

# INTERVENING TO ADDRESS CONSTRAINTS THROUGH HEALTH SECTOR REFORMS IN TANZANIA: SOME GAINS AND THE UNFINISHED BUSINESS

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**Abstract:** This paper describes two projects designed to address health sector constraints. The Community Health Fund attempts to create a community-owned and community-managed prepayment scheme. Although membership growth has been disappointing, substantial funds have been mobilized and the scheme replicated in nine additional districts. The Dar Urban Health Project aimed to improve various dimensions of health service quality, and provides a model which can be replicated elsewhere. The two cases concentrated largely on relaxing constraints related to the availability of inputs, while leaving unresolved macro-level general infrastructural and policy-related constraints. This omission partly explains the limited gains in relaxing constraints at the input level. Copyright © 2003 John Wiley & Sons, Ltd.

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## **1 BACKGROUND: REFORM EVENTS OF THE 1990S AND THE HEALTH SERVICES DELIVERY SYSTEM**

The Government of the United Republic of Tanzania is undertaking health sector reforms which started in 1990 with a policy which stated clearly that it would henceforth be possible for private individuals and organizations to own and manage health facilities. The policy, which lays emphasis on decentralized ownership and management of the health sector, was followed in 1992 by legislation to effect it. Communities, qualified persons, and organizations can now actively participate in the development and management of health services in Tanzania.

This study attempts to address a small area of the health sector reforms, namely that concerned with decentralising financing and management responsibilities from the headquarters of the Ministry of Health (MOH) down to the district, service unit and community levels. It is contended here that there have been significant gains derived from the

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interventions made to improve the quality of services by providing additional inputs. However, constraints remain in the form of elements at the macro-policy and infrastructural levels, for example the slow progress of decentralization, lack of community empowerment, slow pace of reforms to legal provisions, and the poor transportation and communication facilities, especially in remote rural areas. These constraints, which are harder to resolve through the investment of additional funds for the health sector, need to be addressed if health service delivery is to be substantially improved.

Tanzania is one of the poorest countries in sub-Saharan Africa with an estimated per capita income of about \$100, which is far below the average of \$640 per capita for sub-Saharan Africa. The population is estimated at 33 million (2000) with a growth rate of 2.8 per cent. The country is governed as a republic divided into 22 regions (mainland) and five regions in Zanzibar, and 116 districts. The districts are further subdivided into divisions, wards (2354) and villages (9094). It has been the intention of the government to distribute health services equitably by developing a hierarchical health service delivery system, with at least one public dispensary for every village, a health centre for every division and a hospital for each district.

The government remains the main source of financing for the health sector, and the dominant provider of health services in Tanzania. Combining government and parastatal health sector providers, the public sector accounts for more than 60 per cent of health care facilities. Private for-profit units make up 18 per cent of health care facilities, the majority being dispensaries.

Although the government's strategy of investing in infrastructure has succeeded in making health services physically accessible to the population, there have been a number of major constraints facing the health sector. Their effects on the delivery of health care are summarized in Table 1, which is drawn from documentation of the issues to be addressed by the CHF and DUHP. The government's approach to health sector reform is premised on the assumption that improving the delivery of services through this public sector infrastructure will require greater decentralization of management. The two interventions addressed in this paper are both aimed at operationalising this policy.

## **2 EFFORTS TO IMPROVE HEALTH CARE SERVICES**

The proposals for the Health Sector Reform Programme (HSRP) fall within the country's overall Social Sector Strategy (SSS), the aims of which are to improve efficiency, effectiveness, equity, accountability and sustainability of the health services. In this regard, local communities are expected to assume a greater and more direct responsibility for financing health services. This is supposed to take place through greater involvement by the community in the initial project concept, principles and practice. The Health Sector Reform Programme was implemented through the Health Sector Plan of Action (1996–1999), which had the following specific objectives:

1. provision of accessible, equitable, quality and cost effective services at the district level;
2. development and provision of back-up secondary and tertiary services in a referral hospital system;
3. redefining the managerial roles of the central, regional and district health authorities;
4. addressing the challenges of human resources development to ensure that well trained and motivated staff are deployed at various levels;

Table 1. Summary of constraints affecting service delivery in the Tanzanian health sector

