



PARTNERS
IN INTERNATIONAL
HEALTH

DEMAND DRIVEN DISTRICT CAPACITY BUILDING

PREPARATION OF MODALITIES



Consultancy Report

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1. INTRODUCTION

This report describes the general findings of a consultancy commissioned by Danida to ETC Crystal, under the title 'Preparation of Modalities for District Demand Driven Support in the Lake Zone of Tanzania'.

Commissioned in June 2004, the consultancy was guided by a Terms of Reference, that outlined the background to the assignment, the objectives, the scope of work to be undertaken, the methodology, the expected output, the timing and the team composition (see Terms of Reference in Annex A)

As per these terms of reference, the field work for the consultancy was undertaken in two stages:

- a. A first visit to Tanzania by the team leader from June 13th to 24th, 2004, in order to conduct interviews at the central level and in the four regions of the Lake Zone and to make the necessary arrangements for a series of workshops that would be conducted later; and
- b. A second visit in August-Sept 2004, to actually conduct and facilitate the regional workshops.

Annex B contains the consultants' itinerary and programme during the two field work periods.

During the period between the two visits, the consultants prepared the content of the workshops from their respective home bases (in the Netherlands and in Dar es Salaam, Tanzania) through e-mail contact.

The present report describes the general findings of the consultants. It provides a brief description of the approach used and the produced outputs (chapter 2), some general findings and observations (chapter 3), suggestions for further support to demand driven district capacity building (chapter 4), cost estimates (chapter 5) and some general recommendations (chapter 6). This report addresses expected output D of the Terms of Reference.

2. APPROACH AND OUTPUTS

The output of the first field visit, in June 2004, was an outline for four regional workshops, comprising of the workshop objectives, a tentative programme, a draft framework for demand driven district capacity building (D3CB) and the logistical requirements for the workshops (see Annex C). Prior to its adoption, this document was shared with the regional technical advisor (health) at the Royal Danish Embassy in Dar es Salaam and several of the HSPS advisors, who gave their inputs on draft versions. The document was then shared with the four Regional Medical Officers in the Lake Zone to enable them to prepare themselves and send out invitations for the September workshops.

The four regional workshops that were organised in the respective regions of the Lake Zone (Kagera, Mara, Mwanza and Shinyanga) served four distinct purposes:

1. Clarify the purpose of the D3CB support framework and concepts; and further develop the menu of district health support packages to improve district health services which had been prepared prior to the workshops
2. Identify and prioritise the needs for capacity building to improve provision of quality health service delivery at the council level and below through a self-assessment
3. Clarify the modalities of the D3CB support framework
4. Identify and prioritise the needs for capacity building at the regional level to provide technical and managerial support to district teams to be able to deliver quality health services (last day of each of the workshops).

The outcome of the four regional workshops was shared at a so-called market place meeting on Sept 6th in Mwanza, in which clients of the D3CB programme and representatives from local resource institutions as potential providers of technical support participated (see programme of this meeting in Annex D).

Following the four workshops, a separate report has been produced, entitled '*Demand driven district health capacity building – Framework and modalities*', which lays out the agreed conceptual framework and the modalities of support that will be provided under HSPS III. This report, which was submitted to the Danish Embassy and HSPS in October 2004, covers the expected outputs B and C of the terms of reference. Earlier versions of this report were reviewed and commented upon by the regional technical advisor (health) at the Royal Danish Embassy in Dar es Salaam and several of the HSPS advisors.

3. GENERAL FINDINGS

All 25 Council Health Management Teams (CHMTs) of the four regions in the Lake Zone participated in the regional workshops. They are to be commended for their enthusiastic participation, in particular for their involvement in the self-assessment. It was quite a tedious and demanding exercise, which most of them have completed with a great deal of enthusiasm and dedication. Those who were not quite able to complete the assignment during their workshop (because of time constraints) should be able to do so at their own convenience.

The procedures to arrive at performance scores and priority scores for each of the 22 functions that Council Health Management Teams need to perform are explained in the D3CB Framework and modalities document. This document also presents the scores assigned by each of the 25 council teams and some summaries with the average scores by region.

It should be noted that the performance scores assigned by the various teams may give one the impression that the assignment has been a very scientific exercise. That however is not the case. The exercise was a true self-assessment in which the consultants, as workshop facilitators, relied on the sincerity of the participants. They challenged the participants to be critical of their own performance, and asked them to be honest and fair. There were no yardsticks against which the CHMTs could measure their own performance and therefore some of the assigned scores are arbitrary. But the main issue is that the district health managers and service providers *themselves* conducted the assessment, rather than the consultants, who would have passed a judgement without necessarily convincing the managers that there may be some weaknesses that require their attention. Thus, a certain sense of ownership has been created among the participants, which should form a good basis to actually start strengthening local capacities.

Commentary on the performance and priority scores

Below we will highlight the main results of the self-assessment by cluster of functions and at the same time provide a commentary to explain why the performance in some areas was much better than in others. In addition, some comments will be made on whether the low or high scores are justified in the eyes of the consultants, who participated in the group discussions as facilitators.

Cluster I: Service provision		Perform.	Priority
1	Adherence to set standards of health care services	17	4
2	Continuity of care and patient referral	12	5
3	Support of community based health initiatives	16	3

- a. For clusters 1 and 2, the self-assessment scores are obviously affected by the prevailing staff crisis (few trained cadres) and the poor physical infrastructure, in particular the shortage of medical equipment. This implies that, in the view of district health managers, adherence to set standards and continuity of care would benefit greatly from bigger investments in training and deployment of the right staff for the right positions. It is widely known, for example, that Rural Medical Assistants in Tanzania are not trained to diagnose disease and treat patients; yet in many remote areas they are the only cadres that are available.
- b. At the same time, however, the consultants observed a fairly high confidence (over-confidence?) among CHMTs, as if health workers generally do enough to ensure the delivery of quality health systems within the existing resource constraints. For example, some types of equipment may not be available in each and every health facility, but there was a great deal of discussion during the workshops about the insufficient use of simple instruments such as thermometers and about fevers that are being treated indiscriminately as malaria. From this we derive that health workers and CHMT members have a tendency to seek the cause of poor quality of health services outside themselves.
- c. The consultants observed that CHMT members had quite a limited understanding of patient flows and referral patterns: who goes where and why? Where do clients/patients enter the health system (at what level), where do they actually receive a service and where do they end up? Health workers assume a great deal but don't seem to know the actual patterns. A further observation was that there is very limited recognition of the fact that not everyone seeks treatment from existing health facilities and why this is so. As a result, health workers have a limited understanding of why some of the service coverage rates are so low: for instance, only 30-40% of women delivering in health facilities. Health workers, councils, politicians and various aid organisations try to solve such problems by doing more of the same (e.g. adding more clinics, without necessarily ensuring that the necessary staff is available) instead of understanding the problems and doing things differently (e.g. investing in the *quality* of services, rather than the quantity).
- d. Workshop participants gave several good examples of community based health initiatives in the area of sanitation. Yet, the performance in this domain is very low: rank 16 out of 19.

