivery of blood to all facilities in the southern zone. Apart from that, the health sector strategy paper does nowhere state the necessity of such an intervention.

4.7 Participation by Civil Society in Goal Setting and Planning

- At present civil society is not involved in goal setting and planning in Masasi.

4.8 Burden on Time of Staff

Development partners/basket funding

- In general, there is a lesser burden on the time of district staff as the DPs do not require different reporting formats, financial/planning years, separate M&E, etc.

Vertical funding:

- In general, there is a greater burden on the time of district staff as the foreign-funded HIV/AIDS projects require different reporting formats, separate workshops and meetings, have different planning/financial cycles, and require separate M&E reporting, etc. However, e.g. EGPAF pays government staff overtime allowance to compensate the extra work (which is also controversial) and have hired some staff at some FBOs.

Persons Interviewed: Mtwara Region/ Masasi Rural Council

Facilities and organisations visited **Type**

Facilities and organisations visited	Type
RMO and RHMT Mrwara	Government
Regional Hospital	Government
Zonal MSD Store Mtwara	Government
Training Institute, Mtwara	Government
CHSB Masasi	Mixed
CHMT Masasi	Government
District Executive Director	Government
District Hospital	Government
Chiwale Health Center	Government
Chiungutwa Dispensary	Government
Ndanda Hospital	FBO
Lupaso Health Center	FBO
Lukuledi Dispensary	FBO
Dr. Mwambe Hospital	Private Health Center
Village Health Committee Chiwale	Community
Community members Chiwale (CAST)	Community
Community members Mpeta	Community
Deutsche Enwicklungsdienst DED	DP
Clinton Foundation CHAI	DP

Persons Interviewed or Participants in Workshops

Name	Position
Dr. S. M. Budeba	Medical Officer, RMO
Dr. Ernest Kasoyaga	MO of Regional Hospital
Mr. Justus K. L. Bengesi	Regional Health Secretary
Yusuf Mwita	PEE, Malaria Control Program, Central MoHSW
Mr. Haji Kachechele	RAS
Henrick D. Mpili	RLT
Anderson A. Ungani	NO I/C (Patron) Regional Hospital
Juma M. Nassor	Regional Pharmacist
Jamal M. Mbava	RHO
Ahmed Chibwana	RNO
Mohamed H. Mfwato	Accountant
Daudi Msasi	Acting Area Manager, MSD
Aisha Kachema	Sales Officer, MSD
Dr. D.O.N. Mlelwa	Ag. Principal Zonal Health Training Institute (ZHTI)
Dr. T.M. Shengena	Resident Tutor/CHF Coordinator ZHTI
Dr. Maaike Flinkenfloegel	Tutor (VSO Volunteer) ZHTI
Dr. Wilhard Shayo	Tutor ZHTI
Dr. Edward Nandi	Tutor ZHTI
Ms. Judith Andrew	Health Secretary ZHTI
Mr. Noel Mahyenga	District Executive Director
N. J. Maukatt	CHSB Member
L. X. Mchopa	CHSB Member
Ms. Greta Mshamu	CHSB Member

Dr. William Chilumsa	CHSB Chairperson
Swedi M. Abdallah	CHF & NHIF Coordinator, Masasi District Hospital
Ms. Agnes S. Omary	Acting Health Secretary
Ms. Apollonia Peneza	District Nursing Officer
Albano J. Nditi	District Dental Therapist
Dr. Msengi Mwendo	DMO
Mr. Adrian Jungu	District Health Officer
Dr. George Kumwembe	Deputy (Asst.) Medical Officer In-Charge
M. J. Mbatta	Clinical Officer, Private HC, Dr. Mwambe Hospital
Fabian Lucian Mwambe	Accountant, Private HC, Dr. Mwambe Hospital
Celestina F. Mwambe	Owner, Private HC, Dr. Mwambe Hospital
Dr. Joseph C. Hokororo	Medical Officer, Private HC, Dr. Mwambe Hospital
Muhaji Mpili	C. O. In-Charge, Chiwale Health Centre
Hasam Kazimoto	Nurse, Chiwale Health Centre
Neema Nuku	Laboratory Assistant, Chiwale Health Centre
Grace Hassan	Nurse Assistant, Chiwale Health Centre
Devota Mpangala	Nurse Assistant, Chiwale Health Centre
Ajili Issa Mkoma	Chairperson, VHC Chiwale
Muhaji Mpili	C. O. In –Charge (Secretary), VHC Chiwale
Asina Thabit Makumba	Member, VHC Chiwale
Brigita Chande Mkolela	Member, VHC Chiwale
Saluvina Bathoromeo Mitao	Member, VHC Chiwale
Bakari Katambo	Member, VHC Chiwale
Rashidi Khalfa Hanzuruni	Member, VHC Chiwale
Villagers	CAST – Village Government, Chiwale
Sister Lenobia Kimaro	Clinical Officer In-Charge, Lukuledi Dispensary (FBO)
Stephane K. Masudi	Laboratory Assistant, Lukuledi Dispensary (FBO)
Walbulga Pius	Cleaner, Lukuledi Dispensary (FBO)
Theresia Erich	Nurse Assistant, Lukuledi Dispensary (FBO)
Blandina Millanzi	Nurse Assistant, Lukuledi Dispensary (FBO)
Joyce Achimdota	Medical Attendant, Lukuledi Dispensary (FBO)
Rosalia Mwanga	Ward Assistant, Lukuledi Dispensary (FBO)
Blandina Mrope	Nurse Assistant, Lukuledi Dispensary (FBO)
Laura Mtenga	Ward Assistant, Lukuledi Dispensary (FBO)
Filipo John	Security Guard, Lukuledi Dispensary (FBO)
Stephan Lilungulu	Registrar, Lukuledi Dispensary (FBO)
Dorothi Chikawe	Nurse Midwife, Lukuledi Dispensary (FBO)
Agnes P. Mnenje	Principal Ndanda School of Nursing, Ndanda Hospital
Piet Hein Meckmann	Administrator, Ndanda Hospital
Richard Membe	Hospital Secretary Ndanda, Ndanda Hospital
Dr. Crispin Sapuli	Doctor In-Charge , Ndanda Hospital
Dr. Pascal Kolk	Medical Doctor, TGPSH
Dr. Gobera	Medical Officer, CHAI
Mr. Albert Muteeba	Lab. Technician, CHAI
Michael Chimatila	Laboratory Assistant, Lupaso HC
Sister Veronica	Administrator, Lupaso HC
Peter Makaline	Clinical Officer In-Charge, Lupaso HC
Sister Tumaini Tarimwe	MCH, Lupaso HC
Elizabeth Swalehe	Nurse Midwife, Chiungutwa Dispensary
Leah Ponera	Medical Attendant, Chiungutwa Dispensary

Saleya Manganda	Nurse, Chiungutwa Dispensary
Villagers (mixed)	CAST
Ute Steiner	Health Management Advisor, TGPSH

Mwanza City Council

Overall Sector and Program Relevance

Broadly speaking the health sector strategies are assessed as relevant to the needs and priorities of Mwanza City Council population and health system. In the preparation of the CCHP prioritisation is done according to burden of disease and EHIP.

The Basket Fund is considered highly relevant by all parties interviewed. Direct support (projects and programmes) by the Development Partners to the City Council has been very limited, especially in the latter part of the evaluation period. While projects and programmes have addressed relevant needs and priorities, respondents in the City Council also felt that the Development Partners' own agendas had weighed heavily in the selection and design of projects and programmes.

Progress and Achievements under the Health Sector Strategic Plans

Strengthening Council Health Services
The CHMT of Mwanza City Council consists of eight members, five of which are women. Furthermore, with ten co-opted members and nine support staff, the total number of staff is 27. The CHMT is headed by a newly appointed City Medical Officer for Health (CMOH). They are located in a very run down old hospital building, with little office equipment. Main activities: planning and budgeting, supervision of HFs, distribution of drugs and equipment, ensuring/re-allocating staff, M&E, implementation of plans, follow up. Activities are compromised because the CHMT has only two old vehicles to cover more than 100 HFs (public, FBO and private).

Achievements

- Department of Health now feels it is part of Local Government. This means accountability is increasing. City Director does not think the separation of technical (by RHMT) and financial/administrative (by City Council) supervision is a problem.
- Considerable progress has been made in health planning and monitoring in the context of devolution. CCHPs have been made consistently since 2000, using MOHSW guidelines. The Roadmap to Maternal Health is also used for planning. CCHPs comprise both block grants and BF.
- Overall the CHMT was happy with the CCHP and there was nothing they would change if given the chance. Guidelines were found to be helpful.
- The CHSB was established in 2005. Five members were elected by the community and seven were appointed by the council. Three of the twelf members are women. No faith-based representatives, which is problematic given the significant role of FBOs in Mwanza, but the private health sector is represented.
- Quarterly supportive supervision is done for all HFs and the relationship of HFs with CHMT has improved very recently with the appointment of a new CMOH. Supervision is done as a team, using checklists. Feedback is given and reports are made.
- The number of patients in government HCs is increasing. Women and children are the bigger proportion of users, and their numbers are increasing, possibly because mother and

child health care is exempt from cost-sharing. However, utilisation in the visited dispensary had gone down, due to the cost-sharing.

- Staff at PHFs is, in practice, available 24 hours per day, 7 days a week. Patients do come at night.
- The government dispensary visited has had a Dispensary Committee since 2003 (five people chosen from the village; three women, two men), that meets quarterly and discusses the annual plan and budget, education of the community, as well as problems and complaints that community members have about the dispensary.

Constraints

- Time requirements and costs to produce the CCHP are high compared to the amount of resources planned for. Last year Tsh 13 million was allocated to the development of the CCHP. The CHMT does not keep records of staff time spent, but one group of respondents estimated that thirteen people each spent around 30 working days preparing the CCHP. By this estimate, nearly 400 person days went into the preparation of one CCHP.
- No special efforts were made to involve women in CCHP preparation.
- The Officers in-charge of HFs are not involved in the production of the CCHP, they only send in their plans and budgets.
- Final CCHP is printed in 15-20 copies only. Apart from members of Planning Team, RAS, City Director, PMO-RALG and MOHSW receive it. None of the respondents interviewed in HFs had seen a copy of the CCHP.
- CHMT estimated that last CCHP saw a 50% achievement rate only, mostly due to delayed disbursement of funds for the approved budget.
- The benefits of more sophisticated planning and monitoring for the actual provision of health services have not yet fully materialised.
- CHSB is not really operational and only met three times, and in all cases with limited attendance. CHSB does not have terms of reference and City Council does not seek its advice. On the contrary, existing authorities fear the CHSB is encroaching on their areas of responsibility, and so they are not co-operating. CHSB did not approve CCHPs and they do not have a copy of it. Members do not know whether they are entitled to a budget, but did receive sitting allowances. "What we are doing is of no use," said one of the members of CHSB.
- HFs of the same level are allocated the same amount of funds (e.g. Tsh 740,000 for a dispensary, whether rural or urban) irrespective of the number of patients they see.
- There is no council hospital in the City Council, but a HC is being upgraded, funded by GFATM, to serve as council hospital (with 96 beds). Up till now the regional hospital also functions as council hospital and the 35% of basket funds earmarked for the council hospital is thus allocated to the regional hospital. This amount will be allocated to the new council hospital once functional, leaving the regional hospital with lesser resources.
- Despite the multitude of guidelines, some HF in-charges are not conversant with how to access collected user fees. CHMT has no accountant to assist with this.
- Several respondents felt too many reforms were going on at the same time.

Central Ministry of Health

Achievements

- Central MOHSW produced a wealth of guidelines and organised training.

- RHMT gives feedback to the City Council on the HMIS data and on the CCHP. They are also responsive to specific requests for advice. Initiative has to come from the CHMT, however. CHMT needs the regional level mainly as a channel to pass on problems/complaints/requests to the MOHSW.

Constraints

- Due to still unanswered audit queries RHMT Mwanza Region has not received operational funds for the last 3 years and has therefore hardly undertaken any visits to the councils.
- The last time the council received support from the RHMT was in 2004. They considered the supervision useful. The RHMT used to clear doubts, correct issues and would go together with the CHMT on supervisory visits to the HFs. They miss new inputs now – the fact that RHMT is not coming anymore leaves a big gap. RMO also thinks supervision is necessary, because without it the CHMT becomes lax. An indication of the latter is that they nowadays only supervise around 30% of HFs per month, while the target is 75%. Actually, it is not clear why the RHMT is not supporting the City Council, because there is no (or limited) need for fuel or per diem in this case. They could go on supervision with the CHMT, as the latter has money for it.
- Many of the problems in the districts are attributed to malfunctioning of the central level, in particular lack of (timely) disbursement of funds.

Hospitals

There are two hospitals in the City Council, a national referral hospital and a regional hospital. These are situated less than 5 km apart. This section only deals with the regional hospital.

Achievements

- Number of patients using the hospital is increasing, for both general and special clinics.
- Six hospital staff underwent training in health sector reform very recently. Staff can answer for specific issues when probed, but are not aware of the package of hospital reforms.
- Since 2005 the hospital has had a board comprised of ten people (two women, eight men), including religious leaders, politicians and business people. The Board meets quarterly and is felt to have been helpful and supportive of the hospital.
- The Hospital Management Team consists of six men and six women that work well together as a team.The HMT makes appropriate decisions without interference from the Board or RMO.
- A good relationship was reported between the hospital and RMO, who is an advisor on the Hospital Board and attends clinical sessions at the hospital. RMO intervenes in disciplinary actions and administrative issues when invited by the hospital.
- Hospital annual planning was done for the first time in 2005; it was not done in 2006 and then done again in 2007, using MOHSW guidelines. Monitoring of the plan is done mid year through internal review meetings.

Constraints

- Due to the lack of a council hospital and the presence of a referral hospital, the regional hospital functions at a lower than expected level and is seriously overcrowded.

- Although a start with hospital reforms has been made, overall development is slow. Respondents indicate that support from central MoHSW is limited. The changes that have been implemented are more the result of local initiative than of national guidance.
- Shortage of qualified staff and congestion due to insufficient space to provide services result in client dissatisfaction.
- There are no specialists, so specialist services at the hospital are provided by (A)MOs and COs who have received additional short course trainings in a given specialty. It has proved difficult to recruit specialists, as many prefer working with NGO projects/programmes.
- Quality assurance procedures are in place, but because of scarce resources sometimes standards are compromised, e.g. prescriptions depend on drug availability in the pharmacy.

Central Support Systems

Drugs and supplies

Achievements

- Mwanza City Council has been on the indent system since 2005. Stakeholders consider this an improvement, because more HFs now receive the drugs they want/need.
- There are no complaints about the quality of the drugs supplied by MSD. Quality is checked by the TFDA.
- At the Mwanza zonal store there are 26 permanent positions, 25 of which were filled at the moment of interview. They used to have more people employed, while the workload used to be less. This implies an efficiency improvement (but qualifications of staff have increased, so the HR costs involved might not be different from before). All staff has been extensively trained.
- CHMT does supervision and inspection of private pharmacies and drug shops. Drug Inspectors reportedly confiscate publicly procured drugs if such are found in private HFs or pharmacies.

Constraints

- The Zonal Medical Store cannot effectively deal with drug orders: there are many complaints about stock-outs (often 50%); shortages have increased last year; prices are sometimes higher than in private market; delivery time is 12 weeks from the zonal store to the district. If MSD cannot provide, and CMOH does not provide additional drugs, patients have to buy the prescribed medicines privately. This means patients pay twice, because the fee they pay at the HF already (in principle) includes medicines.
- The drug allocation with MSD for the hospital covers only about 20% of the need and is not based on burden of disease and case load. Using user fees to buy additional drugs the hospital is able to meet about 50% of the total drug demand. The gap is covered by patients buying drugs from private pharmacies themselves.
- Drug storage in all facilities, except the government HC, was reasonable, but shelves are generally not marked. FBO HFs have better supplied and organised pharmacies.
- Two CSOs mentioned that some government HF staff take drugs when they are received from MSD and sell them for profit. The Drug Inspectors could reportedly easily be bribed.