1. Structural elements	2. Process/professional/technical elements	3. Drugs and medical supplies	4. Equipment and maintenance constraints	5. Health services management
→ Physical condition of facilities was deplorable	→ Medical personnel were incompetent and sometimes issued wrong prescriptions	→ Drugs shortage was common	→ Poor maintenance of records	→ Unmotivated staff
→ Lacked essential equipment for treatment of diseases, even simple gloves	→ Attitudes toward customers were poor and rude	→ Drugs only available early in the month	→ Inadequate equipment in facilities	→ Unofficial charges of Tshs. 2000 to 3000 were common for services which should bear no charge
→ Some units lacked beds and mattresses	→ Bribery went with service delivery to customers	→ Drug shortage caused underdosage, and unnecessary referrals	→ Lack of equipment maintenance system and culture	→ Unqualified staff were employed
→ Clinical officers and others lacked decent accommodation	→ Health personnel had low morale at work	→ Drug shortages caused over crowding when drugs available	→ Preventive maintenance not practiced	→ Poor supervision
→ Units were without adequate furniture	→ Underdosage was a common problem	→ Poor dispensing and insensitive use of drugs by patients	→ Some units lacked essential diagnostic equipment	→ Little or no community participation in publicly owned units
→ Some had very poor or even lacked toilet facilities	→ Opening and closing time depended on staff.	→ Limited services due to limited drugs	→ Incompetent staff were unable to use available equipment	→ Limited service mix at all levels in government owned units
→ Health care units lacked clean and safe water	→ Some units opened as late as 11 am, closing as early as 2 pm.	→ Lack of uniforms for staff		→ Non-transparent management system
	→ Lack of health information system	→ Lack of essential equipment in some units		
	→ Lack of provision of minimum package of health services expected at health units			

Based on: Robles *et al.*, 1999; Various Reviews, Publications and Reports of the DUHP.

5. ensuring the required sustainable central support systems are in place;
6. developing and ensuring sustainable health care financing through public and private financing alternatives including health insurance;
7. addressing the appropriate mix of public and private health care services and the development and integration of monitoring systems; and
8. restructuring the relationship between the MOH and the donors to the sector.

In the 1980s Tanzania's economy was growing at a discouragingly low rate of 0–2 per cent per annum. Tanzania was heavily dependent on donor funding of the essential social services. Donors contributed 21.2 per cent of total resources, primarily directed to the development budget, while the government's contribution largely went into recurrent expenditure (74.3 per cent), leaving only 4.5 per cent for basic development investment (World Bank, 1997). With such constrained funding the government could not continue to fund the growing (public-dominated) health sector. Alternative funding sources had to be designed. Among the options considered were user fees, community-based insurance, and national health insurance schemes.

An attempt to raise funds from the consumers of the public services was initiated by the 'Cost Sharing Policy' which started on a limited scale in 1993. While it has not generated significant revenue for health sector development, it has succeeded in making Tanzanians aware of the need to contribute to the cost of their own health services. Table 2 shows that cost sharing revenue increased from about 1 to 5.8 per cent of total health sector expenditure between 1993 and 1998. This positive development, albeit in a small way, served to encourage policy makers to explore alternative mechanisms.

However, alternative financing options in Tanzania have been difficult to execute. First, for political reasons, asking a population previously accustomed to free health services to pay creates political resentments in the sense that they think the government is failing to deliver free services as it used to. Secondly, much education is required about the essence and rationale, use and management of cost sharing, including costing, accounting and exemption procedures. Thirdly, different communities of the country have different abilities to pay. Therefore a uniform system is difficult to operationalize. Fourthly, if people have to pay, they expect to pay for quality, which needs to be improved using revenues from the cost sharing initiative itself. The cases discussed here experiment with injecting a substantial amount of donor financing in order to improve the quality of services offered in public health facilities, and to win back the confidence of the consumers.

Community participation in health service financing was adopted in 1993 starting with the referral and district hospitals through a cost-sharing policy. The cost sharing policy was not extended to the primary level, i.e. the health centres and dispensaries, which are

Table 2. Revenue from the cost sharing initiative in Tanzania

	Annual total revenue generated in Tshs.	Cost sharing revenue as % of total health sector expenditure	Cost sharing revenue as % of total non-salary recurrent expenditure
1993–94	26 922 752	0.54	1.9
1994–95	854 195 503	2.1	5.0
1995–96	1 078 120 352	2.8	8.5
1996–97	1 851 580 139	4.1	11.8
1997–98	2 435 157 795	5.8	13.4

Source: MOH—Health Statistics Abstract 1999, p. 125.

usually located in the rural areas where about 80 per cent of the population reside. The two initiatives described in this paper were focused on the primary level. The first case is the introduction of prepaid community health insurance, which was first implemented in Igunga district. The lessons learned encouraged the authorities to replicate the Igunga model in nine other districts. The second case is the Dar es Salaam Urban Health Project (DUHP), which used substantial (mainly Swiss) donor funds to rehabilitate the public health services delivery capacity and its management in the Dar es Salaam region.

For the purposes of the present analysis, a key criterion for a *successful* intervention is its potential to be replicated elsewhere or to be scaled-up. This analysis focuses on the potential for the concepts, procedures and principles developed in these two interventions to be applied in other contexts in Tanzania or equivalent conditions.

### **3 THE COMMUNITY HEALTH FUND MODEL: A COMMUNITY-BASED HEALTH INSURANCE PILOT**

The Community Health Fund is one of the approaches being adopted by the Government of Tanzania to balance the needs of resource generation and equity. The CHF is a form of voluntary health insurance, a pre-payment arrangement for health services in the event of illness. It aims to be flexible in that contributors are encouraged to pay at the time of harvest, with an option of paying in installments for those with more regular incomes.