Support to community based health initiatives is given a high priority, though, partly because health workers acknowledge that the causes of many health problems are at the level of the community, and that hospitals and dispensaries only have a limited effect on people's health status.

- e. Many participants cited the construction of dispensaries or health centres by local communities as a good example of community based health initiatives: that however is very tricky, because it is not easy to provide the necessary staffing and other operating costs for such new facilities. Faith based organisations, community based organisations and other local NGOs play a dubious role in this regard, and there may obviously be instances where there is a great deal of pressure from local politicians. This underscores the need to fit infrastructure development into a long-term plan that takes staffing and running costs into account. This is a difficult but very important role for the CHMT, which most people do not seem to be aware of or decline to acknowledge.

Cluster II: Planning		Perform.	Priority
4	Comprehensive planning	5	11
5	Partnerships	18	13
6	Monitoring and evaluation (incl. HMIS/MTUHA)	14	1
7	Reporting	3	18
8	Disaster preparedness and response	19	12

- a. Most CHMTs appear to be pretty confident with their skills in comprehensive planning. This may be a result of all the training efforts that have gone into this. A few CHMTs indicated they require training because of staff transfers.
- b. The consultants' observation, though, after looking critically at some of the comprehensive council health plans, is that the mechanics of planning may be in order, but there is definitely scope to improve the planning process. For instance, by involving health institutions and other partners in the district and ensuring that planning is not merely a paper work exercise. The CHMTs do not seem to fully recognise this.
- c. Also, although annual plans are being made, very little *strategic* planning is being done: it is not a requirement from the Ministry of Health and therefore there is no routine to develop long-term plans (over 3 or 5 years). Councils/CHMTs do not (yet) have a habit of articulating a vision or a long-term goal, for instance about what they hope to achieve in the next five years or so. There are a few exceptions, though: Kagera and Tanga hospitals have

formulated a vision, from which a strategic plan may be derived. However, strategic planning *is* being done as part of the general reforms of the council. One might say that health is ahead in terms of development of operational plans (and decentralised systems), but behind in stead of strategic planning. The two processes need to be connected and either side (Ministry of Health and councils) has something to learn from the other. For instance, a DPLO/CHMT who would like to harmonise its various planning processes should be able to benefit from support through HSPS/D3CB. This constitutes an opportunity: HSPS/Danida already provides support to PO-RALG, and therefore the challenge would be to stimulate the demand for support to harmonise planning processes.

- d. In addition, the link between the CCHP and the overall Council Development Plan is not very strong: neither in terms of the process (bottom-up versus 'top-down') nor in terms of the content. The two planning processes seem to be viewed as two separate exercises.
- e. In addition, there are other comprehensive planning exercises that are being conducted at the council level, e.g. for HIV/AIDS activities (for which AMREF provides support in certain districts, in Mara region and possibly elsewhere). This may be yet another exercise, of which it is not entirely clear how it fits with the overall Council Development Plan and the CCHP.
- f. Most CHMTs consider partnership (with FBOs, CBOs, NGOs) one of the areas in which their performance is weakest. None of the councils have any health forums in place where partners can meet, except Bukoba Urban.¹ Other than the agreements between CSSC member institutions and the Ministry of Health, there are no examples of written memorandums of understanding, service agreements or contracts between councils and non-governmental agencies. The medical equipment maintenance workshop, which is run by a church institution in Mwanza region is a good exception: several councils have taken membership (a subscription) and utilise the maintenance services provided by this workshop.²

Mistrust is often quoted as a major cause of poor partnership. The discussions during the last day of the regional workshops – in which several of the non-governmental stakeholders in the various districts participated – revealed that this mistrust is often associated with anxiety to lose control over resources, mostly finance. It is odd that despite the low performance score for partnership very few councils consider it a priority area.

¹ The forum operates under the name BUNGO and his presided by the DMO.

² For instance, Bunda hospital (an ELCT facility) and Tarime hospital (under local government).

- g. Monitoring and evaluation is considered as a weak area, and comes out as priority number one to improve. However, the seriousness of not utilising available information may not be fully recognised by all. If M&E systems are not in order, it means that progress is not being measured, and therefore that evidence / information is not being fed into the next planning cycle. One can see that from subsequent annual plans from the same council: they look very similar. Hence the weak M&E in a way suggests that the quality of the annual plans is not as good as some councils seem to believe.
- h. The reporting performance is rated very high (3rd highest out of 19). Because of the lack of reliable data this may be a little overestimated, though. There may have been a slight confusion, whereby some councils were thinking of financial reporting, rather than technical reporting. Anyway: not a priority, first the use of data for decision making and M&E needs to be strengthened.
- i. Disaster preparedness: scores very low on performance, yet it does not receive a very high priority. There is room to learn from the experience in Kagera district, which has a *regional* disaster preparedness unit in place that can be mobilised fairly quickly in case of a disaster. Several people have been trained and there is a certain stock of drugs and supplies available. at the regional level. because of economies of scale). Because of economies of scale it seems appropriate to assign disaster preparedness to the RMO office, in conjunction with the regional hospital. During the discussion it was suggested that *early warning* should remain a task for the council and that it requires strengthening as part of the M&E system (MTUHA).

Cluster III: Acquisition and development of resources		Perform.	Priority
9	Human resource development	7	2
10	Health financing	15	9
11	Procurement of goods and services	9	14

- a. While councils rated themselves fairly high on human resource development (7th out of 19; partly because of the relatively large number of training workshops that are being conducted), HRD ranked second in terms of priority. This reflects that CHMTs tend to overestimate the value of workshops, seminars and training courses. What HRD really means is that councils have a system in place to acquire new staff and at the same time strengthen local capacity. The framework and the guidelines are there, but do not seem to be used that much. It is telling that most of the CCHP's are silent about HRD.