- Some essential supplies for a hospital like ether (for anaesthesia), radiography and laboratory reagents have not been provided by MSD for a long time.
- There are still a lot of drug vendors on the streets.
- RMOs have officially requested to break the monopoly of MSD to provide drugs for the public sector and get the money for drugs in their own accounts.
- Mwanza City Council has decided to open its own medical store. A building has been renovated for the purpose. CHMT will buy drugs from MSD and in the market. HFs will be able to order/buy them cash and carry from the user fees they collect.

HMIS

Achievements

- A nurse midwife in the CHMT has been responsible for the HMIS since 1999, on which she spends 60-70% of her time.
- Completion rate of HMIS reports has increased from 60-70% before the reforms to 90% now. The increase is due to training of HF staff in HMIS, supportive supervision and regular meetings to discuss data with the Officers in-charge of HFs. Supervision has also improved quality of data. HF staff have improved understanding of the importance and meaning of data collection and provide better reports. The general feeling is that reporting requirements are useful.
- CHMT also receives full HMIS reports from FBOs and private sector facilities.
- HMIS at council level has been computerised, but government HFs have not, not even the regional hospital.
- HMIS data are now guiding the planning process, e.g. data allow comparison of BoD between different areas in the council and enable establishment of district mortality rates. The hospital uses data to determine disease burden and purchase extra drugs.
- Vital statistics have become more reliable (CMOH guess 80%), as VHWs and CHWs inform nearest HF about births and deaths – but especially neonatal deaths are still often missed.
- There are two sentinel surveillance sites: one for malaria and one for HIV/AIDS.

Constraints

- HMIS does not collect data disaggregated by gender.
- Data gathering puts a high demand on the HF staff.
- Some HFs have no staff that has been trained on HMIS.

Infrastructure and equipment

Achievements

- There has been a big increase in the number of health facilities. Especially the number of private and FBO HFs has increased.
- All facilities look clean, even when run down.

Constraints

- Grading of HF using standard MOHSW criteria shows that in 2004/05 out of 92 HFs 28 were good, 37 fair and 27 bad. Despite this, only limited renovation of HFs has taken place in the City Council.
- Of the 26 government HFs only 10 have running water, only 9 have electricity.
- Only about 40-50% of required equipment for HFs is in stock at MSD. While insufficient, this is better than it used to be. Special orders take a long time. So the CHMT uses block grants or Council funds to buy the necessary equipment in the market.
- Hospital staff is not aware of a list of standard equipment against which the hospital could be measured.
- Equipment from MSD is said to be of lower quality and expensive relative to private suppliers.
- Preventive maintenance of infrastructure and equipment does not take place. Maintenance is done according to emerging needs. The only equipment that benefits from regular, scheduled maintenance are CD4 count and radiography equipment, as this is centrally organised and financed.

Transport

- According to the CHMT there is an ambulance available for free transport of emergency cases. However, at the HFs the evaluation team heard that patients often have to pay for their (public) transport and those costs form a serious barrier, in particular for referral to hospital.
- Patients still walk up to 7 km to come to the nearest dispensary

Communication

- Communication has improved. Only 3 of the 26 public HFs lack communication equipment. Health workers use their own mobile phones when needed.

Other

- Overall, private and FBO HFs look better than public ones, are better stocked on drugs, and some have computer facilities. Furthermore, private and FBO hospitals were relatively better maintained and equipped.

Human Resources

Achievements

- Mwanza City Council received 23 new posts in 2006, recruitment was done by MOHSW, but not all have reported for duty.
- An open performance appraisal system is being developed. The appraisers have been given three day training.
- The Lake Zone Training Centre has roughly doubled its capacity to take in students for Diplomas in Pharmacy, Radiology and Laboratory.
- The Lake Zone Training Centre is financed through an annual government grant (25%), donations from the Touch Foundation (USA) and cost sharing (student fees) which used to

be Tsh 160,000 but increased in 2005 to Tsh 400,000. 80% of student's fees are paid by employers. The actual cost of training an individual student is Tsh 800,000.

- Both short and long term in-service training opportunities exist. Almost all of the long-term training, e.g. upgrading of COs and nurses, is self-sponsored. Short courses and training workshops are funded. Council Health staff spends about 5% of their annual working time in training and workshops. Selection of trainees is based on the nature of training, the wishes of the organizer of the training, and priority is given to those who have not yet attended. Health personnel in private sector and NGOs are invited to short courses organized by the council at no cost.
- HF staff have job descriptions.

Constraints

- Despite allocation of new posts, the City Council still experiences staff shortages. In the government HC the gap between staff requirements and existing staff is at least 60% for AMO, CO and other technical staff. All dispensaries are understaffed, some have only two staff.
- Several respondents said enough people are trained, output of schools is OK, but they are not employed – many qualified people are jobless.
- Districts are not empowered to decide on important components of HRH: they cannot determine their own needs, they cannot recruit, change staff or reward good performance.
- Some FBO staff has left to the public sector for better salaries and other incentives, but NGOs also do topping-up, which attracts some. It seems that in Mwanza, exit from FBOs to public sector is not yet a serious problem.
- Probably due to the upgrading programme for PHF staff, they are away on long and short courses as well as attending workshops as much as 40% of time. Excluding long courses, the absence is about 20% of time. At the regional hospital about 10-15% of staff time is used in trainings and workshops. In the government dispensary visited, the three staff estimated they had been on training only 1-2% of time over the last 8 years.
- Annual pre-service capacity to train nurses (40) and AMOs (50) has not increased over the years.
- The Lake Zone Training Centre has a shortage of classrooms and student housing, clinical preceptors, teaching aides and tutors. Retraining of tutors is inadequate. Sustainability of donor funding uncertain.
- One CO mentioned that decisions about who can go for training are not always taken upon merit.
- CHMT staff do not have official job descriptions.

Health Care Financing

Achievements

- Cost-sharing for PHFs was introduced in 2005.
- Since 1999 more money has become available for council health services.
- Percentage of user fees over total facility budget is higher for hospitals than for HCs and dispensaries, and they are free to use it. For the regional hospital, user fees constitute about 10%.

- Private sector shows sense of community solidarity by having variable fee rates depending on patients' income levels.
- Exemptions are adhered to, with the exception of elderly who can afford to pay. No serious abuse of exemptions was reported. More people are asking for exemptions. CHMT is doing awareness raising and community mobilisation on the right to exemption.
- NHIF covers 15-30% households in Mwanza City Council.
- CHF has been introduced. Uptake is still low, but increasing.
- The regional hospital modified payment procedures (with support from the board) so payment is made at one point, and patients move with a receipt to respective service points, rather than having multiple points of payment.

Constraints

- There are no systematic records of how many exemptions and waivers are granted in which categories, but the CHMT estimates that around 75% of health services provided are exempt or are provided to people who have a waiver. Collection of user fees in government HFs is therefore minimal.
- HFs are not reimbursed to cover for exemptions. HFs are informed that the refund for exempted services and waivers is included in their drug allocation from MSD.
- PHFs are also not reimbursed for patients with NHIF cards. NHIF pays the council, but the City Council does not pay the HF back.
- While prices are generally posted at government HFs, exemptions are not.
- All FBOs and private HFs visited operate almost exclusively on collected user fees. User fees seem to be higher in CSOs, where patients often pay for each service separately, than in public HFs, which use a lump sum payment for all services needed.
- The private facility visited applied all government exemptions, but did not receive any reimbursement for this, while one of the FBOs did not apply the exemption policy.
- CHF concepts are not well understood by people, and many cannot afford it.
- The procedure to request cash from the Council to spend against approved budget is supposed to take two to three days, but it usually takes two weeks, sometimes up to one month. This hampers implementation.
- CHMT has experienced pressure to spend block grants and BFs on non-health activities. For example, last year CHMT had an approved budget to fence the city dump site and to renovate CHMT building. All this money was taken to build a school. 2006 was the worst in this sense, but it has happened before.
- Mwanza City Council has to prepare separate accounts for basket funds and block grants and for other sources of income.

Public Private Partnership

There are numerous NGOs active in health in Mwanza. The team counted at least ten. There are also many FBO and private HFs, as well as the Catholic Bugando Medical Centre (one of the four referral hospitals in the country), a Hindu Hospital and a private hospital. While in Mwanza, the team visited several of these (see list at end) and attended a PPP Forum meeting for the Lake Zone.

Achievements

- The CHMT has a list of all CSOs in Mwanza City Council. Main FBO partners (who share budgets with the City Council) are ELCT, ASCT and RRC. Among NGOs, Plan

International, CARE and AMREF provide information on activities and budget for the CCHP.

- According to the CCHPs, one representative each from FBOs, NGOs and private HFs have been involved in planning health activities for the district. The CHMT requests all NGOs and FBOs to send their annual plans and budgets for inclusion in the CCHP. Using what is called the "Lead Agency Mechanism", the CSSC has selected one FBO in each council to represent their sector on the Planning Teams.
- CHMT licenses and inspects FBO/NGO and private facilities. CHMT is supervising all HFs, also FBOs and private, and all provide HMIS data.
- There is information sharing.
- Service delivery in the FBO and private facilities has expanded and improved, resulting in higher utilisation rates over the evaluation period.
- The City Council was helpful towards one private hospital in allowing importation of medical equipment without customs or duties.
- Several respondents felt co-operation between government and private HFs has improved, in particular with regard to HIV/AIDS services.
- CSOs are requested to aid in vertical programme activities and receive e.g. vaccines for that, but their time is not compensated. FBOs say government gives them tax exemption in return for this public service contribution.
- Some CSO staff benefit from free inclusion in government training programmes.
- For the last two years, the City Council has held “Quarterly Meetings” with all FBOs and NGOs. According to stakeholders, this works very well and has achieved better division of work and more transparency.
- The previous Regional Commissioner of Mwanza with a 15 person committee of business people, politicians and religious leaders mobilized all working population in Mwanza city to contribute a minimum of Tsh 10,000 a year for two years. In this manner, about Tsh 3 billion was collected. This was used for building, equipping and expanding key infrastructure at the Regional Hospital, including building a new laboratory, mortuary, new general ward and extended the maternity unit. This increased the range of services offered and decongested BMC.

Constraints

- Not all CSOs forward their plans and budgets to the CHMT to be included in the CCHP, and CSOs do not seem to be actively involved in much of the planning, and are not involved in the monitoring of implementation.
- None of the CSOs interviewed were in possession of any of the CCHPs. Only the representative of the private hospital had actually seen any of the CCHPs because he is also a member of the CHSB.
- Some FBO staff have left to the public sector for better salaries and other incentives. However, it seems that exit from FBOs to public sector in Mwanza is not yet a serious problem.
- The Voluntary Agencies receive only 5-10% of the BF resources, falling short of the allowed spending range of 10-15% for VAs.
- No CSO has a service agreement with the government, but both the City Council and FBO and private HFs expressed interest when presented with the concept.

HIV / AIDS

Achievements

- A wider range of interventions are being done. People are seeking care and treatment sooner than before, and more people have been mobilised to seek HIV testing. There are 14 VCT sites in Mwanza City Council. There are more VCT, PMTCT, ARV treatment activities than before.
- HIV/AIDS services like PMTCT, VCT are advertised and provided for free in government HFs. Staff have been trained and services are integrated with regular services.
- There is close collaboration and joint planning between the CHAC and the DACC. The CHAC has a bigger budget than the DACC, but the DACC has more experience and offers technical support to the CHAC. The roles of CHAC and DACC are clearly separated with different reporting lines.
- AIDS activities are included in the CCHP and in the supervision by CHMT. However, not all HIV/AIDS activities by NGOs and CBOs are listed in the CCHP. Plans for large NGOs like AMREF are mentioned in CCHP.
- The home based care activities are coordinated by the City HBC coordinator but implemented mostly by FBOs like ELCT and CRS, and NGOs like CARE.
- There are quarterly coordination meetings between the City Health Department and NGOs and FBOs engaged in AIDS activities.
- ARVs are available in the district and treatment is offered from five centres in the city that include government, FBO and private HFs. All needed ARV drugs are available and there is a three month advance stock and a one month buffer stock.
- More than 4,000 people use ARVs. Drugs to treat opportunistic infections are also available.
- In Mwanza there are three agencies with functional HIV/AIDS workplace programmes and they are all private (including Coca Cola and a fishing company).

Constraints

- There are many effective responses to the epidemic, but these are not spearheaded by the City Council, and do not seem to be due to the incorporation of HIV/AIDS into the HSSP2 strategy.
- The City MO curative was previously doing home visits and supplementation for PLWAs but this was stopped because of lack of transport.
- CHMT and government HFs do not have workplace programmes for HIV/AIDS.
- Human resource shortages and overload – staff that have been trained for various AIDS services also have other duties in the HFs .
- The HMIS demands for the AIDS services are additional to the other information and reporting formats.
- Despite increase in services, remote areas remain largely un-reached. Not all high risk communities are reached.

Health Access, Service Quality and Outcomes

Some of the trends in health outcomes that the evaluation team was able to observe or ascertain in Mwanza City Council include the following:

- Immunisation coverage has improved
- Outbreaks of epidemics like cholera, meningitis have decreased
- Malaria mortality has decreased, though morbidity remains high
- Delivery in HF has increased though maternal mortality remains high.

Development Partnership

Direct Project Funding

According to the information available to the evaluation team, only one bilateral development partner has had direct projects or programmes in Mwanza City Council over the evaluation period.[1] Similarly, GFATM is the only GHI reported to fund activities in the City Council, and this may be channelled through TACAIDS. In addition to this, several CSOs - including Colombia University, Plan International, CARE, AMREF and CRS - are present or fund activities in the City Council. Almost all external funding seems to be directed at HIV/AIDS, while malaria is the leading cause of morbidity and mortality.

Harmonisation and alignment

Given the limited presence of bilateral Development Partners and GHIs, this issue was not addressed directly in any of the evaluation team"s interviews. However, harmonisation and alignment issues also, to some extent, pertain to CSOs.

Two years ago the CHMT, on its own initiative, established a series of Quarterly Meetings for all stakeholders in the health sector. The CHMT finds this is working well, but no others referred to it. According to the CHMT, these meetings have produced a better division of work and more transparency on the activities of different stakeholders. It is unclear whether this has resulted in any real harmonisation of the activities of the CSOs or closer alignment with council procedures.

Aid modalities

Respondents emphasized that the Basket Fund is highly predictable (in terms of getting the funds) and very much appreciated. Significant delays have occurred, however, in the disbursements of Basket Funds. Apart from the Basket Fund, GFATM is the largest source of revenue for the health sector in Mwanza City Council, followed by AMREF. The CHMT is only aware of some of the project funds that are flowing into the City Council, and whatever they are informed about is reflected in the CCHP. The CHMT regretted that some CSOs do not disclose the details of what they provide. Such assistance is truly off-budget.

[1] Danida's *District Demand Driven Capacity Building* is currently the only separately funded Development Partner health project in the City Council.

Monitoring and evaluation

The evaluation team heard nothing to suggest that monitoring and evaluation is harmonised among the DPs, CSOs and City Council authorities. On the contrary, the PPP Forum for the Lake Zone did make the point that there is no such thing as joint monitoring by the City Council and CSOs of the implementation of the CCHP.

Technical assistance

Reflecting the near absence of Development Partner funded projects in the City Council, technical assistance did not come up in any of the interviews of the evaluation team. However, the evaluation team did meet with the only long-term TA posted to the City Council by one of the Development Partners (Danida Health Advisor, Mwanza Region).

Trends in aid modalities and structures for cooperation and dialogue

The City Director felt that the Basket Fund was "much more friendly" to the users. Especially its longer time horizon and continuity were appreciated. The Basket Fund was seen to make the health system more sustainable and to generate more ownership by the Local Government.

The MO in charge at the Regional Hospital pointed out that it was very difficult for the hospital accountant to comply with the formats and requirements of each Development Partner (in this case, CSOs). He also pointed out that they were quite happy to work with their external partners; their workers learned something and capacity building took place. They did not want to have all support through the Basket Fund, even if this were possible. In other words, the current mix of aid modalities suited the Regional Hospital.

The DMO informed that the Health Block Grant and the Basket Funds were kept on the same account. He found this to be a problem because it was difficult to ring fence the resources to prevent misuse of the Basket Funds allocated to health priorities. To solve this problem, the DMO and CHMT want to keep these funds on separate accounts.