The CHF model allows contributors to pre-select a public, private for-profit or religious organization-owned unit from a network of existing health service providers in the community in which members live. The chosen first level unit (usually a dispensary) is linked to the next level (a first referral hospital). Clients are allowed to switch providers each year if they are dissatisfied with the services at their chosen dispensary. This mechanism is aimed to encourage providers to be more sensitive to consumer preferences.

The membership unit is usually the household comprising parents and children aged 18 years and below. In polygamous families, each wife with her children below 18 years constitute a household unit. Unmarried individuals qualify to be members upon contribution.

In order to ensure equity of access to health services, a village (community) council is supposed to administer a system of exemptions for those households and individuals who are unable to pay the required contribution. They are given a free CHF membership card, funded from the district CHF account. The exempted categories usually include the disabled, the elderly and others as determined by the community leadership in the village in which they live.

Participating hospitals, health centres and dispensaries receive an 'up-front capitation grant' in order to enable them to render services to their expected clientele. The participating hospitals have to agree to conditions under which referrals can be made. The capitation arrangement is expected to enable the pre-selected providers to plan for their essential needs in advance, stock up on essential drugs and equipment, and be prepared before the patients start demanding services. This capitation arrangement is also expected to improve service availability at the dispensaries, which in effect amounts to reducing congestion at the district hospital level.

The contribution level for the CHF was based on a cost norm that a well functioning dispensary in Tanzania with a catchment population of about 10 000 people can provide a basic package of curative and preventive services if it is provided with a per capita amount

of TSh. 5000 (US\$ 4.40) per year. This is the amount required to cover operating/recurrent costs for personnel, drugs, medical supplies, logistics, transport and maintenance. Government contributions financed by the International Development Association (IDA) funds provide a matching contribution to that from members, thereby increasing the health units' funding level.

The CHF contributions are pooled and managed together in a specific account. They are then further pooled into a district level administered account in a bid to incorporate the basic principles of pooling risks in an insurance system. With this arrangement of risk sharing, expensive hospital costs of illness or injuries are in principle paid for on behalf of the members of the CHF. The CHF is managed by the District Health Board of the respective district. This is considered to be an interim measure as it is expected that the CHF will eventually evolve into a self-sustaining health insurance venture to finance the health service needs of its members. Ideally, it should be managed by its own members at the community/facility level.

### **3.1 Implementation of the Igunga CHF Pilot and the Roll-Out Districts**

The CHF was introduced as a pilot in Igunga District in December 1995, covering only 26 wards. After six months there were indications that the participating ward health facilities were performing better than the other non-project facilities in the same district. Some of the achievements of the CHF pilot sites include the following.

- Improvement of structural quality, for example buildings were rehabilitated, new toilet facilities and new offices were constructed and water/sanitation improvements were undertaken.
- Efforts were made to train clinical officers and some nursing staff to improve their performance at work.
- With buildings rehabilitated, essential drugs now more available than before, and equipment procured for some of the participating units, the health service personnel were more motivated to work than before the intervention.
- With the availability of drugs throughout the entire month, health facilities were less congested during the first half of the month.

It was therefore decided that the entire Igunga district should adopt the CHF model as from August 1996. From that time, user fees were introduced for non-CHF members attending government health service units. The fees were Tshs. 500 per illness episode at a health centre and Tshs. 1500 for Outpatient Department (OPD) care at the district hospital level. CHF members were required to pay a flat rate of Tshs. 5000 per annum per household for all services. In 1997, the Igunga District Health Board (DHB) changed the fee schedule to be Tshs. 1000 at a dispensary, Tshs. 1500 at a health centre and Tshs. 2000 at the district hospital OPD per visit or episode. Service users had the option of becoming CHF Card holders (prepayment scheme) or pay the stipulated user fees at the government-owned facilities. At the time, there were very few privately owned health service units, leaving users with limited options.

As a result of the six months pre-test at Igunga and the subsequent performance of the scheme, especially the ability to mobilize financial resources, the government decided to extend the experiment to other (similar) districts, namely Nzega, Iramba, Singida (rural), Hanang, Songea (rural), Songea (urban), Iringa, Mbinga and Kilosa. The criterion used to

pick the districts was their ability and willingness to start up the CHF programme, as determined by the respective local district councils. The facilities in the initial and roll-out districts then comprised 17 district hospitals, 43 health centres, 368 dispensaries and 399 health posts.

The Tshs. 5000 paid by each contributing membership unit was about US\$ 9.0 when the initiative started in 1996 and presently (2002) amounts to US\$ 6.25 at the 2002 exchange rate. With the government's matching amount of the equivalent contribution sourced from IDA funds, an amount of \$12.50 per membership unit can be mobilized.