- b. On the other hand there is not so much councils can do themselves in the area of human resource development. Responsibilities are quite fragmented (between the Ministry of Finance, Local Government and the Ministry of Health) and most of the important decisions about staff establishments are taken at higher levels. The discrepancy is big: health facilities have generally few qualified staff, and the ratio unqualified/qualified staff is skewed. Yet, there are many qualified people who are unemployed. Councils seem to have a tendency of recruiting lower trained cadres.
- c. With regard to health financing, the general agreement was that there is scope to increase local revenue generation: NHIF, cost sharing, and local council contributions, which seem to have gone down (!). Councils do not have a habit of setting targets for revenue collection. Kagera region has developed a plan to support districts in health financing.
- d. In relation procurement of goods and services it was noteworthy that councils do not seem to be familiar with the new procurement act. Otherwise most councils seemed to think they were doing reasonably fine.

Cluster IV: Management of resources		Perform.	Priority
12	Management of human resources	11	10
13	Management of finance and accounts	1	8
14	Management of infrastructure and logistics	8	15
15	Management of drugs, vaccines and other	4	21
16	Management of information for decision making	13	6
17	Management of time and space	6	19

- a. The fact that the performance in the area of financial management came out strongest in the self-assessment is surprising: at the central level of the Ministry of Health the general opinion is that there is much room for improvement.
- b. A possible explanation for this discrepancy is that CHMTs themselves may not be very familiar with several of the financial management issues, which are more the responsibility of the council, and therefore they tend to overestimate their own performance. This may therefore represent a weakness in the self-assessment tool and in the groups of people that conducted the assessment. Key functionaries that did not participate, for instance, were the treasurer of the council, the human resource development officer and the council engineer.
- c. Human resource management is one of the key functions of councils, but the performance in this domain is rated rather low (11th out of 19). It turned out that the process of staff transfers

does not seem to be very clear. Many do not know for instance that councils can advertise for posts that can be filled through staff transfers. Councils seem to recruit unqualified staff once they have obtained permits from the Civil Service Management Office. Several CHMTs complain that their councils seem to be interested more in the number of staff than in their qualifications. This issue could be addressed in a HRD plan.

- d. In terms of drugs management the CHMTs rate their performance reasonably high (4th out of 19) and they do not consider this a priority for capacity building.

From the discussions it became clear that the disposal of drugs and obsolete equipment seems to be a very tedious and bureaucratic process. Incinerators may be available, but the disposal process seems to be too centralised, involving even the Ministry of Finance (for accountability purposes). As a result, some districts have drugs in stock that expired up to 10 years ago.

- e. The importance of strategic planning for infrastructure development (see above) is underestimated. This is a difficult issue, because of political interests, but it does require attention, in particular at the council level.

- f. With regard to management of time and space, one issue that stood out is the interference with CHMT affairs by the central government and donors/NGOs. Interference happens in the form of unannounced visits, centrally planned workshops (without sufficient notification and prior information), centrally driven projects and requests for reports. Councils/CHMTs do not have the habit of refusing or turning down requests but in a truly decentralised system they should at times say “No”. The consultants own observation was that some of the weaker councils used the issue of interference from outside as an excuse for not doing what they are supposed to be doing.

Cluster V: Cross-cutting issues		Perform.	Priority
18	Communication	2	22
19	Governance and community involvement	low	7
20	Intersectoral collaboration & poverty reduction interv.	10	20
21	Gender mainstreaming	very low	16
22	HIV/AIDS mainstreaming	high	17

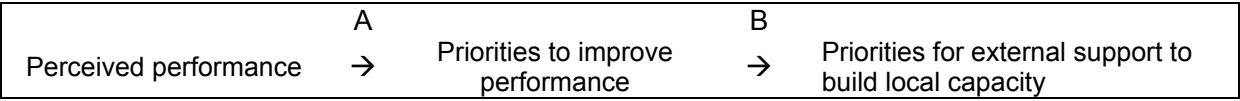
- a. Not all councils were able to complete the self-assessment of cross-cutting issues, and that is why it was considered inappropriate to calculate average scores or exact rankings. The consultants urged the CHMTs to complete the exercise at their own convenience.

- b. Governance and community involvement scored low on performance and some councils gave it a high priority (ranked 7th on average). Two problems were cited in this domain. Some councils are waiting for official gazetting of the composition of their boards and committees. Others have them in place, but in many cases these structures do not function properly. It turned out that the roles and responsibilities of the boards and committees are not very clear and the CHMTs/councils themselves seem to lack exposure and the technical skills to provide the necessary guidance. In addition, some teams suggested the willingness to make it work was not always there. This explains (at least in part) why some did not consider it a priority for capacity building.
- c. The performance in the domain of HIV/AIDS mainstreaming is clearly overrated. This is mainly because of the prevailing medical point of view, which brings along an attitude of “as long as we are rendering a service (counselling, testing, home-based care) we are doing fine.” Mainstreaming does not seem to be well understood.
- d. Only one council has intersectoral collaboration among its priorities. Again, this topic is rather difficult to put into practice, perhaps more difficult than partnership, which is limited to the health sector. Intersectoral starts with sharing information *between* the sectors, for instance on malnutrition. Also, the issue of poverty reduction – high on the national and international agenda – is difficult to conceptualise and operationalise in a rural environment. Many people ask themselves: “How different is it from what we are doing already?”
- e. While few CHMTs rated their performance on gender mainstreaming (because of time constraints), the scores were very low. Especially the teams in Kagera region scored very low: this may be due to a higher level of awareness, as a result of which they are more critical about gender issues. Awareness building elsewhere may be required, but their main challenge is to develop local capacity to really address the issue of gender imbalance.

Commentary on the procedure to determine the needs for external support

On hindsight, the reflection on how to identify and prioritise areas for capacity building and derive these from the self-assessment could be strengthened. The teams that participated in the regional workshops and conducted their self-assessment had in fact little time to analyse and reflect on this. Ample attention was given to assessing performance and identifying the functions

that require more attention against a set of four criteria.³ This represents step A in the following chain.