Aid modalities and civil society

The PPP Forum expressed the view that DPs' movement away from projects in favour of the Basket Fund and general budget support had caused the closure of some FBO operated activities in the Lake Zone. Some FBOs were active before, advocating for changes in the health sector. As their funding has dried up, their voices are not heard as much as before.

Although there has been the participation in the preparation of the CCHPs as prescribed in the guidelines, their overall involvement was seen (by the CSOs participating in the PPP Forum) to be limited.

Burden on Time of Staff

Mwanza City Council does not keep records of how much staff time is spent to comply with the requirements of Development Partners and CSOs in connection with different aid modalities. However, there is little doubt (within the evaluation team) that the Basket Fund has reduced the burden on the time of district health staff. Nevertheless, if the time required for the preparation of the CCHP is taken into consideration, then the gains in reduced transaction costs may not be as apparent.

The CHMT is aware of GFATM spending (directly or indirectly) in the City Council. The evaluation team was informed that GFATM requires separate reporting, accounting and auditing. The CHMT stated it would prefer if GFATM reporting etc. could be fully incorporated into government mechanisms. GFATM has its own objectives and the CHMT has to plan according to these. The CHMT, however, does not see this as a problem.

Persons Interviewed or Participants in Workshops

NAME	POSITION
Mwanza City Council	
Emmanuel Kalobelo	Ag City Director
Daniel Kimaro	DMO
Mathias Kapizo	City Health Officer
Xavier Tilweselekwa	City Human Resources Manager
Alindwe Ndosi	Nurse Midwife / HMIS Coordinator
Reward Moshi	Pharmaceutical Technician
Monica Makolobela	Assistant Accountant
Regional Administration (Mwanza)	
Chistonphere Nyuhalula	Ag RAS
Regional Health Management Team	
Dr. Herbert Bhwana	RMO
Jafley Machebya	AG Regional Nursing Officer
Dominique Luboja	Regional Health Officer
Rehema Masalu	Assistant Matron
Dr. Juliana Mgalula	Ag Medical Officer in charge
Donatha Ollomy	Hospital Pharmacist
Winifrida Byesigwoa	Maternity Ward
Council Health Management Team	
Dr. O. Kilero	City Medical Officer
E. Mahani	City Nursing Officer
Sosthenes Kulwa	City Pharmacist
Reward Moshi	Pharmacy Technician
Yared Msonjili	Laboratory Technician
Alondra Festo	City Reproductive & child Hlth cord
Asia Swedo	Health Secretary
Mary Rusassa	Assist. RCH coordinator
Isabella T. Minga	District AIDS Control Coordinator
Bugando Medical Centre	
Rt. Rev. Aloysius Balina	Chairman of BMC Board Bishop of Shinyanga
Charles Majinge	Director General
Sekou Toure Regional Hospital	
Dr Kajiru E. Mhando	MO In-charge
Dr Juliana Ngalule	CTC In-charge
Mr Nzilenta P Tizeba	Hospital Pharmacist
Mr Thobias Mashiba	Hospital Accountant
James M. Msomi	Hospital Patron
Dorosella Njunwa	Hospital Secretary

Mwanainchi Private Hospital

Dr Invokavit J Mushi	Proprietor

Members of CHSB Mwanza

Justus S. Masalu	Chairperson
Paulina A Nkoma	Member
Natus Magori	Member

Butimba Health Centre (Govt)

Assumpta John	AMO In-charge

Aga Khan Health Centre

Harris Magawila	Administrator
Dr. Neema Chami	Medical Officer In-charge

Sahwa Dispensary

Obedi Makene	Officer in Charge
Isabela Mbilikira	Public Health Nurse
Mariam Mdogo	Maternity Attendant

Kilombero Private Dispensary

Jackson Wambura	Clinical Officer
Brigitha Kajugusi	Senior Nurse Midwife

Nyakahoja Dispensary (FBO, RC)

Sr Cynthia Menezes	Sr i/c Nursing Officer
Emmerenciana Mashiku	Executive Health Sec

Nyakato Ward

Mathias Masegeng'he	Ward Executive Officer (Nyakato)

MSD Mwanza

Valey Borongo	Warehousing Supervisor (MSD)
Kazimira Constantine	Warehousing Officer

AMREF

Josepa Masanda	Project Officer
Medard Rwakatare	Project Assistant
Nicolaus Shilangila	Project Assistant
Obed Mrita	HR & Administration Officer

Lake Zonal Training Centre

Dr.Noamaba SE	Deputy Principal Lake Zone Training Centre

Bugando School of Nursing

Violet Rugangi	Nurse Tutor

Bugando School of Pharmacy

R. Tibabuka	Head, School of Pharmacy

Lake Zone PPP Forum

Dr Shedrack Watugala	MO i/c Mkula Hospital, Ag Health Director AICT
Domina Katunzi	RHMT Kagera representing RMO
Christine B. Ntangeki	PPP Focal person Kagera
Willbald Rugaragamu	Medical Coordinator BCD Kagera
Emmerenciana Mashiku	Executive Health Secretary Archdiocese of Mwanza
Dr Justine S. Ngenda	RHMT, PPP Focal person Mara
Dr Marlene Krag Petersen	JPO/HSPS/HSRS, MoHSW DSM
Dr Valentino Francis Bangi	RMO Mara
Dr Ulomi S. S.	RMO Shinyanga
Rev. Aloysius Balina	Bishop of Shinyanga
Dr Ibrahim I	DMO Kwimba
Dr H E Bhwana	RMO Mwanza
Dr D Morona	CSSC Technical Advisor Mwanza
Dr R D Mbwambo	CSSC Coordinator Mwanza
Dr Emmanuel B M Mwandu	MO i/c Kolandoto Hospital and Lead Agent Shy Muni
Gunneweg, Pieter Paul	Technical Assistant HSPS Lake Zone

Njombe Council, Iringa Region

1. Overall Sector and Program Relevance

1.1. Health Sector Strategies Relevant to Council Needs and Priorities

All 9 strategic areas mentioned in the PoW and the HSSP-II are relevant to the needs of the population in Njombe council and reflect local priorities. A separate strategy for HIV/AIDS was found useful (see under HIV/AIDS).

1.2. Appropriateness of external support to district needs and priorities

As most external support to Njombe comes through the Basket Fund, it is used to finance the CCHP, which reflects district needs and priorities. Additional support for HIV/AIDS is highly relevant, as not all much needed activities could be implemented under the current ceilings for HIV/AIDS budget within the basket and the district council's own funds. Some technical assistance is provided in the form of Finnish specialists and interns working in the FBO hospital. Their skills are certainly relevant and also benefit the government services. There is also some technical support through the externally funded HIV/AIDS activities.

2. Progress and Achievements Under Health Sector Strategic Plans

2.1. Strengthening Council Health Services

Achievements

Health services in Njombe council have improved over the evaluation period in the following aspects:

- In the early days of devolution health staff had problems to accept the authority of the Council in health matters, but these have been overcome (DED).
- Reforms have increased the responsibility of the CHMT and they are now more accountable to the people (complaints of public are being dealt with by the DED, both by discussing issues with health staff and providing more finances to solve the problems).
- Collaboration of CHMT with other Council departments has increased: the engineer is involved in building HFs, the community development officer is involved in community mobilisation for health (probably CHF), the Council HR Officer is involved in promotion and training and of course the financial department deals with the budget and expenditures.

- CCHPs have been produced since 2003.
- A CHSB has been established in 2004, consisting of 12 people: 5 ex officio Council staff (including the DMO, who is the secretary), 4 community members (selected by Council after advertisement), and 1 representative each from FBO, NGO and private sector (self-selected). Council staff cannot vote. One member is also on the Hospital Board and serves as liaison. A budget line for the CHSB has been included in the 2007/8 CCHP for the first time.
- The council has more funds for health since 2004, when they started receiving money through the basket fund, also reflected in more funds for the hospital.
- Each HF seems to have a HF Committee representing the communities it serves.
- Better relationship between the PHF and the communities – communities have more trust in govt PHFs now and drive demand.
- Utilisation has increased, in public, FBO and private dispensaries, HCs and hospitals.
- Due to upgrading of staff, more illness can be dealt with at the dispensary and HC level, resulting in less referrals to the hospital.
- Supportive supervision takes place – each PHF is visited at least once a month by one or more CHMT members. They used to only assess the situation, but now discuss issues and solve problems, give feedback, assist on technical issues, inform about HSR and sometimes also consult village leaders and VHWs. The latter could not be confirmed in Lwangu.
- Patient load in the Njombe Council Hospital is 100 to 130 out patients per day; OR of 174 beds is 90-95% and ALOS is 7 days; 60-80 deliveries are done every month. Demand for services is high and increasing due to increased range of services offered, affordable fees for admission, presence of a theatre, free services according to exemptions, improved drugs availability, improved facilities for investigation (lab, X-ray), and improved availability of qualified staff with more positive attitudes. The hospital therefore also receives more complicated cases than before.
- Hospital does outreach activities to villages and school health activities.
- Hospital funds from all sources have increased – basket, council's own sources, donor partners, and user fees. The hospital adheres to the exemption guidelines and up to 40-50% of services provided at the hospital are exempt. About 20% of users are members of the NHIF.
- Heads of department in the council hospital received training in hospital reforms during 2003/04. The hospital has prepared an annual plan since then, using MOHSW guidelines. The present process of developing plans is better: more people are consulted and involved. Staff find it helpful to plan for the whole year, set targets and monitor the changes.
- Since 2003 there has been a hospital board. Activities planned but not implemented are explained to the board, hospital board members have constructive ideas and they are a channel of communication for concerns of the community and users. MOHSW guidelines have helped to clarify roles and responsibilities of the Board and HMT, so there are no conflicts.
- There is improvement in laboratory capacity, about 70% of needed tests can now be done at the hospital laboratory.

Constraints

- HFs have not been involved in CCHP planning – they just send in their plans (made together with the village(s). They do not receive feedback on their plans and

have never seen a CCHP. Unique HC or dispensary needs are not always included in the CCHP, partly because costs go beyond the ceilings. Sometimes this is solved by spreading the costs over subsequent years.

- Up till now the CHSB has had no funds for its functioning (transport, sitting allowances, refreshments, copying etc.). They had 5 sessions out of 12 (supposed to meet quarterly), and forwarded some four advices to the Council, but they did not receive any response, not even acknowledgement of receipt. The one time they received a budget to approve, they did not approve it, because of mistakes in the figures and not all resources were budgeted for. They sent it back, but never saw a revised version. CHSB did not receive any training on governance, only a one day seminar, explaining their tasks.
- The hospital achieves only 50-60% of plans and targets set, largely due to delays in funding.
- Diagnostic possibilities in dispensaries are very limited, because there are no laboratory facilities. There are no standards for a district hospital to assess how its lab is performing.
- All patients come in the morning, compressing workload and increasing waiting time. It is difficult to introduce an appointment system, because of lack of communication and erratic public transport.
- Outreach activities by dispensaries are hampered by lack of transport (only bicycle)
- Hospital receives many road accident cases (is along a main road), but not well equipped to handle them.

Other

- Additionally to their standard tasks, CHMT mentioned as their roles to ensure good relationships between the community and the HF, to deal with complaints and to resolve conflicts between facility staff.
- Scheduled visits of a surgeon and O&G specialist to the council hospital (from regional or referral hospital) would greatly enhance the services, as surgical and O&G cases are the most commonly referred.

2.2. Changing Roles of the Central Ministry

Achievements

- Despite the financial constraints encountered (see below) the RHMT meets monthly.
- Four RHMT members still spend around 80% of their time on the RHMT activities, the other 3 only around 15%.
- RHMT and its co-opted members do all activities that do not need cash, such as assess plans and progress reports of the councils and advise CHMTs by phone or fax. However, members can only go on planning or supervisory visits to the councils, if they find funds somewhere to finance fuel and per diem costs. They used to go quarterly to all districts, but now only team members who receive funds from vertical programmes can go regularly. The others have gone 1 time per year on average.
- RHMT members are involved as trainers and facilitators in the PHC Institute in Iringa and several other training institutes in the region.

- RHMT organised a regional Health Services Meeting once a year (instead of twice), for which they mobilised funds from different partners.

Constraints

- Questions were raised as to the timing of reforms, as it was deemed undesirable to introduce all of them within a limited period. Council staff simply cannot keep up with all the new developments, guidelines, changes in procedures etc. that come from the centre. There does not seem to be enough time to consolidate changes and assess their effectiveness, before they have to turn their attention to the next reform. There is a need for prioritisation among reforms/reform areas, as well as for a slower process of phasing in.
- The major constraints in the functioning of the RHMT are financial, as the operational funds have not been made available by the RS. The RHMT makes annual plans, their budgets are approved (21 B Tsh for current FY e.g.), but they do not see the money. There were audit queries, but these have been answered. Given the financial constraints the Iringa RHMT can only implement part of their activities.
- Within the RS the funds for the social sector cluster are pooled and there is no formula to allocate funds to the health section.
- Although all RHMT members have received a 3-week management training to support the districts, they lack skills in areas as ICT, research, evaluation, QA, health financing, financial management, lobbying etc.
- Staff in the management cluster of the RS (accountant, economist, local government officer and community development specialist) are supposed to support other clusters, but that is not happening.

2.3. Hospital Reform

In the context of the visit to Njombe district staff of the **regional hospital in Iringa** was interviewed. This section describes the findings for that regional hospital.

Achievements

- Due to the fact that the Officer in charge of the hospital is on the national hospital reform committee, the regional hospital has started several reforms.
- A Hospital Management Committee and Hospital Therapeutic Committee are in place and meet monthly; a health board and client charter provides information to hospital users and allows inputs from users on different aspects of hospital management; a long-term business plan has been produced; annual plans are made bottom-up in a participatory way, based on the MOH guidelines, using objective and results-based planning and financing; quarterly meetings to review progress are held.
- Utilisation has increased over the years, because the population has increased, but also because the hospital is better equipped and staffed, provides new services such as PMTCT and VCT, and mass education has sensitised people on the availability of specialists (a gynaecologist, surgeon and an AMREF Flying Doctors cardiologist for 4 days every 2 months).
- PPP has increased: there is more cooperation and respect between NGOs/FBOs and the public sector; they are involved in planning and FBO specialists in the

region support the public hospital; the hospital has service contracts with institutions and private companies to provide services to their staff; several non-clinical activities have been contracted out.
- With respect to health financing, the hospital's main (steady and predictable) income is through the NHIF, as 40-50% of all patients seen are covered by the NHIF, generating about 2/3 of hospital revenues;
- The hospital has opened 2 private wards, generating additional income.
- As for external support, the hospital has managed to attract additional funds from CUAMM (Italian Cooperation) and has a twinning relationship with a hospital in Italy; FHI funds ARVs and supports the CTC clinic.
- The hospital bought its own computers.
- The hospital organises bi-annual meetings with stakeholders outside the health sector, such as the water dept, RAS Office and MPs who live in Iringa.

Constraints
- Limitations on BF spending are perceived as a constraint.
- Not all relevant hospital staff have been capacitated yet on planning.
- Because there is not enough difference between the capacity of the Mbeya Referral Hospital and Iringa Regional hospital they refer patients to the Muhimbili National Hospital in Dar es Salaam.
- Because there is no district hospital in Iringa, the regional hospital also functions as such.
- Patients also come for services that could be provided at HC and dispensary levels, because the hospital does not charge a bypass fee.
- Although the % of vacancies has decreased, there still is a human resource gap, due to bureaucracy of the recruitment system (qualified people are available) – establishment for nurses is considered too low (1 per 10 beds, none extra for OPD).
- Increase in government salaries has resulted in FBO and private staff moving to the public sector, which decreases the quality of services in FBO and private HFs.
- As a matter of principle the hospital asks every patient to pay; only if they say they are not able to pay, an exemption or waiver will be granted upon presentation of evidence.
- Hospital does not receive feedback on the data provided for the HMIS.

2.4. Central Support Systems

Drugs and supplies

The Zonal Medical Store in Iringa caters for two regions: Iringa and Ruvuma. Renovated buildings look in good condition. Store looks well organised and clean. System of first expiry, first out for drugs and first in, first out for other supplies is used. There is a large cool store and a separately fenced and locked area for addictive drugs and ARVs. 19 staff, 2 on long-term training, no vacancies. Sixty percent of turn-over is cash and carry for FBOs/NGOs, for which they process 6-7 orders per day. All government orders are forwarded to and packed in Dar es Salaam.