The CHF leaves all decision-making powers to the individual communities and district administration. The roll-out districts have followed the basic principles of the CHF as applied in the Igunga pilot case, but have differed in the membership fees. Hanang uses a membership rate of Tshs. 10 000 (US\$ 12.5), as does Songea (urban). Songea (rural) District is charging Tsh. 7000 (US\$ 8.75) per household per year, while Mbinga District charges Tsh. 15 000 (US\$ 18.75) per household per year.

Once a CHF project has been introduced in a district, two major policy steps are taken. First, user fees are applied in a systematic way for non-CHF members who seek services at the government's health units. Secondly, since the CHF is owned by the communities and the respective districts, relevant by-laws are passed to enable its execution. However, such pieces of legislation have not conferred ownership and management authority of the units to communities. The contributing communities are not, for example, managing the health care budget at the unit level even though they contribute to its budget.

A national level exemption policy has been established to be implemented by all the districts (as custodians of the government's district and sub-district level health services units). However, the village level (community) governments are the ones to recommend who should/should not pay. As income levels vary from one district to another and from one crop season to another, the percentage of those to be exempted in a particular period is difficult to predict. Nevertheless the contribution level is calculated so as to ensure that the majority can contribute in order to avoid large scale exclusion from an essential social service. In any case, contributions can be made in installment or in one lump sum, for example at the time of selling farm produce.

### 3.2 Observations on the Performance of the CHF

If membership continues to expand, the CHF is one major alternative to financing health care services in Tanzania. However, membership continues to be low: Table 3 shows that membership of the CHF across all the participating districts is as low as 2.6 per cent. Membership in Hanang is much higher, at about 26 per cent. Igunga showed a big drop in 1999, likely related to complaints that there were problems in releasing funds from ward and district authorities to the dispensaries, due to bureaucratic procedures in the CHF administration. The delay discourages potential members from paying their membership fees.

The low membership rate of the CHF has been caused by, *inter alia*, the fact that the scheme has not been able to deliver health services at the level of quality that the community expects in exchange for their financial participation. An important constraint is the low absorptive capacity of the districts' planning units, which in 1998 and 1999 only managed to spend 27 per cent and 14 per cent respectively of the revenues generated (see Table 3). Had the expenditure of the available funds been properly planned to improve the

Table 3. Some basic statistics on CHF performance

	Number	Percent
1. Membership mobilization		
Total households in the 10 initial districts	563 919	100
Total CHF members in the 10 initial districts	14 480	2.6
2. Sources of revenue, 10 initial districts, 1996–99	TSh.	Percent
CHF contribution (TSh)	209 884 000	41
Matching funds	209 884 000	41
User fees	94 512 746	18
Total	514 280 746	100
3. Utilization of revenue, 10 initial districts, 1998–99	TSh.	Percent
1998 revenue	165 571	
1998 expenditure	44 972	27.2
1999 revenue	267 003	
1999 expenditure	36 603	13.7

quantity and quality of health care services, the units may have attracted more members. Over time, as enrollment increased, it would be possible to phase out government/IDA matching funds.

Another problem is that members expect to receive a full range of services at all levels in the district referral system, including the private health service units. This has been difficult to ensure because it requires a clear contractual framework embodied in service agreements between the providers and the managers of the CHF. This is yet to be institutionalized. In addition, referral to tertiary care hospitals is not accommodated by the CHF arrangement due to low levels of membership and a poor rate of contributions.

Other reasons for poor enrolment include weak implementation of the user fee policy, and the increasing availability of high quality and competitive private sector health services provision.

The CHF has achieved some of the objectives of Tanzania's Health Sector Reform Programme. One of the objectives is to devolve the planning of the health services down to the district level. Another objective is to motivate local communities to mobilize and manage resources at their own levels. For communities which had been 100 per cent dependent on the central government to finance their own health care, a programme which makes them mobilize about 30 per cent of the required revenue is no mean achievement. It is important to note that this is only a fraction of the revenue which could be mobilized if enrolment could be increased. Igunga District, which has been running the longest, remains the most successful.

Of greater significance is the potential for the decentralization approach to improve efficiency, effectiveness and the quality of health care services. Table 4 shows how Igunga DHMT planned to spend their mobilized revenues in order to improve quality of care, efficiency and effectiveness. Admittedly, increased financing is not sufficient to improve these conditions, but it is necessary.

The importance given to drugs and medical supplies cannot be overemphasized here. Shortages of drugs have been a chronic problem which has affected quality of care in Tanzania (Munishi, 1991, 1997; Mnyika and Kilewo, 1991; Kilima *et al.*, 1992). For the year 1998 Igunga district health services' planners decided to use 61.5 per cent of its discretionary funds for that priority concern.

Table 4. Expenditure patterns as planned by Igunga district health management team (1998) (Tshs)\*

Expenditure category	(Tshs.)	(%)
1. Drugs and medical supplies	105 707 458	61.5
2. Public health	44 425 866	25.8
3. Construction and rehabilitation	18 818 850	10.9
4. Equipment, furniture, linen etc.	775 000	0.5
5. CHF social marketing	2 269 000	1.3
Total expenditure	171 996 174	100.0

\*The figures include both the central government and the local (district or community-level mobilized funds).  
Source: Ministry of Health, CHF Coordination Office.