Step B, however, would have required more attention: based on the priorities identified to improve performance, how can one distinguish between actions that CHMTs (or health institutions) can undertake themselves without external support and actions for which they require external support to build or strengthen local capacity.

In the first workshop (in Mwanza) all teams asked for support in all the areas in which they considered their performance as weak. Nobody seemed to be consider whether CHMTs could perhaps improve their performance themselves without external assistance. The consultants then changed their approach in subsequent workshops. The question whether teams required external support was asked later during the workshop, which worked out much better. But still, it would be better to allow more time to analyse (for each of the 22 functions) whether CHMTs have sufficient local capacity to put things into practice or whether they need external support.

Some final observations

In relation to the composition of the teams involved in the workshops: the self-assessment was conducted by a selection of CHMT members, not by the entire CHMT as would have been ideal. Some teams did not include some of their core members. It would therefore be good if councils repeated the self-assessment and involved the rest of their teams, other key officers from the council (e.g. from the accounts section, the human resource section) and some of their partners within the district.

There is a tendency among CHMTs towards a strong involvement in planning and management activities, much less so in supporting the actual service delivery, which is the core business of the health sector. As a result, most CHMTs seem to be less comfortable with clusters I and V. This may be due to expectations from the Ministry of Health HQ and donor agencies who have invested a lot in capacity building in the area of planning and management. According to the consultants this is an anomaly that needs to be redressed and the present D3CB approach has the capacity to do so.

³ Relevance, urgency, feasibility, level of innovation: see page 10 of the D3CB Framework and modalities document.

4. FURTHER SUPPORT TO D3CB

The modalities of support under the D3CB component of HSPS III have been laid down in Chapter 3 of the D3CB Framework and modalities document, of which all councils have received copies. These modalities include the application procedures for support, the approval procedures, financial ceilings and cost estimates, contracting modalities, financial disbursement procedures and requirements for reporting and accounting.

In order to further develop D3CB it is useful to make a distinction between support activities that are required in the next half year or so and longer term actions.

Support in the next half year

Most councils and regional health management teams in the Lake Zone have concrete ideas for external support they would require for strengthening their own performance. Some have already put down their ideas on paper, in a format suggested during the regional workshops.⁴

The challenge for HSPS III will now be to maintain the momentum and provide support to institutions in the Lake Zone that are actually ready to start building their own capacities. The public health advisor who will be based in Mwanza will have the responsibility to follow-up on the ambitions of the various RHMTs, CHMTs and individual health institutions and assist them. As long as this advisor has not yet been appointed and has not taken office, the other technical advisors and component managers (based in Dar es Salaam) will have to make a special effort and actually travel to the Lake Zone to provide support in the transition period.

It is suggested that one-day meetings will be organised in the Lake Zone at regular intervals – for instance every six weeks or at least once every two months – involving the four RMOs. They will present the progress in the development of proposals and in the implementation of approved projects in their respective regions for discussion with HSPS technical advisors.

These meetings may not provide sufficient insight and it may be necessary to call meetings in each of the four regions with representatives from the respective CHMTs to discuss the progress more in depth and identify areas in which HSPS would need to provide additional technical support. The points to be included on the agenda for such meetings could be:

⁴ See page 18 of the D3CB Framework and modalities document.

- a. Whether all CHMTs have been able to complete their self-assessment (as far as relevant);
- b. Whether all CHMTs have settled for one or two priority topics for which they wish to strengthen their capacities;
- c. The stage of development of project proposals and/or problem analyses;
- d. Results so far of contacts with resource institutions that provide external support;
- e. Progress in implementation of projects;
- f. Lessons learned that are worth sharing between CHMTs.

It may turn out that some potential D3CB clients are not able to submit a project proposal in line with the requirements set out in the Framework and modalities document. Such clients may need external support – from local resource institutions or directly from Danida advisors – to conduct a problem analysis and identify areas in which they should strengthen their performance.

For individual capacity building projects, it may be necessary to call separate meetings with the individual client (CHMTs, health institution or NGO) and the provider (the resource institution) to review the progress and address problems that may have come up in the process.

In this manner it should be possible to get five to ten D3CB projects underway in the next six months.

Support in the long run

The self-assessment, which the 25 CHMTs in the Lake Zone have been taken through during the regional workshops in August-Sept 2004, was a first exercise of this kind for all the teams involved. It is suggested that this self-assessment will not be a one-off exercise, but that it will be repeated after some time by the same teams. The results of the first self-assessment would serve as a baseline and the repeat might reveal changes in performance on some of the 22 district health functions and/or new priorities for capacity building.

The self-assessment tools would need to be revised based on the experiences that will be acquired in developing D3CB project proposals and implementing projects. Already at this stage we recommend to include *infrastructure development* as an additional district health function. It was left out of the menu of 22 packages, but came up during the regional workshops as an area in which several CHMTs face serious problems.⁵ All councils need to look very critically at their performance in this domain and some of them may require external support to strengthen their capacity.

⁵ This function would belong to cluster III, acquisition and development of resources.

The HSPS III Project Document suggested that the D3CB component would include “comprehensive support” to institutions “in all areas of management”. This would involve a *generic* type of support, from which all institutions (councils, district health authorities, regional secretariats, NGO institutions) would benefit, as opposed to the support to discreet interventions as per expressed need which is the approach that has now been adopted. There are many forms of generic support on offer in Tanzania, mostly in the form of workshops and often funded by external donors through ‘vertical programmes’. In many cases this type of support is driven by supply rather than by demand. For the moment, the D3CB component does not provide for such support. The results of the self-assessment have shown quite a diverse picture of the performance of CHMTs and individual health institutions. As a result their interests and requirements for capacity building are also rather diverse. The experiences with implementation of D3CB projects will show whether lessons learned in one district may be useful for another and whether this calls for the provision of similar (generic) support to several clients at once. For the moment, the sole type of generic support that seems appropriate is assistance to relatively weak councils to conduct a problem analysis in the priority areas that they identified during the self-assessment. This would assist these councils in identifying the core problem and the main contributing factors.⁶ Once such a problem analysis has been made, it will be easier for them to derive an action plan and possibly a D3CB project proposal.

Depending on the capacity of the *providers* of D3CB support in the Lake Zone and elsewhere in Tanzania and their actual performance in assisting clients, it may be necessary to strengthen the capacities of these providers as well. This could be in the form of training in consultancy skills or coaching over a certain period of time, in which senior international consultants could be involved.