Achievements

- Much more and more relevant drugs (and supplies and equipment) are available now than a few years ago.
- ILS system for supply of drugs and other commodities, including those for most vertical programmes, was introduced as a national pilot in both Iringa and Ruvuma in 2005.
- The system is computerised (Wide Area Network).
- Zonal store, RHMT, CHMT and i.c. of HFs all agree that the pull system is better, because push was insensitive to local needs and resulted in stockpiles of expired drugs in PHFs, which have now disappeared.
- Zonal store delivers 100% of ARVs within 1 month (according to policy)
- According to the CHMT there are hardly any complaints anymore about drugs – PHFs mostly receive from MSD what they order.
- Prices of MSD goods are generally lower than those in the market.
- Also in the council hospital the new ILS system is appreciated and preferred, and 90% of hospital drug needs are met by MSD. If an item is out of stock with MSD, user fees are used to buy it in the market. Prescription practices are influenced by which medicines are available.

Constraints

- A push system is still used sometimes for FP commodities.
- Majority of staff in the zonal medical store still needs to be trained .
- On average 20-30% of drugs ordered cannot be delivered. Items can be out-of-stock for anything between a few days to 6 months. According to the RHMT 30-40% of commodities for the regional hospital are out of stock at any given time. According to FBO HC in Njombe MSD can supply 60% of their needs.
- Public HFs face a problem, because their allocations by the MOHSW might be less than needed, or there is no money against the allocation.
- Allocated funds in the MSD account, that are not used due to stock-outs, cannot be taken out to purchase missing items in the market, but can be carried over to the following year.
- Sometimes WAN is not working due to intermittent power supply, leading to delays in order processing.
- In Njombe council there is a lack of equipment, due to the sharp increase in number of facilities in the past 3 years.

HMIS

Achievements

- According to the council hospital and the dispensary visited the HMIS system is now more understandable and easier to use. Amount of work is manageable.
- At the CHMT and Hospital HMIS data are entered in the computer.
- Meetings to discuss HMIS reports with HF in-charges are useful, because they give direction (but these are not held regularly apparently).
- All FBO and private HF data are collected and included in the HMIS.

Constraints

- It is time-consuming for CHMT staff to follow-up mistakes in the data with the HFs. More training of HF staff and CHMT is needed to prevent and correct these mistakes. When HF staff is properly trained demand on their time would also diminish.
- Reports from HFs are regularly delayed.
- CHMT does not regularly discuss, compare or analyse HMIS data, although some is used for the CCHP. The focal person does report to the DMO when she notices something out of the ordinary.
- Feedback from higher levels is restricted to administrative issues, such as missing data. There is no support or feedback for data analysis and use, apart from a one-off meeting in 2003 organised by the RHMT. The HMIS focal person had not seen or used the Annual Health Statistical Abstract.
- Apparently the questions on drugs in the HMIS books are not pertinent anymore once the ILS is in place, but they have not (yet) been adapted. MOHSW is probably waiting till the whole country is on ILS.
- Although the CHMT has the HMIS data in the computer, hard copies or diskettes are sent to Iringa and MOHSW, because the CHMT is not on e-mail.

Other
- Njombe does not have a sentinel surveillance site
- The RCH coordinator is the focal person for the HMIS. She spends around 40% of her time on the HMIS, but data entry is done by 3 other (trained) staff, who each spend 10% of their time on this, making the total time investment 0.7 full-time-equivalent (without analysis, comparison and feedback).

Infrastructure

Achievements
- In Njombe 22 new dispensaries were constructed by the communities over the last 3 years and given to government to staff, equip and run them. The Council paid for the staff and the MOHSW for drugs and equipment.
- Other HFs have been renovated through the Joint Rehabilitation Fund; 28 dispensaries and 2 HCs are presently under renovation. There are 220 villages in Njombe and 92 HFs: 4 hospitals, 11 HCs, 77 dispensaries
- In the hospital number and types of equipment have increased. Maintenance is either done locally, by the referral hospital in Mbeya or from Dar es Salaam.

Constraints
- None of the rural PHFs have electricity from the grid, and only 10 have solar power.
- None of the rural PHFs have running water inside the facility, but they do have water close by.
- Preventive maintenance is not yet happening.
- Government PHF do not have telephone or other means of communication. In emergency cases staff use their private mobile. Internet is not available at CHMT or government hospital, only in Ilembula Lutheran hospital (provided by MEMS).
- Although government HFs have improved, FBO and private HFs generally look better and have more facilities, drugs, supplies and equipment.

Transport

Achievements

- The team heard mixed accounts on public transport – some said it has improved, which makes for easier access to the HFs – others said there was no improvement. Transport during the night is impossible.

Constraints

- Transport to the hospital, when referred, can be very costly – a multifold of the treatment costs.
- CHMT has had transport problems, hampering supervision of HFs, but TACAIDS has provided a vehicle.
- The hospital never had an ambulance and uses regular vehicles to transfer patients to Mbeya or Iringa, but per 1 July 2007 the Council will provide an ambulance.

2.5. Human Resources Development

Achievements:

- A good number of staff have been or are being upgraded, from Clinical Assistant to CO, from CO to AMO and from AMO to MO.
- Staff have job descriptions. The open performance appraisal system (OPAS) was introduced to replace the annual confidential forms, requiring staff to set quantifiable objectives, targets and plans against which they will be assessed.

Constraints:

- There are now bigger staff shortages than before, due to increased population, many more HFs and higher demand for services. Salary increase has improved the situation, but at the moment about 60% of established positions especially for MO, AMO and CO are vacant. The district has 22 established posts for AMOs to work in HCs and has none in post. All HCs are run by COs. Njombe is not benefiting from the emergency recruitment programme, because it is not a peripheral council.
- Example of workload: in the dispensary visited, the CO and nurse auxiliary see 25 patients a day, 2-3 each night and 5-6 over the weekend. They are always on call. When they attend a delivery during the night, they continue to see patients in the morning, then go to sleep in the afternoon.
- Retention of staff is hampered by lack of staff housing, electricity and/or water in the HFs and the cold climate.
- The new staff appraisal system is not yet completely understood or applied, because not all staff have been trained yet.
- Financial support by the district for long and short courses is limited, but DMO tries to enable by temporarily replacing staff on training.
- Promotions do not always follow length of civil service (seen by CHMT as something that creates problems between staff, but could be an achievement, if promotion is based on performance)

- Staff from FBO and private health facilities want to join government, because of higher salaries, possibility to get loans, improved retirement benefits and more training opportunities, which is posing serious problems for FBO facilities.

Other

- In Njombe (and other rural areas) the open recruitment procedure did not result in enough applicants and councillors doing the interviews did not possess sufficient skills and "professionalism". They therefore asked MOHSW to go back to the old system, whereby staff is posted by the MOHSW to a certain location. So they voluntarily gave back their power to hire, but retained the power to fire.
- The national target to phase out unskilled staff by 2007 was not reached by far. In the view of the CHMT this is also not possible, because they do a lot of work and are not redundant.
- The council budgets and plans for training by the ZTC in Iringa. Courses are affordable and relevant to needs. A number of district and hospital staff are trainers or TOT for the ZTC.

2.6. Health Care Financing

Achievements

- After the CHSB, HMT and communities were sensitised and trained on CHF in early 2006, the scheme was officially launched by the District Commissioner in all 40 participating government dispensaries in June 2006. The Officers in-charge of dispensaries were trained in cash collection in Nov 2006 and the scheme started operating in Jan 2007. The Lwangu VHC interviewed said that people accepted that services could no longer be free (which they had been up till then), although the FGD participants presented a mixed picture on the issue of costs of services.
- Several HFs have started to provide better services for patients who are willing to pay more (private, self contained room)
- Several HFs have signed a service contract with private companies
- After complaints about hospital staff asking patients for money under-the-table this was discussed, 2 people were fired and signs put up all over the hospital. DMO thinks it does not happen anymore.
- Health finances are regularly audited (both internally by the DC and externally).
- The CHMT in Njombe does not have any problems with retrieval of cash for activities. The Council has contracts with preferred suppliers of fuel, office materials etc. CHMT procures what they need for their approved activities and the Council is billed directly by the supplier. Although some checks and balances are in place, the system does not seem fraud-tight. But it has the advantage that the CHMT can always implement their activities without having to wait for funds.
- According to the DMO the CHMT has had no experience with misuse of funds earmarked for health or pressure to use these funds for other purposes.

Constraints

- Uptake CHF has been limited, but is expected to increase after the harvest in June, when farmers have more cash.
- CHF contribution can not be paid in instalments.

- There is confusion on the procedures for approval of proposals by HF committees to use the funds collected as CHF contributions and user fees, resulting in no funds yet having been used.
- The School Health Coordinator, who coordinates the CHF in Njombe, only received a 2-day training from the MOHSW. Her information was not up-to-date.
- HFs keep track of the total number of exemptions and waivers granted, but not by category. These figures are not sent to the council level, making it impossible to evaluate the exemption policy. However, the increase in HIV/AIDS and HIV services has certainly resulted in an increase in exemptions.

Other

- The Lutheran hospital gets 85% of its revenues from user fees, NHIF and NSSF. They also receive staff and bed grants from government (about 50% of beds is 'approved' for this purpose), and the 10-15% of the BF for VAs. The church now only owns the HFs, but has no resources to run them. In principle they ask everybody to pay for services, but poor people will be treated for free, if they cannot pay. Because the hospital is close to a main road, they receive many accidents – this is a burden on the hospital because they pose a financial risk. The Anglican HC also sustains itself from user fees. Only HIV+ patients, staff and first degree relatives are exempt.

2.7. Public Private Partnerships

Achievements

- Staff from the Lutheran hospital have been involved from the beginning in the CCHP planning process, their ideas are included and they possess a copy, but no other FBO facilities, NGOs or private sector agencies were involved.
- Some NGOs are members of health committees (DED) – relationship has improved, we now speak one language, they feel more recognised.
- While CHMT previously only supervised public HFs, they now supervise all FBO and private HFs as well, which has resulted in higher quality services (less non-licensed HWs, increase in knowledge)
- The Anglican HC, and Marie Stopes Hospital receive support in kind from the CHMT (such as equipment, fuel, vaccines + refrigerator, vitamin A, contraceptives and training). The government HC sends complicated deliveries to Marie Stopes, as the latter has an AMO. Marie Stopes does tubal ligations, implants and IUDs as outreach service in numerous government HFs in Mbeya and Iringa regions. The Lutheran Hospital receives the 10-15% for VAs in cash and procures the goods themselves, according to the CCHP.
- The Council recently signed a service agreement with Marie Stopes to conduct outreach services on RH and Child Welfare: the district will pay all operational costs, except time of Marie Stopes staff involved.
- The Tanganyika Wattle Company is supporting a number of infrastructure, water and electricity projects at government HFs.

Constraints

- Anglican HC and Marie Stopes were never involved in the CCHP planning process, but CHMT did discuss the annual plans of Marie Stopes and other NGOs with them.

- Due to salary raise in public sector, 5 out of 23 staff of the Anglican HC have recently resigned and moved and the Lutheran hospital lost 36 people to the government in 2006 (in 2005 19 people resigned). Staff of the Lutheran hospital that is approved for staff grants also received increase in salary (delayed), but this created an internal equity problem. The Lutheran hospital therefore increased the salaries of their own staff. Marie Stopes has also increased staff salaries to stay above government salaries, in order to prevent staff leaving to the public sector.
- Up till now no service agreements have been signed between FBOs and government.

Other

- Anglican Diocese of SW Tanganyika has recently filed a proposal with MOHSW for salary top-up by the GoT for their health staff. The Anglican HC Committee in Njombe town mentioned that, although quality in the government HC has improved, they still think the Anglican HC performs better, because the waiting time is less ("we do outreach"), the facility is better laid out and cleaner and all essential drugs are available, while at the government HC the price is lower, "but you don't get everything you pay for". Although in principle there is no competition between the 2 HCs, which are close to each other, because they have agreed on serving different villages, in practice there is some patient flow from the government to the Anglican HC, mainly because of less waiting time.
- Also Marie Stopes thinks that government HFs have improved, while there still is a shortage of drugs and equipment. They used to get many patients from government facilities who were unhappy with prescription of quinine for malaria, but since government HFs have ACT that has stopped.
- There are several private dispensaries in Njombe council, particularly in Makambako, a town at an important cross-roads. Private facilities seem to charge very similar fees as public HFs. They earn money from a mark-up on drugs and laboratory services. The private HF visited would like to be more included in district activities, be allowed to buy drugs from MSD, have more training opportunities etc.
- The FBO hospital orders drugs from MEMS (Mission for Essential Medical Supplies) for the hospital and for the Lutheran PHFs in Njombe and neighbouring districts. MEMS supported the hospital with computer, printer and Internet access and also advises on drug use in relation to case mix. MEMS delivers in 2 weeks at the doorstep and are more reliable than MSD (from which the hospital used to procure their drugs and supplies).
- The influence of the Lutheran Church on the daily operations of their HFs has become much less: "The professionals are now in the driver's seat". The Church is still involved in the recruitment of higher cadre, but religion is no longer a recruitment criterion.

2.8. HIV/AIDS

Achievements

- Having HIV/AIDS as a separate strategic area in HSSP2 was considered positive, because it resulted in a higher priority and additional funding for HIV/AIDS activities (outside the basket and council's own funds, which both have a ceiling for what can be used for HIV/AIDS activities) without compromising other activities.

- Additional funds from DPs (through CUAMM and FHI) have supported setting up of CTCs, drugs for opportunistic infections, training of staff, technical assistance, reagents and equipment for laboratories and improvement of infrastructure. Access to CTC services has increased and an increasing number of people are on ARVs.
- DACC and CHAC roles and responsibilities are clear and clearly divided. The establishment of a CHAC position relieved the DACC of multisectoral duties, allowing more time to be spent on the health and medical aspects. A number of activities are planned and implemented together.
- A high profile District HIV/AIDS Committee has been established to oversee and coordinate the council response to the epidemic. There is also an NGO forum in Njombe council.

Constraints

- Njombe is a big council with transport problems. Not all who need HIV/AIDS services are being reached – only three sites offer ARVs for example. AMREF is considering to start mobile VCT services.
- Home-based care to back up the HF services is not yet well developed.
- Current response is focused more on treatment and care and less on awareness and prevention of infection. Staff needs to receive additional training in behaviour change communication skills. Behaviour change is sometimes hampered by negative attitudes of FBO staff to condom use.
- The ZTC in Iringa has not been consulted or involved in the training, while this is a major component of support for HIV/AIDS.

3. Health Access, Service Quality and Outcomes

Achievements

- Geographical access has improved because new dispensaries have opened (both public and private), and old ones renovated, increased, and public transport has somewhat improved.
- Access to hospitals has improved because number of beds have increased.
- In urban areas provider choice of people and therefore competition has increased.
- Overall quality of service has increased, due to upgrading of staff skills and supportive supervision. Renovation and construction have also improved the physical quality of the HF premises. Men and women in all four focus discussion groups indicated an improvement in cleanliness of HFs, attitude of staff, waiting time, availability of drugs, and capacity to deal with malaria.
- Number of women that deliver in health facilities has increased.
- The number of admissions and case fatality rate for malaria are decreasing due to improved treatment and increased use of bednets.

Constraints and barriers

- Financial access has somewhat decreased since the introduction of the CHF and at the same time user fees for those who do not contribute to the CHF. Because women benefit more than men from exemptions financial access is less of a problem for them than for men. In general costs have increased, but people appreciate that more value for money is now obtained.

- Exemptions and waivers are not advertised. Because no relevant records are kept about the number of exemptions and waivers not much can be said about whether the access of vulnerable groups has improved or not.
- Key health outcomes (IMR, CMR and MMR) as presented in the three CCHPs available for Njombe district seem to be unreliable, as figures jump up and down, and figures for a specific year differ widely in different CCHPs.
- Maybe because the number of TB admissions has decreased, the case fatality rate has increased over the years.