The CHF is also expected to have given the local communities a voice in the way the health services should be managed. However, there are some areas which need to be further addressed in order to consolidate the CHF. These include education and communication and the role of the government bureaucracy at the district level *vis-à-vis* the power of the local communities. The district level managers and the ward-level CHF collectors are seen to be dominant in CHF affairs and in operationalising the CHF concepts, and the voice of the local communities needs to be strengthened.

Indeed, one of the major weaknesses of the Health Sector Reform Programme is its top-down approach. The CHF also has a strong top-down dimension because the idea originated at the MOH with the support of the World Bank. The main question, however, is how to make it possible for the CHF intervention to function and to achieve better results. Some policy options are suggested in Table 5 (discussed later).

#### 4 THE CASE OF THE DAR ES SALAAM (CITY) HEALTH SERVICES

Given Tanzania's policy of socialism and rural development (TANU, 1967), the majority of the development effort during the 1970s and 1980s was directed to the rural areas where more than 80 per cent of the population reside. The Essential Drugs Programme (EDP) for example, which was initiated with support from the Danish government (1984–93) focused on equipping and supplying the rural health centres and dispensaries (the primary or first contact levels). The District and the Regional Hospitals (as referral points) which are mainly in urban locations were not included in the programme.

By the late 1980s and early 1990s, most of the urban units were poorly supplied and equipped for the purpose of sustaining services to a fast-growing urban population. Consequently it was reasoned that there was an urgent need to develop an urban primary health care (PHC) strategy. The population of Dar es Salaam is well over 2.0 million with an estimated annual growth rate of 5 per cent. Communities in Dar es Salaam have often faced problems of unemployment, inadequate access to health services, sanitation and environmental hazards and overcrowding at the government owned health services units. It is with this background that the Dar es Salaam Urban Health Project (DUHP) was created in order to improve health services at the district level in the city of Dar es Salaam. It was intended that the Dar es Salaam case would provide some lessons with regard to what can be done to improve other urban publicly owned health services.

#### 4.1 Constraints to Health Services Delivery in the Dar es Salaam Region

Earlier studies identified some stumbling blocks to delivering health services in the Dar es Salaam region (Kilima *et al.*, 1992; Gilson *et al.*, 1994; Gilson *et al.*, 1994; Munishi, 1997). Most of these studies pointed out the inadequacies in the quality of health services. The constraints facing urban health service delivery are largely the same as those facing the sector as a whole (see Table 1).

Addressing these constraints primarily involves addressing the different dimensions of quality of service delivery. The first of these is structural constraints, arising from the inadequacy of buildings, space, and equipment for the delivery of standard and quality services. Their state undermined the operation of the referral system.

The second area of constraints involves professional practice in the sense that the processes of examination, diagnosis, prescribing and dispensing were not correctly done. Health service personnel had low levels of morale and were not following standard procedures.

The third group of constraints was in the area of medical supplies and drugs availability. There had been a national essential drugs list which was not followed by most prescribers. There were inadequate procedures for drug identification, quantification and distribution in accordance with established needs of each level of service.

The fourth group of constraints was in the area of administrative and managerial inadequacies in the design, development and provision of health care services in the Dar es Salaam region. There were problems of undefined roles and mandates between the central government and the City government, and most of the health services personnel had little or no training in modern management, which the on going reforms required (Munishi, 2000).

#### 4.2 The Establishment of the Dar es Salaam Urban Health Project

The creation of the Dar es Salaam Urban Health Project sought to:

- address the problem of the health services infrastructure, which was poor and distributed inequitably within the three districts of Dar es Salaam region;
- reverse the fast deterioration of the quality of the health services including attending to buildings and equipment which were not receiving preventive maintenance and rehabilitation;
- address the chronic shortage of essential drugs and equipment; learning from an earlier experience of how to deal with an acute shortage of essential drugs, the Dar es Salaam authority decided to extend the concept of the Essential Drugs Programme to the Dar es Salaam urban areas (Pichette and Mutasiwa, 2000)
- reform the system of health management which was centralized and bureaucratic, and without real authority at all levels;
- address the problem of the health delivery practices which did not adhere to Primary Health Care principles; inadequacies in this area included the distorted referral system.

The Dar es Salaam Urban Health Project (DUHP) was a strategy devised to put in place a reliable and efficient public service delivery system. The project concept and design was to define and specify a minimum package of health and related management activities in

which communities would be involved. The minimum activities comprised a concerted effort to:

- (i) specify and define systems of standardized inputs (human, material, financial, information and managerial capabilities); and
- (ii) identify which resources would be needed for and by each level of service provision (United Republic of Tanzania, 1997).