Extension of the D3CB component of HSPS III to other parts of Tanzania should be considered at some stage. Given the size of the Lake Zone and the large number of potential clients, it will be wise to concentrate all efforts on the Lake Zone at least for the next two years. Meanwhile, however, it is recommended to accept D3CB project proposals that institutions from outside the Lake Zone may submit in the first 2-3 years, provided of course that these proposals are of good quality and meet the requirements set out in the D3CB Framework and modalities document. For the time being, it is recommended to

⁶ There are several resource materials that can be utilised for conducting a problem analysis. A very good resource is: Varkevisser, Pathmanathan and Brownlee: Designing and conducting health systems research projects – Volume 1: Proposal development and fieldwork. KIT Publishers and IDRC, 2003. Especially Module 4: Analysis and statement of the problem.

- a. Make the D3CB Framework and modalities document and the self-assessment tools available through the HSPS website;
- b. Maintain and expand the database of resource institutions that are potential providers of D3CB support, and make this available through the website;
- c. Make available a list of ongoing D3CB projects and reports of completed projects through the website;
- d. Take the opportunity to make publicity for the D3CB approach at national forums, such as the DMO's conference (planned for May 2005), the RMO's conference (each year in September).

Review of experiences

A review of the D3CB experience in the Lake Zone in the course of 2006 would be useful to assess the progress made and the extent to which the programme actually contributes to capacity development and strengthening of district health systems. Such a review should include:

- a. An assessment of the quality of the proposals received;
- b. An assessment of the completed and ongoing projects;
- c. An assessment of the quality of the support provided by the resource institutions;
- d. The identification and analysis of problems that may impede progress in demand driven district health capacity building.

The review could be designed as a peer review, in which councils/CHMTs review the D3CB experience and performance of their peers, against a standard set of criteria. This process of learning from each other may generate an extra value, in the sense that replication of good experiences will be encouraged.

The review would also inform the decision of whether or not extension of D3CB beyond the Lake Zone is appropriate in the second half of HSPS III's lifetime.

5. BUDGET

The total budget that is available under HSPS III for D3CB according to the project document amounts to DKK 59 million over five years. This includes the fees for contracting local resource institutions. It does not include long-term technical assistance (provided through the Danida technical advisors) or short-term international and/or regional technical assistance (for which 10 person-months have been reserved over and above this budget).

Table 5.1 shows the budget allocation over four sub-components and the distribution over the years, as presented in the project document (in Danish Kroners) and converted to Euros and Tanzanian Shillings.

Table 5.1: Budget for D3CB

	2004/05	2005/06	2006/07	2007/08	2008/09	TOTAL
	In millions DKK					
a. Comprehensive district capacity building	2	4	5	6	5	22
b. Support for specific demands	1	3	4	4	3	15
c. Test innovative approaches	1	3	3	3	3	13
d. Experiences used for policy development	1	2	2	2	2	9
TOTAL	5	12	14	15	13	59
	In 1,000 Euros					
a. Comprehensive district capacity building	269	538	673	807	673	2,959
b. Support for specific demands	135	404	538	538	404	2,018
c. Test innovative approaches	135	404	404	404	404	1,749
d. Experiences used for policy development	135	269	269	269	269	1,211
TOTAL	673	1,614	1,883	2,018	1,749	7,937
	In millions TSh					
a. Comprehensive district capacity building	350	700	874	1,049	874	3,847
b. Support for specific demands	175	525	700	700	525	2,623
c. Test innovative approaches	175	525	525	525	525	2,273
d. Experiences used for policy development	175	350	350	350	350	1,574
TOTAL	874	2,099	2,448	2,623	2,273	10,318
<i>Assumption: average cost per proposal (in millions TSh)</i>	20	20	20	20	20	
Number of proposals that can be funded (from b and c)	17	52	61	61	52	245

Exchange rates:

1 DKK = approx. 175 TSh
1 Euro = approx. 1,300 TSh

It is proposed that the budget available for (a) *Comprehensive district capacity building* be reserved for scholarships for formal training (MPH training,⁷ MBA training, short courses) and generic types of support that are yet to be identified. The budget available for (d) *Experiences used for policy* will mostly be utilised at the national level. This leaves the budgets for (b)

⁷ Master in Public Health

Support for specific demands and (c) Test innovative approaches to be used for D3CB projects at the level of regional secretariats, districts/councils and individual health institutions. With an average of some TSh 20 million per project, this means that there is room to support 17 projects in the first year (2004-/05), 52 in the second (2005/06), and a total of 245 projects over the five years project.

6. RECOMMENDATIONS

The consultants have the following recommendations towards the HSPS programme managers and advisors.

- 1) As long as the public health advisor in Mwanza has not yet taken office, the other technical advisors and component managers (based in Dar es Salaam) will need to make a special effort to provide D3CB support in the Lake Zone. This will require (a) meetings at regular intervals with the respective RMOs, (b) meetings in the regions with representatives from the respective CHMs and (c) technical meetings with individual clients (CHMTs, health institutions, NGOs) to assist them in getting D3CB projects off the ground.
- 2) The self-assessment should be repeated after some 1-2 years involving the same council health management teams. When repeating the exercise, it is recommended to involve all key members of the CHMT as well as other key officers from the council, such as the heads of the accounts section and the human resource section, and some of the non-governmental partner institutions in the district.
- 3) The self-assessment tool will need to be revised and adapted according to experiences that will have been acquired by then. Already it is clear that the topic of infrastructure development needs to be incorporated into the D3CB menu, and that several councils may require assistance to develop a long-term infrastructure development plan that takes staffing and running costs into account. Also, as part of the exercise of priority setting, more attention should be given to making a distinction between actions that CHMTs (or health institutions) can undertake themselves without external support and actions for which they do require external support to build or strengthen local capacity.
- 4) In providing D3CB support, HSPS should give priority to clients that are able to develop good quality project proposals that meet the standards as set out in the D3CB Framework and modalities document. Councils that are not able to come up with a good quality D3CB project proposal should be considered for assistance to conduct a problem analysis.
- 5) HSPS may consider providing support to resource institutions that have been identified as potential providers of D3CB support. Experience in seeing them collaborate with clients in the Lake Zone will tell how capable these institutions really are. Support may include training in consultancy skills or coaching trajectories over a certain period of time by senior consultants.