4. Development Partnership

4.1. Direct Project Funding

- Direct external support in Njombe council is only given to NGOs and FBOs and the overall significance of this external support is very limited compared to the total district health budget.
- The council receive supplies for care and treatment of HIV positive people, including ARVs through FHI.
- Marie Stopes Hospital receives external support from its HQ in London.
- The Ilembula Lutheran hospital receives some support from private donations and has two Finnish specialists and medical students working there.
- The regional hospital receives support from Cuamm (Italian Cooperation) and has a twinning relationship with Vicenza Hospital since 2004 (received equipment, renovation and exchange of staff).
- The Regional Hospital makes use of AMREF Flying doctors programme.
- Support by private companies is increasing. The Wattle company improved hospital infrastructure.

4.2. Development Partner Harmonization and Alignment

The CHMT approaches all organisations active in the health sector to discuss their plans and budgets and incorporates them as much as possible in the CCHP. However, not all organisations provide the requested information. There is no formal coordination mechanism during implementation of the CCHP, but members of the CHMT seem to be in regular contact with individual FBOs and private sector HFs.

4.3. Aid Modalities

The bulk of the health funds are received through the block grant and the basket fund. The CHMT receives all funds earmarked for health in the district plan and passes on part of the funds to the FBOs. GFATM funds are received through those channels as well.

4.4. Monitoring and Evaluation

In as far as DP funds reach the district through separate organisations (such as FHI, CUAMM) they are accounted for separately by those organisations. However, as the activities are done in close collaboration with or by government staff, they are monitored through the regular mechanisms.

4.5. Technical Assistance

Apart from the Finnish specialists there is no technical assistance in the council.

4.6. Trends in Aid Modalities and Structures for Cooperation and Dialogue

The District is very content with the extra income through the Basket Fund, but FBOs are less happy, because they used to receive more directly from the donors than what they are now getting through the BF. Discussions on (dis-)advantages of different aid modalities seem to be absent. There is no direct dialogue with DPs in the district.

4.7. Participation by Civil Society in Goal Setting and Planning

Obviously the fact that the FBOs now receive their DP funding through the government basket fund, increases their involvement and interest in goal setting and planning at the district level. This seems to be restricted, however, to the FBO hospital. Lower level FBO HFs, as well as international and local NGOs, are not actively involved in planning.

4.8. Burden on Time of Staff

DPs were hardly present in Njombe over the evaluation period, so not much has changed.

Composition of CHMT Njombe Council

Core team (6 men, 1 woman)
DMO
Health Secretary
Health Officer
Nursing Officer
Laboratory Technician
Asst Dental Officer
Pharmaceutical Technician

Co-opted members (6 men, 7 women)
District AIDS Control Coordinator
TBL Coordinator
Malaria Coordinator
Eye disease Coordinator
RCH Coordinator = HMIS focal person
Cold Chain Coordinator
Continuing education Coordinator
School Health Coordinator = CHF Coordinator
Physiotherapist
MO i.c. of district hospital
Matron of the district hospital
AMO i.c. of FBO hospital
Accountant

Facilities and agencies visited	**Type**	**Location**
Regional Administrative Secretary		Iringa
Regional Health Management Team		Iringa
Regional Hospital		Iringa
Zonal Medical Store		Iringa
PHI Institute/ZTC		Iringa
District Executive Director		Njombe
Council Health Management Team		Njombe
District Hospital	Govt Hosp	Njombe
Ilembula Hospital	FBO Hospital	Ilembula
Marie Stopes Hospital	INGO Hosp	Makambako
Urban HC	Govt HC	Njombe
Anglican HC	FBO HC	Njombe
Hekima Dispensary	Private disp	Makambako
Lwangu Dispensary	Govt disp	Lwangu village
FHI	INGO	Njombe
Health Committee Anglican HC		Several villages
Village Health Committee (12 members)		Lwangu village
CAST Groups of 12 men and 14 women		Lusisi village
CAST Groups of 11 men and 11 women		Mdandu village

Persons Interviewed

Name	Title Position
Iringa Region	
Bernard M.N. Nzungu	Regional Administrative Secretary, Iringa
RHMT Iringa	
Dr Ezekiel Y. Mpuya	Regional Medical Officer Iringa
T. Likangaga	Regional Health Officer
Dr Oscar Gabone	Regional Dental Officer
Joseph Kinigu	Regional Lab Technologist
Robert Chiteji	Regional Nursing Officer Iringa
Adeodatus M Mhagama	Regional Health Secretary
Dionisia M Ngatta	Regional School Health Coordinator
Sospeter N. Magambo	Regional Pharmacist
Iringa Regional Hospital Staff	
Dr Oscar Gabone	Regional Hospital In-charge & Dental Officer
Ibrahim J. Kaminsa	Principal Clinical Officer, In-charge OPD
Dr Ngalla S. Mwalusamba	AMO Medical Department
Dr Abbas Y. Nsgenzi	ADO Dental Department
Chrispin B. Mpangala	PMR i/c OPD Records
Dr Kevin Mtega	Public Health Specialist Medical Dept
Rustica Tungombe	Matron i/c Nursing Department
Alphoncina Kaduma	Nursing Officer Antenatal Department
Fatuma Waziri	Nursing Officer Obstetrics and Gyn Dept
Teodosia Mbele	Nursing Officer Postnatal Ward
Nuru Ligonige	Nursing Officer OT Dept
Evaristo Lupumbwe	Radiographer Radiology Dept
Huruma Mwasipu	Dental Technician Dental Department
Andrea N. Mwinuka	Nursing Officer VCT Counsellor VCT Unit
Estherian M. Shimiyu	Nursing Officer OPD
Vivian Mfuru	AA Mhasibu
Dr Paul J. Luwanda	AMO/DVO In-charge STI/Skin/CTC
Sinai Lunyungu	Nursing Officer Psychiatric unit
Joyce Mbamba	Principal Nursing Officer Paediatric Unit
Florida Mhomisoli	Principal Nursing Officer Eye Clinic
Nguruka R.M	Health Officer Environmental Health
Adelina Rugabandana	Nursing Officer
Adeodatus M. Mhagama	Health Secretary Administration
Dr Rugakingira Geros	In- charge Medical Department
S William	NHIF
PHC Institute Iringa	
Dr John S. Mosha	Ag Director PHC Training Institute Iringa
Mr Damian Mwamwongi	Administrator PHC Training Institute Iringa
Zonal Medical Stores Iringa	
Andrew Kanyika	Warehouse Officer/Ag Area Manager
Njombe District	
District Council	
Mohamed J. Mkupete	DED Njombe
CHSB	
Augustino Mbanga	Member CHSB – District Councillor for Njombe Town
Sylvester Udope	Member CHSB – FBO representative
Wilson Mwigune	Member CHSB – MO private practitioner

CHMT	
Dr. John Ruanda	DMO Njombe District
Michael Banyemaa	Health Secretary CHMT
Abbey Nyagawa	Lab Technician CHMT
Emmanuel Makambaza	Asst Dental Officer CHMT
Beatrice Wilson	Pharmaceutical Technician CHMT
Patrick Msilwa	DACC Njombe District
Anzinwise Duma	RCH coordinator/HMIS focal point
Maria ……	School Health Coordinator/CHF Coordinator
Njombe District Hospital MT	
Patrick Msilwa	In-charge Clinical Officer
A. Mlimbilah	Matron
R. Mwiguva	Nursing Officer
R. Mpete	Nursing Officer
C. Nyalusi	Nursing Officer
W. Payovela	STN
C.N. Tossy	Senior Orthopaedic Technicians
F. Mgimba	Lab Technician
Njombe HC Board & IC	
Edward Mhagana	Secretary CCM, Member HC Board
Partson C. Kabutu	Mkurugenzi SHD, Member HC Board
Onolina Chang'a	MAM, Member HC Board
Omary S. Mwakasege	Katibu BAKWATA, Member HC Board
Elizabeth Mtaki	Head teacher, Member HC Board
Christina P. Mwambeta	Nurse in-charge Njombe HC
Thomas A. Mgulisi	HC in-charge, Board Secretary
Leo Tamambele	Chairman HC Board
Lwangu Dispensary	
Leo Crispo	CO i.c.
Lwangu Village Health Committee	
Leo C. Chaule	Katibu
Baseo S. Kigahe	Mhudumu / Afya
Lioba K. Njulumi	Mjumbe zahanati
Valeliana Y. Nichombe	Mhudumu / Afya
Ben A. Kipangule	Mjumbe
Erasto T. Kigahe	Mjumbe
Victory Mayemba	Mjumbe
Kassian I. Kigahe	Mjumbe
Ditrick S. Danda	Mjumbe
Jesco A. Nyangela	Mkiti zahanati
Blasius M. Lwiwa	Mkiti (s)
FBO/NGO/private sector	
Dr Clement Mango	Regional Technical Officer FHI Tanzania
Godfrey Mwang'amba	Clinical Officer Hekima Private Dispensary
Leah Musa Midyelle	Nurse Hekima Private Dispensary
Grace Mhagama	Matron Illembula Lutheran Hospital
Happy Mbwilo	Accountant Illembula Lutheran Hospital
Charles Lunogelo	AMO i.c. Ilembula Lutheran Hospital
Sylvester Udope	Health Secretary Ilembula Lutheran Hospital
Dolorosa Okama	Hospital matron, nurse midwife Marie Stopes Makambako
Benedict Sandagila	CO i.c. of Anglican HC Njombe town
Mary Elias	Nursing Officer Anglican HC Njombe town & Asst

	Secr. of Diocese of SW Tanganyika, Anglican Church of Tanzania
Paul Mnyamagola	CO Anglican HC Njombe town
11 members of HF Committee	Anglican HC Njombe town

Same Council, Kilimanjaro Region

1. Overall Sector and Program Relevance

1.1. Health Sector Strategies Relevant to Council Needs and Priorities

Broadly speaking yes. Interviews (and facility visits/inspections) with the AAS, RHMT, Regional Hospital, DED, CHMT and Council Hospital confirm the need to address continuing issues in hospital and district management, to address HR needs, strengthen supervision, improve drug supply and management.

There are differences of opinion regarding the need for and priority of some strategies such as PPP. There is also a strong body of opinion that health financing, especially establishing a functional CHF at a significant level is important to the district despite the many problems associated with getting it launched (with only eight months experience). HIV/AIDS is a strong priority for HF staff interviewed at all levels so there is some rationale for the investments in HIV/AIDS programming. However activity in reducing MMR seems low compared to the challenge and its stated importance in Mkukuta and recent priority statements at national level. Elements of efforts to improve maternal mortality were noted including an apparently recent emphasis on improving antenatal care by focusing on higher risk mothers and by improving life saving skills of staff conducting deliveries (at hospital level).

The volume of resources and programmatic activity being devoted to HIV/AIDS is remarkable in the region and district and some key informants question whether this is distorting priorities. Examples include the construction of a new ward for HIV/AIDS patients at the regional hospital and topping up salaries to health workers involved in VCT services (funded by the Elizabeth Glazer Paediatric Aids Foundation – EGPAF – under PEPFAR).

1.2. External Support Appropriate to Council Needs and Priorities

The evaluation team encountered two main forms of external support to Same council health services: support provided through the basket fund and support to HIV/AIDs originating with PEPFAR but currently delivered through EGPAF. At council level there is no significant direct external support reported. At regional level, however, more support is provided by bilateral donors and international NGOs. External support in project form is overwhelmingly focused on HIV/AIDS (although there has been some activity in malaria programs), to the extent that, for example, the HIV/AIDS related facilities and program areas at Mawenzi regional hospital are visibly better equipped and housed than other facilities and programmes. There are also incentive payments provided to VCT and other workers engaged in AIDS related work at the hospital to compensate them for longer hours.

At the Same council hospital this is also the case but the hospital has a policy to rotate staff through the VCT, PMCT and other works supported by EGPAF funding. RHMT, CHMT and HFs have made various efforts to integrate HIV/AIDS program activities into, for example, the outpatient departments, the maternity wards, the paediatric wards, etc. At a planning/budgeting level there is very little integration however.

In short, the authorities place value on both forms (basket funded and direct funded) but the funds and other support flowing through EGPAF for HIV/AIDS are not integrated into the planning and budgeting structures although there is frequent contact between EGPAF and the two hospitals visited.

EGPAF also has monitoring and reporting requirements outside the HMIS framework and their staff make visits down to the dispensary level to check on program progress and provide support.

It is difficult to reach a definitively conclusive statement on this issue. The main distortion of large and small external funds in HIV/AIDS seems to be to provide a very significant input of resources in comparison to other sectors. Funds that flow through NACP are accounted for in the budget process of the CCHP but PEPFAR funds are not. On the other hand, hospitals at regional and council level seem to be fairly effective at trying to integrate HIV/AIDS services into their functioning departments rather than isolating it in one part of the facility.

At HC and dispensary level almost all newer services cited by facility staff are in the area of HIV/AIDS programming.

Finally, it should be noted that in the area of drug supplies, the large national vertical programs (HIV/AIDS, Malaria, Tuberculosis, EPI, all provide drugs or vaccines directly to the health facility level and outside the indent system of ordering. These are reportedly almost never in short or inadequate supply.

2. Progress and Achievements Under Health Sector Strategic Plans

2.1. Strengthening Council Health Services

Achievements

Positive changes in council health services noted during the 1999-2006 period at both regional and local level include:

- Establishment of the basket fund – highlighted by staff at both council and regional level as an essential component of stable funding and which (along with block grants) makes the budgeting process meaningful.
- Development and implementation of the Resource Allocation Formula which had the effect of ensuring each district of a basic level of funding free from “other” considerations, which meant that favoured districts used to receive much better funding from the center.
- Introduction and support (including training for CHMT members) of the CCHP process which gives a focus to planning and budgeting efforts and which has (they report) improved over time.

- Health service staff training (mostly through short courses) which has helped to upgrade staff skills (but which does not address the problem of human resource shortages overall (i.e. reduce the number of vacancies).
- Establishment of a Council Health Services Board with representation from the community at large, from FBOs and private facilities and with formal responsibility for oversight of health services in the council.
- Establishment of HC and dispensary management committees;
- Reported improvement in supervision of HCs and Dispensaries by the CHMT.

When asked about actual **service improvements** over the period staff at both the region and district point to:

- Improved immunization services, including the cold chain, increased and better mobile clinics serving hard-to-reach areas with a resulting drop in vaccine preventable diseases.
- Better treatment of malaria including malaria among children through availability and use of improved drugs (ACT) and better prevention through ITNs.
- Better care and treatment of HIV/AIDS including better integration of VCT services into other clinics and services at hospital level.
- Better family planning counselling and a slight increase in the use of contraceptives.
- More focused ante-natal care and more informed expectant mothers.

FGD with women villagers in Maore village scored service improvements in cleanliness of facilities (some improvement); attitude of staff (some improvement); some improvement in staff qualifications; large improvement in availability of drugs; and some improvement in ability to deal with malaria and HIV/AIDS, but no improvement in services for labour and delivery. They indicated there had been some improvement in the overall health situation in the community. They saw a strong deterioration in the cost of medical services and some deterioration in their access to lab tests (which they have to pay for at a private clinic).

Constraints

There are, however, important constraints noted to strengthening services (this section deals mainly with changes in planning, budgeting and management rather than with HRH, central support services etc. which are dealt with in subsequent sections:

- Funds transfers are still delayed with the least delay experienced in direct project financing by bilateral agencies, the next most reliable being the basket fund, followed by health sector block grants.
- Some central government resources allocated to the council through, for example, the District Development Grant are subject to changes relating to central government initiatives. As an example, the national priority for building and refurbishing secondary schools meant that resources originally planned for the health service (by the Council under the CCHP) were re-allocated to education. On the other hand there is no evidence that the Council itself is pushing resources away from the health sector. Basically the view of the CHMT

is that it cannot do that anyway because of ring fencing of basket funds and block grants.

- If plans are improved, the improvement of performance will be dependant to some extent on supervision. In Same district there has been a decline in the number of supervision visits by RHMT staff since a reported reduction of funding by PMO-RALG in 2004. Visits are intended to be scheduled quarterly, but Same CHMT reported they had not received one in the past year.
- The CHSB is in a very weak position relative to the CHMT. It is supposed to meet quarterly in its supervisory role but has only met twice in the past two years. Meetings are called by the secretary who is the DMO and therefore are held at his discretion.
- HFs below the district level do not participate in the CCHP process.