With funding from the Swiss Agency for Development and Cooperation, and the Swiss Tropical Institute as the implementing partner, the DUHP has gone through three phases. Each phase has had specific constraints and tasks to deal with. The first phase (October 1990–June 1993) was basically concerned with rehabilitation and equipping the Dar es Salaam region's health services facilities in order to improve the health services infrastructure.

The second phase (July 1993–June 1996) concerned itself with the development of the system's capacity to deliver improved services. This included an extension of Phase I activities plus training; and the development of standard treatment schedules clearly specified in manuals, for each level of service provision.

The third phase July 1996–June 2000, with an extension into 2001, focused on the implementation of the Ministry of Health's Health Sector Reforms (HSR) in the framework of decentralization and local government reform (for Dar es Salaam city). The extension period of the DUHP (July 2000–June 2001) was intended to follow up on the other phases with a view to consolidating the DUHP's 10-year achievements, and to be in harmony with the Ministry of Health's new system of government–donor relations and financing. In this system a Sector Wide Approach or SWAP has been adopted. This involves integrating all vertical donor projects, and pooling funding for the health sector into a MOH-managed 'basket'. This is intended to improve co-ordination and integration of donor funded projects. This is a promising development for increased funding for the hitherto neglected or underfunded areas such as public urban health services delivery, providing the Government of Tanzania places priority on urban health service development.

### **4.3 The Experience of the Dar es Salaam Urban Health Project**

The DUHP has created a reorganized system and a much needed infrastructure; it has embarked on promotive services at the unit level; it has created the culture of health services planning, monitoring and evaluation; and it has also motivated more community participation in committees and cost sharing. In short, the DUHP has offered to Tanzania's policy makers a need to concern itself with urban health policy development and an approach to doing so.

A major message coming out of the DUHP is the need to improve structural quality before addressing the other dimensions. This calls for paying careful attention to the sequencing of the programme activities, and initially prioritising infrastructural investment. Once this has been done, then the other areas can be addressed.

In the first phase most of the funds (56.3 per cent) went into capital expenditure, to rehabilitate and to repair the three district hospitals. Additionally, more funds were expended to rehabilitate the Dar es Salaam region's health centres and dispensaries. Hospital wards and some offices were also constructed to improve the environment in which services are delivered. During that period the Tanzanian government could

contribute only 3.7 per cent to the initial direct project funding. The donor contribution was extremely important and without it, the Government of Tanzania would have been unlikely to have been able to execute the Phase 1 activities.

The expenditures during the second phase put more emphasis on the procurement of drugs and equipment. Once the buildings and equipment were put into an acceptable operating environment for health services delivery, then concern with drug and medical supplies followed. The Government of Tanzania continued to shoulder responsibility for non-contract and non-project items such as salaries, wages, insurance, fringe benefits, etc. Otherwise the government contribution directly to the project was insignificant in financial terms.

During the third phase expenditure continued to be concentrated on drugs and equipment procurement and the rehabilitation of Dar es Salaam's government health centres and dispensaries. In 1998 the purchase of drugs consumed about 26 per cent of the actual expenditures of the DUHP funds. Rehabilitation, maintenance and construction continued to consume a substantial amount, that is 38 per cent. The third most important expenditure item was training, which claimed about 14 per cent of funds.

What the DUHP has accomplished, starting from 1990, is a structural and functional rehabilitation of the Dar es Salaam public health delivery system. In short, the DUHP has resulted in the creation of elements and concepts such as the minimum package of health and related management activities and practical experiences which can be regarded as critical determinants for the development of Tanzania's national urban PHC strategy. The DUHP experience can be scaled-down to suit a smaller urban setting. It can be scaled up in the sense of using the guidelines and practical solutions already produced to replicate the project in other urban centres of Tanzania or elsewhere.

On the other hand, there are several areas of 'unfinished business' which could not be fully addressed through the project activities. These include the following.

- The slow implementation of the government's decentralization policy in which the definition of roles between the Ministry of Health and the Ministry of Regional Administration and Local Government is contested and unclear. This is because the implementation of the Local Government Reforms is in its initial stages.
- There are elements of bureaucratic hang-over of some seasoned administrators of the old centralized system who are suspicious of the envisaged decentralization.
- Given the low level of funding by the government, the employees in the publicly-owned health service sector are poorly paid, and they remain mainly unmotivated
- Even with the DUHP training, there are inadequacies in management skills on the part of some medical personnel
- Community participation seems to be construed as controlling and managing the use of what is granted by the government and the donor community rather than communities taking up responsibilities to mobilize funds for the publicly-owned units.
- The DUHP has been heavily donor dependent so that one might be doubtful about the sustainability of the good achievements made so far. This stems from the fact that the government's and the community's own financial contributions have been relatively small compared to the donors' contribution.

## **5 REFLECTIONS ON THE LESSONS FROM THE CASES**

The purpose of studying the two cases in Tanzania is to examine approaches to overcoming some of the constraints to an efficient and effective health service delivery

system. The cases are important as they allow for an analysis of particular ways of intervening in a specific context. The key features of this context include a general government policy of decentralization and an extremely high level of poverty.