- 6) Extension of the D3CB component of HSPS III should be considered after proven success in the Lake Zone; this may require an independent review in the course of 2006 or early 2007.

ANNEXES

- A. Terms of Reference
- B. Itinerary and programme
- C. Outline of the four regional workshops in Aug-Sept 2004
- D. Programme of Market Place meeting of Sept 6th in Mwanza
- E. Debriefing note of Sept 7th, 2004
- F. Demand driven district health capacity building – Framework and modalities (separate document)

ANNEX A: TERMS OF REFERENCE

104.Tanz.810.

TERMS OF REFERENCE PREPARATION of MODALITIES DISTRICT DEMAND DRIVEN SUPPORT LAKE ZONE TANZANIA

Background

Danida has been supporting the health sector reforms in Tanzania through its phase I and II Health Sector Programme Support (HSPS) since the mid-nineties. Under the guidance of Health Sector Reform Secretariat of the Ministry of Health impressive gains have been made with putting in place the required decentralised systems as part of the reforms of the sector.

Recent technical reviews indicated that further efforts are required at the district level to bring about tangible improvements in the quality of service delivery and care, being the priority issues for the Health Sector Strategic Plan which covers the period 2003 to 2008.

Preparations are underway for phase III of HSPS, expected to last from July 2004 till July 2009. After extensive consultations it has been decided that as one of the main tenets around which Danida proposes to focus its support during this phase, will be the development of district/council demand-driven support on the assumption that complementary specific support in a variety of areas will better address the needs at district and regional level and will lead to marked improvement of the quality of service delivery and care.

It is assumed that this support will be additional/complementary to the regular support received at the districts/regions and can either be provided through available expertise among the Danida advisers or can be obtained through other channels be it governmental or non-governmental, for profit or not for profit.

This constitutes a new and different approach for the further working out of which a short-term consultancy is proposed to develop the broad frame-work as well as the modalities to be put in place by HSPS / MoH to arrive at an optimal use of available resources as well as to prepare the districts/councils and regions of the Lake Zone for their active participation.

The approach is described in more detail in the draft HSPS III Document, to which reference must be made.

Objectives

A framework for demand driven support to improve district services developed, including:

- Areas that can be supported;
- Institutions that can give support;

- Modalities of support; and
- application and selection procedures.

Scope of Work

The consultancy will include but not necessarily be limited to the following:

- Prepare workshops with councils, DHMTs, private sector and regional staff to discuss the nature of the support.
- Survey the resource base in terms of institutions, persons and material available within key areas both at different levels (local to national).
- Assess the capacity and possible role of the Zonal Training Centre.
- Suggest modalities of the support within the three main approaches, i.e.: comprehensive support for management; support for specific demands; and support for innovative approaches. Apart from support to solve specific problems this should include assistance to analyse the root causes of identified problems.
- Suggest design of menu of options for support as well as suggest appropriate supporting material. Within this area specifically assess the scope for web-based services, and if found useful outline this. The areas where additional support is expected to lead to tangible improvements in the quality of health service delivery and care can be found in the draft HSPS III Document (currently chapter 4.2.1.3).
- Propose the concrete coordination mechanism to be put in place, specifically whether this can be taken care of by the Health Sector Reform Secretariat or should fully or partly be outsourced.
- Assess the cost range for the different types of support.
- Suggest a specific application and selection procedure. This should include suggesting roles of Regions, MoH and RDE. It should be done with a view to have quick procedure and secure a flexible and innovative approach; and to strike a balance between different modalities and areas of support.
- Assess the need for information on the demand driven approach to Councils, Regions and private sector institutions, and outline how this should be given.
- Advice on how experiences gained in Lake Zone can be utilised nation-wide.

Methodology

The consultants will work in close consultation with the important stakeholders: MoH, PO-RALG, Danish Embassy (RDE) and Christian Social Service Commission (CSSC).

The Consultants will conduct interviews with stakeholders at the various levels, e.g. MoH, PO-RALG, RS, Councils, Zonal Training Centre, CSSC, Evangelical Lutheran Church in Tanzania (ELCT) and RDE and by making field-visits to the Lake Zone.

A series of workshops will be organised, one in each region. The workshops will be conducted in such a way as to foster innovative ideas and articulate all levels of the health system, e.g. clinic, hospital, district and regional including private sector.

Assessment of likely resource institutions, like MoH programmes, universities, NGOs, Zonal Training Centres (e.g. Arusha), consulting companies, and centres of excellence in public or private sector (e.g. DHMTs, hospitals etc.).

The consultants will aim at achieving consensus between the important stakeholders regarding the design of the sub-component.

Output

The following outputs are expected to be available at the end of this consultancy:

1. Plan for the Regional workshops
2. A frame-work clearly indicating the areas in which support can be provided, indicating how and by whom the support can be delivered.
3. Clear guidelines on how the support will be structured and delivered
4. A short, concise report on the general findings of the consultants.

Timing

The consultancy will be conducted in two phases:

1. For a period of approx. ten days at the end of June – beginning of July 2004, in order to conduct the first interviews at the central and regional level and to make the necessary arrangements for the workshops / brainstorming sessions in each of the four regions;
2. For a period of four weeks during the month of August 2004, to actually conduct/facilitate the regional workshops / brainstorming sessions and interviews.

Final outputs (2-4) are to be delivered by mid September 2004

Team composition

The team will consist of:

- One (1) international consultant, with extensive experience with development of the concept of district demand driven support;
- One (1) representative of the Health Sector Reform Secretariat, MoH
- One (1) local consultant, with extensive experience with health
- Service delivery systems in Tanzania.
- HSPS advisers, will act as resource persons as well as active participants in development of the concept of district demand driven support.