Other

The evaluation team tried to track evidence of the Roadmap to Maternal Health without a lot of success. At both the regional hospital and the district level. Reproductive and Child Health coordinators at both level were unaware of it as a specific strategy. They did point to some efforts to improve maternal mortality through:

- Staff training in focused antenatal care;
- Introduction of an audit committee to review maternal deaths in the hospital; and
- An effort to upgrade the operating theatre so that caesarean sections can be performed more safely.

2.2. Changing Roles of the Central Ministry

Achievements

Over the period the region and district have come to see the MOHSW as a source of the following:

- Policies, priorities and guidelines;
- Sensitization and training in health sector reforms especially health financing and the CHF;
- Technical supervision as well as some management responsibility for vertical programmes or vertical elements of more integrated programmes including disease surveillance, immunization, etc.

Constraints

- There is a continuing mismatch between the responsibilities of the RHMT and its financial and human resource capacity which is directly related to the lack of agreement between MOHSW and PMO-RALG on the roles, responsibilities and lines of authority of the RHMT.

Other

- There is less direct contact between the district and regional level and the central MOHSW than expected. It seems that many training and sensitization activities are organized at the zonal level with MOHSW organizing training and

sensitization sessions which draw together regional and district personnel from the zones.
- The staff of regional and district hospitals and other HFs say they still report for technical purposes to MOHSW meaning that MOHSW has responsibility for QA but not for administrative (including financial) matters, except for national initiatives such as the CHF and the NHIF.

2.3. Hospital Reform

Achievements

The regional hospital plan is integrated into the CCHP for Moshi Urban Council while Same hospital is part of the Same Council CCHP. Both hospitals report strengthening in the same areas of the overall health sector reforms such as:

- some improvement in the HR situation (which remains dire) mainly through the reduction of the number and portion of untrained/unskilled staff;
- upgraded laboratory facilities;
- provision of some new equipment;
- some improvements in HMIS;
- rehabilitation and new construction of theatres (Mawenzi regional hospital) and construction of new HIV wards;
- significant improvement in the availability of drugs (from 50% supply to 75%) at the regional hospital; and
- reduced travel costs to transport drugs with the advent of a zonal medical store.

Constraints

- Continuing problems in securing sufficient financing;
- Continued human resource problems (especially recruiting– but not retention)
- Problems in the supply of basic supplies and in the maintenance of equipment;
- Delays and shortages/stock-outs in drug supplies from MSD;
- Despite some reported improvement in the referral situation there still is a major problem of bypassing and Mawenzi regional hospital is very overcrowded, especially in comparison to the Council Hospital in Same and even the HCs and dispensaries visited thus far;
- Continued problems with transport including shortages of ambulances and the high cost of transport for patients;
- Reduced revenues from cost sharing charges as the list of exempted services has been expanded in recent years to cover patients suffering from chronic illnesses including diabetes, cancer and HIV/AIDS.

Other

- It seems that the situation in the regional hospital is one of searching for contributions in the areas where donors (bilateral and NGO) are most interested in making investments. This has resulted in the construction of a new addition to the paediatric ward for acute cases of malaria; a newly constructed HIV/AIDS treatment ward and other initiatives. The result is a patchwork of old and new buildings depending on donor interests.
- At the same time the MOHSW has provided funds for new operating theatres and other improvements (although equipment is not yet available for the new

operating theatre which was not able to be funded this year, reportedly because the supplementary funding for the roadmap was not approved by MOF, as the proposal arrived too late in the fiscal year).

2.4. Central Support Systems

Drug Supply

Achievements

- All those interviewed reported some improvements in the supply of drugs. The hospitals report that the improvement is partly associated with the establishment of a zonal store in Moshi, which reduced the amount of time and effort spent to pick up drugs. At the HC, Dispensary and community level the improvement is associated with the advent in 2003/04 of the indent system which is seen by all as a very significant improvement.
- Reviews of drug availability at Hospital, HC and dispensary level showed reasonably good stocks of ACT for malaria, of vaccines (with an intact cold chain in every facility), and (in hospitals, since they are not allowed below that level) of ARVs.

Constraints

- Improvement in drug supply is reportedly less noticeable at hospital level than at HC and dispensary level.
- There is a persistent problem of MSD shipments either being delayed or not containing from 10 to 25% of the drugs ordered. All facilities visited raised this issue rather strongly but always also said the situation had improved since the period before 2004.
- In most cases the most severe shortages were of reagents for testing, of SP malaria drugs for pregnant women (at the regional hospital) and of x-ray film.

Infrastructure and Equipment

Achievements

- A new hospital surgical theatre and an addition to the paediatric ward at Mawenzi Regional hospital in Moshi (an addition devoted to treatment of acute malaria cases funded by the JMP) have been constructed.
- A number of new laboratory and other equipment and facilities associated with HIV/AIDS programming have been constructed.
- Some improvement in infrastructure has been funded by the MOHSW from central funds but apparently not through the PMO-RALG emergency fund for rehabilitation. The joint rehabilitation fund has been used to upgrade 24 facilities, in three rounds of 8.

Constraints

- The process to upgrade 24 facilities was to be an annual one, but they have only completed one round (after three years) and are entering the second.
- There are persistent problems in communications which has the effect of reducing the effective use of, for example, transport facilities. One dispensary visited was just 6 kilometres from a HC with an ambulance but never contacted

the HC to ask for ambulance services for its patients. All of its referred patients, including emergency patients have to organize and pay for their own transport to Same district hospital.

- There are a number of HFs with very poor physical infrastructure and there are persistent problems of water availability among the HFs below the hospital level. Indeed, more than half the HFs in the district have severe or chronic shortages of water.

HMIS

Achievements

- There is some indication that staff have over time become more proficient in the use of HMIS and all are familiar with its requirements.
- Checks of HMIS documents at all levels of HF show them being compiled and reported to the appropriate level.
- HMIS documents are being compiled and reported by FBO and private facilities.

Constraints

- Health facilities face additional burdens relating to, for example, reporting to EGPAF on HIV/AIDS and, especially, reporting around the CHF (established in November 2006) and NHIF.

2.5. Human Resources for Health

Achievements

Changes noted include:

- Improved pay;
- Better opportunities for training; and
- Some improvement in recruiting, especially the emergency program.

Constraints

- The numbers of those recruited under the emergency programme are not so significant when spread across the whole country and divided by the districts and regions;
- Very limited recruiting benefits of the emergency programme for the regional hospital and for Same council hospital;
- Some of those allocated to the region/district have not reported;
- Some of those who reported were not able to hold out for the three months they had to work before getting their first pay and so left;
- The CHMT and the RHMT report (and provide data) that retention of staff once they are on strength and receiving pay is not so difficult (other than the problem in the first three months noted above). What is difficult is getting staff recruited and reporting;
- For the FBOs and the private service providers the recent increases in the salaries of public health workers has led to direct losses of staff to the government, to take advantage of improved pay and better career development

and training opportunities. This has been confirmed in interviews at Gonza Lutheran Hospital and at a private dispensary. Staff at Gonza noted that a nurse midwife in the government system now receives more than three times the salary of one at the FBO hospital; and

- Despite efforts to establish incentives for staff assigned to remote areas, this has still not been done and so remains a problem.

Other

- Data provided to the team at all three levels indicates an increase over time in patient loads (especially outpatients), while staffing levels seem to have been static or have slightly declined in the period under review.
- The role of the ZTC in Arusha (CEDAH) has been to provide mostly short courses in council health management and elements of the NETTS programme. They do provide short courses to CHMT members in IMCI, Management, PLANREP2, and the Management Cascade. Still very early days yet. What is clear is that CEDAH has increased its capacity over the past 6 years and is able to provide some important support to council strengthening, including a 3 year course in council health management which is divided into 9 months with one module for each month. CEDAH has also been provisionally accredited by the National Council for Technical Education (NACTE) and strengthened its QA systems and processes. CEDAH can contribute to improving HR in two main ways: by providing education for those who teach health professionals (a one year residential course for a diploma in education of health workers) and through short courses aimed at strengthening health systems management and directly improving service delivery. CEDAH is also semi-autonomous in that it is quite successful in submitting and winning proposals for external support and in offering its services on a cost recovery basis to government and individuals.

2.6. Health Care Financing

Achievements

There have been three major changes in efforts to generate sustainable sources of financing for the health system at council level over the period of the evaluation. These include:

- Efforts to improve the operation of the NHIF so that health facilities claim the payments for treating NHIF members and have access to those funds;
- The establishment of a CHF Governing Board and launching of the CHF in November 2006 (with a consequent imposing of cost sharing fees for consultations at HC and dispensary level for those without CHF membership);
- Efforts to clarify the requirements for both the Council (through the DMO and DED) and for facilities to access funds associated with the CHF and other cost sharing funds;
- The basic establishment of the CHF, although still at a very low level in many communities.

Constraints

There are still a considerable number of problems in communication and smooth functioning of these systems (CHF, NHIF and cost sharing). These and the associated evidence are:

- There are problems in the NHIF claims and refunding process in that the funds are deposited with the DED, but HFs do not receive either the funds or an accounting of how they have been used to support the HF where they were generated (in contrast, funds due to Gonja Lutheran Hospital are sent directly).
- There is a problem in the conjoining of CHF and user fees generated at the HC and dispensary levels. These are deposited in the same account at the council level although there is apparently an accounting of which is which.
- There is real confusion at the CHMT level as to the rules about how it can access CHF contributions and the matching funds MOHSW provides. Some felt that these were not accessed because there is a minimum level in the CHF account which must be reached, others said one had to reach a threshold of households enrolled in CHF to access the same funds.
- The introduction of the CHF has meant the imposition of consultation fees (500 shillings) at the HC and dispensary level for non-exempt services for those not enrolled in the CHF. With a relatively low CHF enrolment, most members in the community face more costs (which they do bear) but there is a major problem with the waiver system used by those who cannot pay.
- The waiver system requires those who cannot pay to be certified to receive services for free (as if they were CHF members). In some facilities this is done by having the patient receive a CHF card after being certified as needing aid. In most, the patient goes to the village leadership and asks for a letter to take to the DED to get the waiver. This literally takes months. While HF staff say they treat patients who cannot pay and then seek the waiver forms later, community members indicate "if you can't pay for treatment you just have to die". Either way, the waiver system is not seen as effective.
- The CHF has a scale of annual contributions depending on the level joined (dispensary, health centre or hospital). At the same time, the benefits are not portable, if you join at one dispensary you cannot go to a different dispensary, health centre or hospital as there is no way for them to share data and revenue.
- There are problems in communicating to members that there fee is to be paid annually. If the annual renewal date has passed and they present their cards at the HF they are refused. Thus enrolment tends to drop after the first year. There is a real need to improve understanding of the annual contribution.

If the CHF can be established on a wider basis it does have the potential to provide considerable resources but care has to be taken to devise an effective waiver system if it is not to exclude those who cannot pay (for example HIV/AIDS orphans or students living away from their parents, or the very poor).

2.7. Public Private Partnerships

Achievements

Some changes and positive signs in this area include:

- Accreditation of Gonja Lutheran Hospital under the NHIF and a flow of claims compensation to that hospital;

- An increase of the share of Gonja Lutheran Hospital from 10 to 15% of the council budget for health expenditures;
- Payment by the MOHSW of salaries grants to some Gonja hospital staff;
- Inclusion of a representative of Gonja Hospital in the CCHP planning team.
- Cooperation at a working level between private dispensaries and public ones with, for example, cross referrals depending on who is able to provide services (this is at an informal level).

Constraints

- There is little evidence of an active effort to promote PPP. Indeed there is some evidence of continued competition between the two systems, a competition which is being tilted in favour of the public system.
- The CHMT does not feel that local authorities should take account of existing FBO or private facilities when deciding to build new public ones. In their view, since public HFs often have a wider range of services the community should decide where they are sited and should not have to do without a public facility to protect the interests of a private one;
- Private facilities have not been consulted in the development of the CCHPs or informed of its results;
- The recent increase in the salary (and training opportunities) of health workers in the public sector has had a real impact on FBO and private facilities in the district as they are not able to raise salaries to competitive levels if they are significantly dependent on fees for their income.

Other

Same council seems to illustrate a conceptual problem in the ideal of PPP in the context of current programming (and the use of donor funds) under HSSP2. Since the bulk of sector resources (domestic and external) are devoted to improving the management, planning, operations and service quality (including number of services, availability of drugs, qualifications of staff etc). of the public system and as the public system becomes more used to cost sharing there is an element of competition, at least at the lower levels in the system. To some extent, despite elements of cooperation especially at the hospital level) the continued strengthening of the public system will place it in competition with the private system at the HC and dispensary level. It seems that FBO hospitals have carved an acknowledged place for themselves in the national, regional and council health system but the same cannot be said of private operators or smaller facilities.

2.8. HIV/AIDS

Achievements

There is an unequivocal pattern at regional (Kilimanjaro) and council (Same) level of the introduction over the past 3-4 years of new services in the identification, care and treatment of HIV/AIDS. These are the most visible form of direct improvement in health services in Same Council and at Mawenzi regional hospital. They have included:

- Significant improvements in laboratory equipment for HIV/AIDS testing at the hospitals and the HCs;

- Construction of a large new ward for HIV/AIDS patients at Mawenzi regional hospital;
- PMTCT introduced into hospital, HC and dispensary levels usually integrated into maternity wards;
- Introduction of CTC for HIV/AIDS at hospital levels;
- Establishment of VCT facilities at the hospital and HC level sometimes integrated into the outpatient department;
- Introduction and maintenance of adequate stores of ARVs at the hospital level with connections in diagnosis and follow up down to the dispensary level;
- Ongoing technical support from the Elizabeth Glazer Paediatric Aids Foundation (EGPAF) on behalf of PEPFAR;

Constraints

- A major question must be sustainability over time of these intensive services.
- While NAPC funds are integrated into the CCHP process, funds channelled through EGPAF are not. However, EGPAF does seem to have made an effort to be integrated into some service areas such as outpatient departments, RCH clinics and maternity wards.

3. Access, Service Quality and Outcomes

Achievements

- The main innovation to improve access has been the extension of the system of exemptions and efforts to put in place a functional system of waivers (not as successful as the exemptions which FGD participants had good knowledge of).
- Some improvement in services available at the HC and dispensary level in the public system (see description above). This was noted by FGD participants as one way that the transport system had been made more equitable (dispensaries close to them now had services for which they formerly had to travel to the hospital to get).

Constraints and Barriers

- Unavailability of staff at dispensary level after hours and at night (due to lack of staff housing in or close to the dispensaries);
- The cost of transport, especially for those living in hard to reach villages in the more isolated parts of the district;
- Absence of simple diagnostic tests in some dispensaries which lack laboratory assistants;
- Some FGD participants reported that they were charged for supplies required during deliveries (for example, gloves) which were supposed to be provided for free.

4. Development Partnership

4.1. Direct Project Funding

Direct project funding seems to be most significant at the regional level. EGPAF may be seen as large programme funding rather than direct project funding since it works across the region and is the local manifestation of PEPFAR investments in HIV/AIDS programming. In the sense of a single vertical initiative financed directly by an external agency it has all he hallmarks of project funding. At the same time, the same interviewees often felt that HIV/AIDS was being over-financed in relation to some other urgent priorities including maternal health and treatment of malaria.

4.2. Development Partner Harmonization and Alignment

Few DPs are directly active in this council.

4.3. Aid Modalities

The basket fund is reportedly more predictable, despite reported delays, than other central government provided finances. Direct project funding (EGPAF) is prized by administrators and staff at regional and council level for its direct and rapid disbursement of funds. In terms of predictability and efficiency the next best intervention from the regional and district perspective is the health basket fund followed by development grants to councils which may or may not be allocated to the health sector. The basket fund remains a valued tool for support to the regional and council level.

4.4. onitoring and Evaluation

Monitoring of service quality at the health centre and dispensary level is carried out by the CHMT and the team verified their visits in the logs of the dispensaries (approximately quarterly and sometimes more frequently). They use a fairly detailed checklist and this is discussed in a meeting at the health facility and maintained on file at the District headquarters. EGPAF/PEPFAR does have monitoring requirements which go considerably beyond those of the HMIS.