The Community Health Fund intervention is an attempt to create understanding, responsibilities, and a participatory system which will work to create a voluntary community health insurance scheme. Even though the percentage of households joining the scheme is low, it has created an understanding of the need for local communities to take responsibility for their own health. It has also created administrative systems geared towards collecting and managing a common fund for the health services in the community.

The aim of the Dar es Salaam Urban Health Project was to invest supplementary funds in creating an efficient and effective public health delivery system, which is community focused. The DUHP strategies with the (Swiss) donor assistance emphasized the development of a minimum package of health and management related activities. The strategies also aimed at rejuvenating Dar es Salaam's government-provided health services which were judged to be poor. The DUHP is important as it highlights public concern for urban health investments, and it points out lessons of experience on strategies to rehabilitate the Tanzanian government urban health services.

One major constraint for the two cases is the financial limitation on the part of both the central and the local governments. The two cases show how an injection of donor funds can make a positive difference in effective health services delivery, and also shows some attempts to reduce donor dependency in funding and to put responsibilities on communities. Some limitations to this effect have been pointed out. The CHF has been less successful than anticipated in attracting members. On the part of the DUHP, the reduction of donor dependency is expected to occur through an increased district (local) government budgetary allocation and increasing the user charges once the services have been improved. It is assumed that with improved quality of services people will be willing to pay more and service utilization/sales will increase to an extent that public service units will eventually become self-financing.

At the time the two projects were started it had been reasoned that the quality of public health services was so poor that it was not useful to initiate reform policies such as cost recovery or even cost sharing without an improvement in quality. It appears that a health system's managerial dimension was not the government's concern at that early stage. Yet both projects have come to show that there are structural (central/local government) relationships to be clarified, policy territories for various levels of health services management to be mapped, as well as inadequacy in managerial capacity (planning, budgeting, control, evaluation, incentive management, etc.) to be rectified. These are some of the constraints which must be overcome if the projects' initial concepts are to be achieved.

More generally, both projects have originated at the central government level and later dropped to the district level for implementation—a top-down approach. One item of unfinished business is how to transform such projects into bottom-up user-owned and user-managed programmes. A failure to realize this may threaten the sustainability of the two initiatives. A number of other measures are also required.

First, the legislative and regulatory framework needed for policies of decentralization to operate effectively has been slow to develop. This has implications for efforts to involve communities in the management of health facilities. In particular, the issues of community ownership of public facilities, and the implications of this for their control over key inputs such as staff, remain unresolved. The CHF continues to be administered by district

authorities, which also creates a contradictory re-centralizing tendency. At the same time, many communities in Tanzania adhere to the ideal of continuing to have a government-owned health unit from which they access health services free-of-charge. They have not fully bought into this particular model of community involvement.

Second, the incentive structure remains extremely weak in publicly-owned health facilities. The level of wages is not sufficient to support health workers for the whole month, forcing them into corrupt practices and alienating those who are supposed to contribute to the CHF. At the same time, consumers are ill-informed of their rights and are unable to advocate for greater transparency and accountability. Payment of a living wage is a clear prerequisite for successful strengthening of health services.

Third, there remain elements of unisectoral and vertical programmes which address service provision at the sub-district level. These include drug supply, malaria control, a number of other preventive initiatives, family planning and population programmes. Districts need to find ways to integrate national level initiatives, while maintaining a bottom-led approach.

Finally, problems of macroeconomic stability, poverty, and inadequate transportation infrastructure undermine the operation of Community Health Funds. While it is possible to address some of these through careful design (e.g. allowing payments to CHFs to take place immediately after harvest when funds are available), others are entirely outside the control of the health sector.

## **6 REFLECTION ON THE APPROACHES**

The interventions have in various ways tried to work within the context of Tanzania's Health Sector Reform policy which emphasizes decentralization. In both cases the lack of funds has been (rightly) seen as one of the major constraints to implementing the objectives of developing an effective public health delivery system. In this regard donor funding has been sought to finance a programmed series of interventions, hence concentrating on the relaxation of the inputs related constraints. However, most of the donor-funded projects in Tanzania have been vertically conceived and executed. The initiators, funders and managers have often been the donors' programme officers and/or the MOH headquarters' personnel.

The two cases have taken on a project approach, meaning that the funding has to come to an end at some point. This raises issues about the feasibility of transferring responsibility to local government or communities for continuing these initiatives. One can conceive of four approaches to create and manage health services interventions (Table 5).

In Table 5, levels of sub-national participation increase from the left to the right-hand side columns. The extreme right hand column indicates the ideal approaches which enhance health sector decentralization, local responsibility and chances of sustaining the interventions. The extreme left hand column indicates traits of dependency and centralization which are in themselves constraints to be relaxed given the current situation in Tanzania.