Timing

- | | |
|---|---------|
| • preparatory work, including visit June 2004 | 3 weeks |
| • field work August 2004 | 4 weeks |
| • report writing | 2 weeks |
| • additional work | 2 weeks |

BP/FS/ - 29-05-04

ANNEX B: ITINERARY AND PROGRAMME

<i>Dates</i>	<i>Activity</i>	<i>Consultants</i>	<i>Place</i>
13 June	International travel	LB	Arrival in Dar es Salaam from Amsterdam
14-17 June	Briefing, interviews	All 3	Dar es Salaam and Morogoro
18-23 June	Interviews, field visit to two districts, meeting with RMOs	All 3	Mwanza
23-24 June	Preparation of workshop outline; interim debriefing at Danish Embassy	All 3	Dar es Salaam
24-25 June	International travel	LB	Departure from Dar es Salaam to Amsterdam
July-early August	Preparation of workshop tools and procedures	All 3	Through e-mail exchange
12 August	International travel	LB	Arrival in Dar es Salaam from Amsterdam
13 August	Preparation of 1 st workshop	All 3	Dar es Salaam
14-21 August	1 st workshop in Mwanza region	All 3	Mwanza
21-28 August	2 nd workshop in Kagera region	All 3	Bukoba
28 August-4 Sept	3 rd workshop in Mara region; and	LB, GS	Musoma
	4 th workshop in Shinyanga region	AH	Shinyanga
5-6 Sept	One day meeting with all regions	All 3	Mwanza
7 Sept	Debriefing at Danish Embassy	All 3	Dar es Salaam
7-8 Sept	International travel	LB	Departure from Dar es Salaam to Amsterdam
Sept-Oct	Preparation of documents, report writing	All 3	Through e-mail exchange

AH Ahmed Hingora
 GS Godfrey Swai
 LB Leon Bijlmakers

ANNEX C: OUTLINE OF FOUR REGIONAL WORKSHOPS

Demand driven district capacity building (D3CB) component of Danida HSPS III in the Lake Zone

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Outline of the (4) regional workshops

Objectives of the workshop

1. Clarify purpose of D3CB support framework and concepts; and to further develop the menu of district health support packages;
2. Identify and prioritise the needs for capacity building at the council level and below (through a self-assessment);
3. Clarify the modalities of the D3CB support framework;
4. Identify and prioritise the needs for capacity building at the regional level (last day).

Approach

Self-assessment by council health management teams (CHMTs) based on a review of existing Comprehensive Council Health Plans and activity reports. In order to facilitate this self-assessment, a variety of instruments will be developed for use during the workshops.

Participants

- Five participants from each district/council:
 - Three CHMT members (DMO, DPLO and one of the following: DNO, DRCHCo, DHO, DPharm, Health secretary);
 - The lead agent from CSSC in the district (district medical secretary);
 - One representative from the management team of the district referral hospital.
- Four RHMT members: RMO, RNO, RHO, RHS;
- Others from the regional level: RPLO from the Regional Secretariat, a representative from APHTA (if present);
- From the zonal level: Representative from the Mwanza office of the LG Reforms Programme (HR officer, as resource person); and the CSSC health coordinator for the zone;
- Danida advisors (as resource persons): Bou, Sam, Hans, Jan, Finn, Helene;
- Moderators: Hingora, Swai, Leon.

Venues and timing

- 16-20 August: Mwanza;
- 23-27 August: Bukoba;
- 30 August – 3 Sept: Shinyanga and Musoma (parallel sessions).

Two assignments have been prepared to assist CHMT's and the RHMT, respectively, in preparing their presentations on day one of the workshop.

Logistical arrangements: venue, accommodation, transport, secretarial support (computer/ printing facilities), LCD projector/beamer/OHP, flipcharts and markers, laptops?, stationery.

Moderators will prepare a set of instruments to enable CHMTs to conduct self-assessments in relation to five clusters of district health support activities.

Tentative programme:

Sunday p.m	Arrival at workshop venue
Monday	Introduction Presentations by CHMTs (prepared in advance): max 20 min for each team, followed by 20 min for discussion Presentation by the RHMT (prepared in advance)
Tuesday andWednesday	Self-assessments in relation to five clusters of district health support packages: group work (on the basis of instruments that will be prepared by the workshop moderators) and plenary presentations
Thursday	Modalities of support Follow-up actions by CHMTs, RHMTs and the programme District teams will depart at the end of this day.
Friday	Continuation with RHMT and Regional Secretariat members to (a) discuss their own capacity building requirements, (b) review the list of resource institutions, (c) review the modalities of support to councils, and (d) agree on the follow-up actions.

Exercises for self-assessments: to be developed

Materials to provide during the workshop:

- Inventory of Tanzanian resource institutions and individuals;
- Examples of best practices of district health systems strengthening;
- Inventory of written materials: standards, technical guidelines, manuals, handbooks, training modules, ...

Key principles of the D3CB approach

1. Support will be provided upon an explicit request, based on a project proposal or formal requests based on priority areas of need as detailed under the situation analysis chapter in the Comprehensive Council Health Plan.
2. Requested support should match with the broad framework of the comprehensive council health plan.
3. Ultimate focus should be towards improving health services.
4. No requests for capital investments (infrastructure, vehicles, equipment)
5. Request for support may come from both public and private health facilities and institutions.
6. Project should not interfere with other planned and ongoing activities and be realistic in terms of implementation capacity.

7. Project should take sustainability considerations into account.
8. Project implementation should not hinge on one or two people and contribute to team building.
Support will come from Tanzanian institutions, public or private, in the Lake zone or outside including international institutions/ consultancies. Project or support needs will be properly documented, accounted for and disseminated.
9. Subsequent support will depend on satisfactory completion of previous projects.

Framework for D3CB

Overall objective of the D3CB programme:

To ensure that the health system becomes more responsive to people's needs.

Specific objectives:

1. To improve district health management capacity with an emphasis on: planning, implementation, human resource development, monitoring and quality assurance, effective interventions against priority diseases.
2. To reinforce partnership and collaboration among all health service providers and stakeholders at the operational level
3. To support innovative approaches for quality health services, to promote the use of best practices and to contribute to policy development.

Potential beneficiaries:

1. Individual health institutions (govt, church, private), NGOs, community based programmes
2. CHMTs/DHB, Hospital Management teams, Hospital Governing committees and other facility committees
3. RHMTs.RHBs

Potential resource institutions may play three distinctive consultancy roles:

1. Providing assistance with problem analysis and identification of the main contributing factors
2. Assisting potential beneficiaries in developing project proposals or research proposals
3. Provide training and technical support as part of implementation of the approved projects/studies.

Categories of support under D3CB:

1. Comprehensive management support, based on generic/common needs
2. (e.g. introduction of the District Health Accounts tool, developed by TEHIP and already used in all districts of Kagera region)
3. Support to discrete interventions, as per expressed need, including support for innovative approaches.