4.5. Technical Assistance

Other than frequent visits by EGPAF staff there is no resident TA being provided to Same district as far as the evaluation team could determine.

4.6. Trends in Aid Modalities and Structures for Cooperation and Dialogue

See above on aid modalities. From the perspective of the council health system the main priority seems to be to maintain the integrity of the basket fund and block grants for health and to extend the CHF and make better use of NHIF premiums and user fees (the latter are quite often used to pay for drugs missing from MSD shipments to hospitals, health centres and dispensaries. All health sector staff interviewed at RHMT and CHMT level place considerable value on the "ring fencing" of the block grant and the basket fund so that councils must use the resources for health expenditures.

4.7. Participation by Civil Society in Goal Setting and Planning

The CCHP process is clearly not participatory or bottom up. Essentially the CHMT assisted by the medical director of Gonja Lutheran Hospital and the representative of the RHMT prepare the CCHP. HC and dispensary staff indicated they do not participate in the CCHP process and do not receive copies of the plan. Staff did not cite any examples of participation by villages or wards in CCHP development. They did say that the bottom up element in the CCHP process may perhaps come when PMO-RALG facilitates an Obstacles and Opportunities for Development process in the district. This is PMO-RALG's fully elaborated process for bottom up development planning at council level using PRA methods and encompassing all key sectors. As this has not been done in Same there is no way of knowing at this time if it would provide the kind of participation that this issue implies.

4.8. Burden on Time of Staff

Same has never been a district with very extensive bilateral programme or project funding (with the exception of PEPFAR delivered first through Columbia University and now through EGPAF) so it is difficult to comment on this issue.

Persons Interviewed: Same

	NAME	POSITION	PLACE
1.	Mr. Iddi Juma	District Executive Director	Same Council Office
2.	Dr. O. J. Kimnda	District Medical Officer	
1.	Jasper E. Tenga	Chairperson	Council Health Services Board
2.	Elizabeth Mchomee	Member	
3.	Rusaa S. Makenya	Board Member	
4.	Alfred S. Mrutu	Board Member	
1.	Joseph Ndosi	P. Haman I/C	Same Hospital Management Team
2.	Freddy Kaduma	DCCO (EPI Coordinator	"
3.	Victoria Mboya	DRCH Co.	"
4.	Dr. taudesia Kilawe	DDO	"
5.	Conrad S. Kimaryo	DLT	"
6.	Abdy J. Msuya	DHO	"
7.	Rachel E. nota	DNO	"
8.	Modesta S. Mugafy	RCHCO	"
9.	Eliena Joseph	R/HSST	"
10.	Monica R. Nyaki	Matron	"
11.	Edith J. Mosha	N/M	"
12.	B. I. Msemo	Hospital Secretary	"
13.	Halima M. Mgowa	Health R. Tech.	"
14.	Eusebia Kimario	N/O	"
15.	Azania I. Gusoyamah	N/M	"
16.	A. H. Msemo	N/O	"
17.	P. Sekibojy	DTLC	"
18.	Ritha Shija	P. N. M.	"
1.	Chambua E. Nswambo		Maore Dispensary

1.	Yonafika Msangi	A M.O.	Gonja Lutheran hospital
2.	Dorah G. Mtanog	Hospital Matron	Gonja Lutheran hospital
3.	G. S. Mjema	Assistant Treasurer	"
4.	Mary Msemo	Dr. I/C	"
5.	Nasempsa Mhamba	RCHC I/C	"
1.	John J. Kunita		Maore Community Discussion
2.	Credo Stephano		"
3.	Senkondo A. Kabuse		"
4.	Khamisi Juma		"
5.	Juma Karata		"
6.	Peter C. Mrutu		"
7.	Ramadhani H. Kobero		"
8.	Ngabalu A. Kihedu		"
9.	Nathaniel Msuya		"
10.	Elifart Solomon		"
11.	Athuma S. Mrutu		"
12.	Said Chimani		"
13.	Mlughu Omary		"
14.	Bakari Selemani		"
15.	Juma Kalisti		"
16.	Mahandu Mussa		"
17.	Luhwa Abdala		"
18.	Mwl. G. Mbwambo		"
1.	Emmanuel K. ateri	A. M. O.	Rika private Dispensary
1.	Gabian Chuwa	C.O.	Vunta Rural Health Centre
2.	Violeth Chilewa	N/M	"
3.	Elibarich R. Ngoda	C. U.	"
1.	Haika Lyatuu	S/N/ATT	Hedaru Dispensary
2.	Eliakesia Mbise	M/ATT	Hedaru
3.	Rukia John	P. H. N.	Hedaru
4.	Lilian Mlay	M/ATT	Hearu
5.	Mwajuma Fadhili	M/ATT	Hedaru
6.	Scolastica Swai	N/M	Hedaru
7.	Ernest J. Kitururu	SEO I/C	Hedaru
1.	Zainabu Maneno	A.C.O.	Kitivo
1.	Samweli Emchomemku		Bangalala Dispensary Community
2.	Benard Frindiku	Villager	"
3.	Bakari Mkwizi	Villager	"
4.	H. H. Ngaghe	Villager	"
5.	Juma Lusingu	Villager	"
6.	Solomon Omari	Villager	"
7.	Godwin C.	Villager	"
8.	Gadieli Elitayi Mudeme	Villager	"
9.	S. Kilngo Mohamed		"
10.	Mgulu	Villager	":
11.	Elitai Juma Mundeme	Villager	"
	Dennis Mjewa Mrutu	Ward Councillor	
1.	Dr. Mashaka Godwin	Ag. M.O.I/C	CHMT
2.	F. Kaduma	D.C.C.O.	CHMT
3.	V. Mboya	D.R.C.L.C.O.	CHMT

4.	Dr. Tandesia M. Kilawe	D. D. O.	CHMT
5.	R. E. Nzofa	D. N. O.	CHMT
6.	J. J. Ndosi	D. Pharm. Tech..	CHMT
7.	H. Mgowa	H. R. T.	CHMT
8.	A. J. Msuya	D. H. O/P.H.O.	CHMT

Interviews in Moshi/Arusha

	NAME	POSITION	PLACE
1.	Dr. Mtumwa S. Mwako	Regional Medical Officer	Kilimanjaro Regional Headquarters, Moshi
2.	Ruth E. Malisa	Assistant Administrative Secretary – Social services	"
3.	Dr. Eligy Mosille	RAC (Regional AIDS Coordinator)	"
	25.5.2007		
1.	Dr. M. S. Mwako	RMO	Mawenzi Regional Hospital , Moshi
2.	Dr. E. C. Mosille	RACC	
3.	Faustin M. Shayo	RLT	"
4.	Dr. C. F. Irongo	RTLC	"
5.	Dr. L. Shayo	CTC site	"
6.	G. H. Makunzo	Matron	"
7.	J. A. Elisa	R. Pharmacist	"
8.	Kyara, A. S	Reg. Health Officer	"
9.	L. R. Msami	R. H. Secretary	"
10.	Dr. K. B. Sagauda	M. O.	"
11.	Dr. Nduka A. I	RDO	"
12.	Kaale Elihoita	RRCH Co	"
13.	A. Matee	LAB TECH I/L	"
	25.5.2007		
1.	Dr. D. E. Martin	Principal CEDHA	Central for Educational Development in Health, Arusha (CEDHA)
2.	Mr. Daniel Muhochi	Administrator	
3.	Ms. Renata Mwega	Warden	
4.	Dr. Ramadhan Mwampambe	Tutor	"
5.	Dr. Melkiory Masatu	Public Heath Dept	"
6.	James Mwesiga	Tutor	"
7.	Wilson Lendita	Senior Librarian	"
8.	Dr. Catherine Jinun	Tutor – Public Health Dept	"
9.	Ms. Linda Hanai	Tutor – HPEd departments	"
10.	Ms. Evelyn Ndowo-koka	Tutor – public health Dept	"

Singida Rural Council, Singida Region

1 Overall Sector and Program Relevance

1.1 Health Sector Strategies Relevant to Council Needs and Priorities

The health sector strategies are addressing needs and priorities relevant to Singida district, e.g. by increasing the numbers and qualification of health staff, making treatment services free for children under five years and pregnant women, and making malaria treatment readily available.

Other health related priorities like water scarcity, and food shortages and hunger are being addressed by other sectors, central government, donor partners and CSOs, though they remain constraints to health. Physical access, poor roads and low availability of public transport both to the district and within the district remain constraints to implementing health sector strategies and meeting the needs and priorities of the district.

1.2 External Support Appropriate to Council Needs and Priorities

Basket fund is the main funding form for health needs in Singida, and is the preferred funding form as it is more integrated and flexible compared to other forms of external support. Basket funds are often disbursed with delay and unspent monies at the end of the financial year have to be returned. For example, by June 2006/07, 255 of the TShs 301 million had been received, meaning that TShs 46 million are lost to the district. Basket funding for health is ringfenced so cannot be used for other sectors. Even across budget lines, finance committee approval is sought. Quarterly internal audits and bi-annual external audits monitor financial discipline.

The following direct external support has been or is available in Singida: AXIOS is closing down support for the regional hospital after 4 years. Global Fund initiatives are supporting HIV/AIDS CTC activities, mostly at the hospital and a few health centres. Save the Children has just started to work in Singida. WFP, which is also new, is supporting supplementary feeding for children and women. Helen Keller International has been supporting eye care in the district since 1998, but is leaving this year. The local NGO HAPA works in the areas of dispensary and staff housing construction and health preventive work. It is funded by UN agencies, TACAIDS, international NGOs and others.

External support is addressing HIV/AIDS, malnutrition and eye diseases, which is relevant as childhood illnesses, HIV/AIDS, malnutrition, and eye diseases are among the top ten causes of illness in Singida District. AIDS specific support covers essential areas of HIV/AIDS care and infrastructures (at regional hospital and health centres), that are needed but not adequately or completely addressed with basket funding, and therefore additional rather than a duplication and certainly relevant.

2. Progress and Achievements under Health Sector Strategic Plans

2.1 Strengthening Council Health Services

Achievements

- The CHMT in Singida consists of 8 members (1 female) and many more co-opted members. Team work, long experience in the district, support from the district administration and being overseen by a functional CHSB facilitate and guide this CHMT in their work.
- The CHMT has been preparing the CCHP since 1999. They feel the process has become easier, though it remains a time consuming exercise. The process starts in November and is completed in April/May. The new PlanRep2 tool has been used for the 2007/08 planning and is appreciated as an improvement. Guidelines from central MoHSW influence allocations across main categories of the CCHP.
- There is input from the lower health facilities into the CCHP, although their participation is not well developed. Health facilities - through the technical and facilities committees - prepare a list of items for inclusion in the CCHP, but they neither get a copy of the CCHP nor are they informed right away which of their requests to the council were funded. Despite these limitations, the process of contributing to the CCHP has improved work practices at some health centres.
- The DED is recognised by the CHMT as the head, through which communication related to finances, management, and HR issues is channeled to the regional and national levels.
- The CHSB is fully constituted and functional and has assumed a second term of office after successful completion of the first one. CSHB support has improved communication between the LG Council, CHMT, health facilities and communities, and has improved equipments, basic furniture, and access to water and electricity for some health facilities. The Singida CHSB is often visited by other councils to learn from a best practices case.
- Health facility committees are functional. Their input is sought and included in communication between the health facility and the CHMT. Training and orientation for facility committees are essential for their effective functioning. For example, expectations of a new untrained committee contrasted sharply to those of an outgoing committee that had served for 3 years.
- Efforts have been made to improve access to and quality of health services: 1. all HFs, including the remote ones, have at least one staff stationed there; 2. FBOs are supported by seconding staff to ensure they remain functional; 3. drug availability has improved by topping up gaps from MSD kits.
- The CHMT manages monthly supervision to all HFs in the district (confirmed by the HFs visited).
- Some progress in disease occurrence: 1. no cholera outbreaks in past 6 years; 2. measles cases have drastically decreased; and 3. malaria deaths have reduced, though morbidity remains high.

Constraints

- Like other health services in Singida, the CHMT has human resource shortages. CHMT is expected to have 7 core members, but only 2 out of 7 of the present core members are confirmed in their posts. The rest are acting, including for key positions like DMO and Health Secretary. Present members of the CHMT have to assume extra duties to cope with the human resource shortage.
- The human resource shortage is also clearly felt in most health facilities in Singida, as they are led by a cadre lower than the prescribed one. Despite this there is improvisation and service delivery continues. Of the 57 health facilities, only 20 are headed by a CO or an AMO, 29 by a NO/PHN and 8 by health attendants. There is no doctor in the public sector in the entire Singida region.

- Despite increased funding, there are insufficient resources, especially for infrastructure like major renovations of health facilities and construction of staff quarters. Most public health facilities need renovation and staff quarters.
- Maternal mortality remains high. Despite many mothers attending ANC, delivery at home remains common in Singida, and TBAs remain active. Caesarean sections are only possible in 4 of the health facilities in the district.
- In contrast to health facility committees and CHSB, the Regional Hospital Board is absent and local government and community input and voice in regional hospital governance are very low. The CHMT and Council Administration have no jurisdiction over the Regional Hospital; they work through the RMO office. Thus, complaint procedures about hospital staff and services go through a long process and take time to be heard and addressed.

2.2 Changing Roles of the Central Ministry

Achievements

- The human resource needs of Singida for HC and dispensary level staff have been boosted by the Public Service and MOHSW, reassuming the hiring and posting of staff and guaranteeing their payment.

Constraints

1. The facilitative, policy guidance role of MOHSW to regional hospitals and RHMT is not as clear as that to CHMT.
2. Some issues seen as responsibility of MOHSW, e.g., quantity, quality and timeliness of MSD supplies, have not been favourably resolved for districts and regional hospital, despite repeated complaints.

2.3 Hospital Reform

Achievements

- The hospital serves as the regional hospital as well as the council hospital for Singida Rural Council and is also the first point of contact for those who choose to come here for PHC. The number of people seeking services is increasing. The reasons given are varied, including more 'specialists' than in HC, more laboratory services and drugs and presence of special services like CTC. Common disease conditions remain preventable and easily treatable illnesses. With few staff, the emphasis on preventive health activities at the hospital has reduced and there is a greater emphasis on curative care.

Constraints

- The hospital is not adequately staffed or equipped to serve as a regional hospital, while demand for services at the hospital is increasing. There are no doctors or specialists. Specialist services are done by clinical officers with additional training or experience.
- Efforts to strengthen the regional hospital and hospital management team's technical competence, management and governance structures have been slower compared to the district and CHMT. The regional hospital is yet to fulfil its function relative to the other council hospitals in the region and the FBO hospitals.

- Governance - until 3 months ago when a new RMO was appointed for Singida, the hospital was basically self-administered/governed. Not surprising therefore that the efforts by the new RMO to streamline hospital activities are being seen as an encroachment by the hospital management team.
- There is no Hospital Board and the HMT has not seen the guidelines. Note that this is the same council that has a functioning CHSB since 2002 and the in-charge of the regional hospital is a member of the CHSB.
- The hospital has no strategic plan and has produced an annual plan for the first time this year. There is no organized plan or schedule for monitoring the implementation of hospital activities. Opportunities for regional hospital in-charges (and HMTs) to exchange ideas and learning from others are few.
- The ability of Singida regional hospital to provide back up to the HCs and dispensaries and quickly respond to medical emergencies are constrained by lack of transport and by not being linked to the referral network that is being developed by the CHMT. The regional hospital does not have any comparative advantage over the FBO hospitals in the district.
- The future of Singida regional hospital is being challenged by 2 new developments, i.e. the construction of a new (public) regional referral hospital about 15-20 km away and the transformation of one of the FBO hospitals in Singida rural to a DDH, meaning that the 30% the regional hospital had been receiving from the urban and rural councils for serving as a district hospital would no longer be available. Nobody seemed to know what will happen with the present regional hospital.

2.4 Central Support Systems

Drugs

Achievements

- For HCs and dispensaries drug availability has improved over the years. There are sufficient stocks of malaria drugs all year round.
- Quality control for drugs and prescription practices are done at the health facilities and for clients on health insurance. Copies of prescriptions for NHIF clients are sent to Dodoma for scrutiny and if they feel there was poly pharmacy, that amount is not paid and the hospital makes a loss. Thus, poly pharmacy is not done.
- Cost-sharing funds are available as a back-up to purchase drugs from private pharmacies after approval of management or therapeutic committees.