A choice is therefore made depending on the country's grand policy concerns as well as the capacity of community level populations in rural areas to take up responsibilities such as programme planning and management. The dominant model in Tanzania in as far as the interventions examined are concerned has been option (a) and moving towards (b) in Table 5, i.e. a top-down, top-initiated approach. This is due, in part, to the limited funding ability and expertise at the sub-national level.

Table 5. Alternative approaches to designing and executing decentralizing health services interventions

	(a) Top-down and top-initiated	(b) Top-down and Bottom-up supported	(c) Bottom-up and top-supported	(d) Bottom-up and bottom managed; the ideal approach
1. Programme conceptualization	<ul style="list-style-type: none"> <li>• Donor predominance</li> <li>• Minor inputs from the central government staff</li> <li>• Sometimes external consultants are sought</li> </ul>	<ul style="list-style-type: none"> <li>• Donor/ministry of Health Experts or consultants conceive</li> <li>• Communities mobilized as silent end-use partners</li> </ul>	<ul style="list-style-type: none"> <li>• Policy problems identified by sub-national stakeholders,</li> <li>• Projects created at sub-national and support sought from above.</li> </ul>	<ul style="list-style-type: none"> <li>• Programme conception and designing at local level</li> <li>• Expertise sought from partners, stakeholders and supporters.</li> </ul>
2. Programme design and planning the execution	<ul style="list-style-type: none"> <li>• Domain of donor and/or central government personnel</li> <li>• Sub-national level stakeholders are on lookers and passive recipients of the supply-driven approach</li> </ul>	<ul style="list-style-type: none"> <li>• Donor dominance</li> <li>• Central government dependent on donor advice and financing</li> <li>• Sub-national levels take as passive recipients of supply-driven approach</li> </ul>	<ul style="list-style-type: none"> <li>• Dependent on donors' consultants in collaboration with central government experts</li> <li>• Central government executes</li> <li>• Some donors execute</li> </ul>	<ul style="list-style-type: none"> <li>• Concepts and programmes initiated by sub-national level</li> <li>• Sub-national authorities manage and evaluate programme implementation.</li> </ul>
3. Programme management and control	<ul style="list-style-type: none"> <li>• Centralized management and accountability relations</li> <li>• Reviews are centrally made and alterations are made with little or no consultations with sub-national levels</li> </ul>	<ul style="list-style-type: none"> <li>• Management systems are created by the central government authority in consultation with the sub-national authorities and communities</li> <li>• Sub-national representatives are accommodated on the centrally created committees</li> </ul>	<ul style="list-style-type: none"> <li>• Sub-national management structures and authorities are rationalized by the central government authorities</li> <li>• Central government representatives/experts are accommodated on locally created management authorities</li> </ul>	<ul style="list-style-type: none"> <li>• Within an integrated government health system, sub-national responsibilities are known and the sub-national authorities execute interventions falling within their mandates</li> </ul>
4. Programme financing	<ul style="list-style-type: none"> <li>• Basically donor funded, or</li> <li>• Basically central government funding</li> <li>• Combination of the two is a possibility</li> </ul>	<ul style="list-style-type: none"> <li>• Basically donor or central government funded</li> <li>• Sub-national authorities are given lesser financing responsibilities</li> <li>• Sub-national authorities tend to avoid responsibilities for fund raising</li> </ul>	<ul style="list-style-type: none"> <li>• Substantial amount of financing is mobilized at the local level or consumer level</li> <li>• Central government may be called to assist in large scale interventions, especially those in the category of public goods</li> </ul>	<ul style="list-style-type: none"> <li>• Finances are almost entirely sourced at the sub-national/service utilization level, e.g. by prepayment</li> <li>• Finances are locally operated, monitored and audited</li> <li>• Service-level decision-making for expenditure and revenue</li> </ul>
5. Programme sustainability chances	<ul style="list-style-type: none"> <li>→ It lasts as long as there is central government or donor support for funds and technical staff</li> </ul>	<ul style="list-style-type: none"> <li>→ Partnerships between central and local authorities can enhance sustainability</li> <li>→ Unclear responsibility for sustainability at sub-national level</li> </ul>	<ul style="list-style-type: none"> <li>→ Increased chances for sustainability and integration into sub-national planning processes</li> </ul>	<ul style="list-style-type: none"> <li>→ Much enhanced chances of sustainability and programme ownership</li> </ul>

A shift toward more sustainable interventions will occur when the ideals of options (c) and (d) are attained. This means the priorities and programme concepts are conceived and worked out at the local community levels: top level inputs would then become supplementary or complementary, and when complex technologies, large-scale cross-cutting inputs are required, and expertise is lacking at the community level. This is yet a super structural constraint to be relaxed. It means the approaches (a) and (b) are in themselves a constraint. Only by overcoming this constraint will it be possible to create those interventions which are bottom-up and top-supported (scenario c) and better still, those interventions which are conceived, financed and managed at the sub-national level, while at the same time contributing to universal health service principles and national health policy concerns such as primary health care, preventive services and equitable access to services.

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