Constraints

- Singida District is still on the essential drug kit system. Compared to six years ago, the availability of drugs has improved, although there are still problems. Some medicines are in excess, while others are in short supply. Supply is not regular, for example, no drugs were supplied in December 2006, March 2007 and May 2007. The irregular supply strains systems and forces staff to ration drugs during shortages to ensure that NHIF and CHF clients get drugs at the expense of those not enrolled [could potentially include the exempted categories]. Sometimes NHIF and CHF clients also have to buy unavailable drugs, a situation that could undermine these schemes in Singida.
- *"If the kits do not come, then we go to DMO, CHMT for supplementation. If they also do not provide, then patients go without drugs"* Ikungi Health Centre staff said.

- Some quality aspects of drugs have yet to be sorted out, e.g., when a box of medicine has a different expiry date from medicine inside the box (health staff do not know which to believe).
- The situation of drugs is more serious for regional hospital than for lower level facilities. The regional hospital reports that only 30% of their drugs and supplies needs are met by the budget allocation. At the same time MSD provides only 70 to 80% of requested drugs and supplies.
- Since prices of drugs have significantly increased since 2006 and the cost-sharing funds have not, the health facilities are getting fewer drugs for the same amount of money.
- MSD only supplies medicines and no technical support is provided to hospitals or districts, even though often needed. This is different from the services offered by MEMS to FBO health facilities.

Equipment

- Equipment from MSD like blood pressure machines is of low quality. There is no guarantee of replacement or refund when they break or stop working within a short time.
- KCMC repairs most of the equipment in laboratories and theatres on scheduled visits. These are supported by a separate arrangement and not the district budgets.

Transport

- There are few transport facilities at the regional hospital. Health centres through CHMT have vehicles that can be used for referrals and outreach services.
- The CHMT has initiated a radio call (mobile phone) system for HCs and dispensaries to call them to transport emergencies to the hospital; however, the system is still plagued by problems and not yet fully functional, as the hospital is still not connected to this system.
- Condition of roads and absence of public transportation are major constraints to accessing and delivering health care.

Laboratory Services

Achievements

- More health facilities are able to do lab tests, and there is a high demand for tests. The demand for laboratory tests is high as over 90% of patients coming to the HC get lab tests (most people want to be tested). "*Those days we used to be given medicine like sweets, but now there is first a test before medicines are given.*" Said a community member Dung'nyi village

Constraints

- Dispensaries are now expected to have a laboratory; therefore, the demand for laboratory staff has increased. Many labs are however managed by lower cadre staff (assistants) and even these are in short supply.
- Quality control and supervision for laboratories has to come from the RHMT and not the CHMT (no capacity in CHMT).
- Shortage of reagents limits the number of tests that can be done at the HC, as reagents needed are not routinely supplied by MSD.

HMIS

Achievements

- The understanding and local usefulness of the HMIS system at health facilities has improved.
- The same HMIS forms are used in public, FBO as well as private health facilities. Reports are regularly followed up and collected by CHMT.
- Most staff has learnt how to complete and use the HMIS system on-the-job. CHMT provides technical back-up during monthly supervision visits.

Constraints

- The demand on time and effort placed to complete the HMIS forms is heavy, especially in OPD sections of hospitals. When staff is few and busy, data collection is compromised. Moreover, the reporting requirements are increasing, e.g. gender disaggregation.
- There have been delays in getting blank forms for OPD, e.g. in 2007 the forms were only delivered in March 2007 so that data from January, February and part of March was lost.
- There is no local technical support to fix computer problems; consequently, the system remains largely manual. For example, the regional hospital computer HMIS system collapsed in 2006 and still has not been repaired, the result being reverting back to the manual system.
- The RMO noted that most staff has a mental blockade to learning how to use a computer, making computerisation in the regional hospital very difficult.

2.5 Human Resources for Health

Achievements

- There are some human resource improvements in the recent 2 years compared to previous years. In 2005/06 11 new health staff positions and in 2006/07 a total of 32 positions have been funded. Despite the creation of positions, it remains hard to attract and retain staff in Singida, as it is considered a hardship post. Of those posted to Singida, less than half come to report and stay. It is estimated that currently 60-70% of positions are filled in comparison to 40-50% 2 years ago.
- Opportunities for promotions are improving. Before 2002 promotions were rare; some health workers have worked 10-12 years with no promotions.
- Improved terms of service in government, including salary, allowances, in-service training and retirement packages, have attracted staff to government.
- Better terms of service in the public sector challenge the private and FBO sector to reconsider their terms and explore more benefits and incentives for their staff. For example, a private facility in Singida town provides call allowance TShs 4,000/= a night, house rent 15% of salary, medical allowance of TSH 10,000/= a month and guarantees bank loans for staff.
- Staff in the CHMT and at HC/dispensary level feel they get their fair share of short training/workshop opportunities.
- Staff that goes for upgrading are more likely to stay in Singida district than new recruits. Is upgrading a potential option for stabilising HR especially in remote districts?

Constraints

- While the numbers of staff recruited in Singida have improved since 2005, there remains an imbalance between staff numbers, expectations and workload. Although

the number of recruited staff is increasing, it is not enough to replace those that die or retire.

- It remains difficult to attract staff to Singida. It is considered remote, inaccessible and poor, but with the roads to Singida improving, this outlook may change. The CO/AMO and MO are harder to attract. Lab technicians, pharmacists and nurse-midwives are also few. HCs and dispensaries with power, piped water, staff housing, access to public transport, access to primary and secondary schools (for health staff's children) are more able to attract and retain staff.
- Though numbers of staff have increased, they are not enough to cover the duty sessions (3 in a 24 hour period) at facilities expected to provide 24-hour services. Thus, in facilities where there is one CO and one nurse-midwife they are on call 24 hours a day, 7 days a week.
- There has been HR movement from FBO to government health facilities, especially for younger staff. In return, retired civil servants are finding work in FBO facilities.
- The opportunities/budget ceilings for upgrading are fewer/lower than the staff that need them, so that courses that are not budgeted for in CCHP are 2/3 self funded.
- ZTC tutors facilitate training sessions organised by regional hospitals, but hospital staff is rarely invited to training sessions organised by ZTC.
- A Form 4 certificate is the minimum academic standard that has been set by government for employment. So many staff without the certificate have to study for and take Form 4 exams; this has increased demands on staff time.
- Current budgets and intake of training schools are not meeting needs of districts and staff that need upgrading. Vacancies in training institutes are few compared to the demand of people who need upgrading. Many more people pass the entry exams, but the entry marks are set very high.
- A new appraisal system - open performance appraisal system - was introduced (Public Service Reform), but orientation has been slow and few staff or their supervisors understand or use the system. The annual confidential forms were discontinued. So how will health staff performance be assessed?
- Current staffing levels compromise referrals e.g. between dispensary and HC; between regional hospitals and district (FBO) hospitals, i.e., there is no significant difference in cadres.
- Staff skills mix for each level of facility has not been adequately assessed to comment on appropriateness by level and expected functions.

2.6 Health Care Financing

Health Financing

- Generally there are more funds to work with than before.
- The regional hospital has multiple sources of funding such as basket funds, NHIF, cost-sharing, OC from RAS, Global Fund for AIDS, Tuberculosis and Malaria, and other partners/agencies like AXIOS (project specific).
- CHF has been operational in Singida for at least 3 years, and its introduction is linked to improved services. However, the irregular drug supply, problems with staff at the facilities, and double charging in case of self-referral have slowed down enrolment in some places.

- NHIF is increasing as a source of income. More people are being registered and the regional hospital makes a special effort to ensure that drugs are available for NHIF clients (by even purchasing from local private pharmacies when necessary).
- The income from user fees varies according to availability of drugs. Within the first 3 weeks after drugs have been received, attendance is high and therefore income is high. In contrast, when drugs run out, the attendance is low and patients have to buy drugs from private pharmacies.

Exemptions

- Exemptions are done according to MOHSW guidelines. Fifty percent of patients seen at the hospital belong to the exempted categories.
- Exemptions for persons above 60 years are controversial.
- Only 5% or less of patients are unable to pay:
- CHF members do not have to pay, if they are officially referred (with referral letter) from the HC or dispensary. The accounts are reconciled between the two facilities by the DMO.
- The hospital 'looses' more in exemptions than the value of drugs received through MSD.

2.7 Public Private Partnerships

Achievements

- There is close collaboration between Council/CHMT and FBO facilities, e.g. through supervision, staff exchange/secondment, bed grants, and provision of medicines, supplies and equipment.
- There are examples of one-off goodwill gestures from individuals/parastatals to hospitals: individual private initiatives to support the hospital through donations include mattresses from NBC Bank, bed sheets and mosquito nets from TTCL, Mosquito nets and soap from Members of Parliament for the area.
- A local NGO called HAPA is instrumental in supporting the construction of many new dispensaries and staff housing as well as in health preventive activities. The CHMT staff supports HAPA technically, if HAPA pays for their allowances. The Council/CHMT approves all construction of HAPA before it commences and provides staff for the new health facilities.
- There is one private health center in the municipality, whose prices for laboratory tests and consultation are comparable to public facilities.

Constraints

- In order to be certified and allowed to operate higher standards are expected and required of private and FBO facilities (and met) than what public health facilities of the same level are able to meet. Different yard sticks are used for minimum standards in private and public health facilities. Should government not be challenged to attain the same minimum standards in their own facilities?
- There are no private hospitals/health centres/dispensaries in Singida rural as it is financially not attractive.

2.8 HIV/AIDS

Achievements

- Increase in AIDS services like VCT and CTC compared to previous years. There are Global Fund activities in Singida since 2006 and TACAIDS since 2003.
- The DACC and CHAC in Singida work in collaboration.
- VCT centres supported through Global Fund have increased. Utilization of the VCT centres is increasing, though males remain in the minority.

Constraints

- Not all HF are providing the basic HIV/AIDS services, for example, dispensaries doing ANC and deliveries, but not yet offering PMTCT because the staff have not been trained.
- There are only two sites providing ARV treatment in the district. Plans to decentralise to health centre level are yet to materialise. Health workers are aware that there are many people living with HIV/AIDS, who cannot get ARV treatment because of the long distances and costs of transport to hospital.
- Home based care (HBC) services are offered by public health facilities and NGOs (ANGAZA, NURU and FARAJA), but coverage remains limited and needed kits are few. Health facility attempts to do HBC but is limited by staff numbers, transport and lack of HBC kits. HBC kits are not routinely provided in MSD kits or CHMT basket fund.
- Numbers of affected people remain high and while some practices have been modified, e.g., more use of condoms, in general, behaviour is hard to change.
- There are no formal workplace programmes for HIV/AIDS within MOHSW. Some staff trained in VCT services has taken initiative to offer services to other staff members.

3 Health Access, Service Quality and Outcomes

Health Access

- Increased access of services for children under 5 and women needing reproductive health services.
- CHF makes services accessible even in times of low cash.
- Access to health services remains difficult to and within Singida, due to bad roads and lack of public transport.
- During rainy seasons the district is cut off.
- Some elderly may not be getting services.

Service Quality

- Efforts have been made to improve quality – especially with drugs and lab tests.
- Community perception of staff attitudes is mixed and varies by health facility, being lower for the hospital.

Health Outcomes

- Reports of reduced morbidity and mortality from immunisable diseases for children.

- Malaria occurrence remains high, especially in the rainy season, but complicated cases of malaria and deaths from malaria have decreased.
- Cholera outbreaks are fewer.
- Endemic diseases like schistosomiasis are reduced through mass treatment of school children.
- Nutrition remains problematic in Singida, as a combination of floods and drought reduces food production.

Other

- Water availability in Singida is a problem. There is water scarcity and almost all water sources are unsafe. There is a World Bank and Government supported project to increase water in the community and health facilities (communities get water at TSH 20-30/= a pail/bucket).

Persons Interviewed: Singida Region / Singida Rural Council

Persons met at regional level

Name	Title
Mr. Sungita	RAS Singida
RHMT Singida	
Dr. Robert Mahimbo Salim	RMO
Frank Samuel	Regional Pharmacist
Lameck Michael Mongo	Regional Nursing Officer
Ernest J. Mugetta	Regional Dental Officer
Joseph Mgseni	Regional Health Officer
Hamisi Dinya	Regional Health Secretary
Regional Hospital Singida	
Dr. A. Mushi	MO In-charge
T. Mghenyi	In charge Gynaecology ward
M. Shanalingigwa	Staff responsible for Exemptions
J.L. Tamba	In charge Female Surgical ward
M.P. Bugabu	In charge OPD
N. Almas	In charge Operating Theatre
E. Matola	In charge General Stores
S.A. Ndege	In charge Maternity Surgical Ward
M. Alute	In charge Maternity Normal Delivery
O. Tarimo	Dental Unit
E. Ndanu	X-ray
V. Lyangu	MCH Clinic in-charge
E. Domma	MTHUA in-charge
Usili Mpondo	Matron

Persons met at district level

DED Office	
Annunciata A. Lyimo	District Executive Director
DC Office	
Ms. Rehema Vyas	District Administrative Secretary
Private Health Centre	
Dr. Halvin S. Mlay	Owner of Singida Tumaini Health Center
Council Health Service Board	
Naftali Gwea	Chairman
Theresia Nkuwi	Member
Imakulata Mikindo	Member
Hamisi Mwiru	Member
Maria Borda	Member
Ashura Shaban	Member
Juma H. Tantau	Ag Health Secretary
Fernando Msofe	Ag DMO Singida
Dr. Mushi	MO In charge Regional Hospital
Council Health Management Team	
Steven Msambu	Health Officer
Saidi J. Kitiku	Assistant Medical Officer
Mary A. Lungwa	District Repro and Child Health Coordinator
Mary S. Alute	District Nursing Officer
Athuman Stephen	District TB and Leprosy Coordinator
Emmanuel Maldi	District Cold Chain Coordinator
Juma H. Tantau	District CHF Coordinator & Ag Health Sec

Kariston Mwensa	District School Health Coordinator
Steven Msambu	Health Officer
Fernando Msofe	Assistant Health Officer and Acting DMO
St. Carolus Hospital, Mtinko FBO	
Sr. Josepha C. Lyimo	Administrator In-Charge
Dr. Peter Mtallo	Medical Officer In-Charge
Sr. Mirjam Caroli	Nursing Officer, Matron In-Charge
Dr. G. M. Paul	Principal Assistant Medical Officer
Sr. Epiphania Ngowi	Accountant In-Charge
Diagwa Dispensary FBO	
Sr Gemma Kavishe	Administrator
Elipendo Nalompa	Nurse Midwife
Elifaraja Malambi	Nurse Assistant
Neema Mathew	Nurse Assistant
Sarah E. Daudi	Nurse Midwife
Mohamed M. Sima	Clinical Assistant
Sr Christa Mrosso	Nurse Midwife
Ikungi Government Health Centre	
Yahaya Ngaima	Clinical Officer
Maria Kinyenje	Matron
Anna Elia	Public Health Nurse
Rehema Maganga	Health Officer
Edward M. Lazaro	Lab Assistant
Victoria Mmasi	Nursing Officer
Ikungi HC Health Committee	
Haji Suleimani Mukhande	Councillor Chairperson Development Committee
Solomon Mnkenyi	Chairperson Member health committee
Isaya Njiku	Member
Flomena Julius	Member
Amos Ndee	Member
Calister Jimbo	Member
Abdalla Msuri	WEO Ikungi
Dung' unyi Government Health Centre	
Joseph Fissoo	Clinical Officer In-Charge
Marietha Jinau	Nurse Midwife
Evaline Hucheda	Medical Attendant
Illongero Government Health Centre	
Grace I. Kishindo	In-charge Clinical Officer
Neema Swai	Clinical Officer
Tabusia Godson Mushi	PHN
Bertha Mikindo	Matron Nursing Officer
Community CAST Sessions	
Dung'unyi community CAST, 13 men	
Dung'unyi community CAST, 10 women	
Illongero community CAST, 30 women	
Illongero community CAST, 20 men	