Menu of district health support packages under D3CB: 5 clusters of support packages:

1. Service provision
2. Planning
3. Acquisition and development of resources
4. Management of resources
5. Cross-cutting issues

Implementation modalities that need to be specified further:

1. Procedures for applying for support
2. Approval procedures
3. Monitoring (incl output & outcome indicators) & Reporting
4. Articulation of roles and responsibilities of various actors
5. Financing mechanisms
6. Cost estimates and financial ceilings
7. Dissemination of information on the D3CB through various channels and forums

Minimum requirements for a D3CB project proposal:

1. Title of the proposal
2. Brief background (max ½ page) and justification
3. Problem statement and analysis showing the link with the Annual Plan and the result of previous efforts to address the problem
4. Objective specifying the desired outcome (rather than outputs); with a statement on how the project will be sustained beyond the end of the project.
5. Proposed activities specifying who will do what
6. Indicative time frame
7. Resources/inputs required specifying locally available resources and resources required from outside
8. Itemised budget indicating local contributions and budget requested from outside

Maximum 6 pages.

Footnote: In case a client is not able to develop a full project proposal, they may request assistance based on a problem statement.

ANNEX D: PROGRAMME OF MARKET PLACE MEETING

HSPS III – D3CB

Market place meeting, Sept 6th, 2004 in Mwanza

Programme

<i>Time</i>	<i>Activity</i>	<i>Responsible</i>
08.30	Registration	
09.00	Welcome and self-introductions	Dr Winani
09.15	Introduction to Demand Driven District Capacity Building under HSPS	Dr Hingora
09.45	Self-assessment of district health performance: results from the Lake Zone, plus commentary	Dr Leon
10.15	Priorities of CHMTs for capacity building; requirements for external assistance	Dr Leon
10.45	Tea break	
11.15	Role of the RHMTs and requirements for capacity building	Dr Winani, Dr Nyaywa
11.45	Faith-based organisations, NGOs and CBOs: identity, organisation, representation, partnerships and priorities for capacity building	Dr Morona, Dr Leon
12.15	The private for-profit sector: identity, organisation and the potential of D3CB	Dr Hingora
12.30	Presentations by potential D3CB providers (10 min each)	Resource institutions
13.15	Lunch	
14.00	Presentations by potential D3CB providers: cont'd	Resource institutions
14.45	Modalities of D3CB support, the way forward	Dr Nyaywa
15.00	Closing remarks by Dr Finn Schleimann and Dr Hingora	
15.20	Departure	

ANNEX E: DEBRIEFING NOTE OF SEPT 7TH, 2004

HSPS / D3CB consultancy

Debriefing note (revised)

The terms of reference of 29-5-2004 refer.

The Objective of the Consultancy "Preparation of modalities district demand driven support, Lake Zone, Tanzania" was to develop a framework for demand driven support to improve district health services, which would include:

- Areas that can be supported;
- Institutions that can give support;
- Modalities of support;
- Application and selection procedures.

The expected output was four-fold:

1. A plan for regional workshops
2. A framework clearly indicating the areas in which support can be provided, indicating how and by whom the support can be delivered
3. Clear guidelines on how the support will be structured and delivered
4. A short concise report on the general findings of the consultants.

The final outputs would be delivered by mid September 2004.

Comments on the output/deliverables

Re. Output 1.

Four regional workshops have been held in Aug/Sept. In addition, a 'marketplace meeting' for potential providers of D3CB consultancy service was held on Sept 6th in Mwanza, so as to:

- i. Present and discuss the requirements for capacity building in the Lake Zone
- ii. Provide an opportunity for resource institutions to introduce themselves as potential providers of D3CB support.

All four RHMTs, the zonal CSSC coordinators (for the Lake Zone), various resource institutions and HSPS advisors were represented in the meeting.

Re. Output 2.

Project proposals are expected based on a menu of 22 D3CB support packages.

HSPS should now prepare itself for receiving and appraising proposals from interested clients in the Lake Zone who wish to seek external support from resource institutions that would enable them to strengthen their human capacities.

The potential D3CB clients and providers (resource institutions) have been specified as part of the consultancy.

1. Procedure for applying: → see flowchart in annex
2. Criteria for approval: → see list in annex, for discussion; and appraisal form
3. A committee will appraise D3CB project proposals submitted by clients/ beneficiaries. To be coordinated by HSPS.

→ Proposed membership of the D3CB Appraisal committee:

- Dr Njau, MoH
- Dr Kalinga, MoH
- Mung'ongo, MoH
- Hingora, MoH
- Mr Maganga, PO-RALG
- Sam Nyaywa – Acting SHA,
- Helene Probst – JPO
- Public Health advisor (in due time)
- Districts Systems Support advisor (in due time)

Other experts may be co-opted depending on the type of the proposal (e.g. from Dept of Human Resource, Planning & Policy, Finance, Hospital Services, ...).

For each project proposal, a minimum of four of the above experts would need to conduct the appraisal.

4. Support for developing proposals: key role for HSPS technical advisors, who will work in conjunction with the four respective RMO's and resource institutions. This will require visits by CTA/TAs to the region, e.g. once a month. They will also follow-up on the scoring/prioritisation and possible inclusion of cross-cutting issues (Cluster V) in the CHMT priorities.
5. Generic support to councils (or other clients): see comment below.
6. Financial ceilings for proposals: see excel sheet → for discussion.
Proposed budget: maximum of 20 million TSh per proposal (including external assistance). More money could be made available, as long as it can be justified.

Re. Output 4.

→ The final report will indicate the type of information that needs to be disseminated to the various clients (councils/CHMT, NGO, FBO) and providers. This information should ideally go out around October 1st (for follow-up by CTA/SHA).

→ The report will also contain a section/annex with suggestions what information could be made available on www.hspstz.org

→ The report will contain an updated inventory of resource institutions available in the Lake Zone, with a description of their capacity to provide consultancy and training services in relation to the 22 support packages offered under D3CB (some work to be done by consultants)

Comments on the scope of work that the consultancy should entail

1. “An assessment of the capacity and the possible role of the Zonal Training Centre in Mwanza (based at Bugando Hospital)”.

→ A thorough assessment has not been possible, due to non-availability of the people concerned during a large part of the assignment. However, we think that the ZTC at present does not have the capacity to take on additional work and play a leading role in the provision of capacity building services within HSPS/D3CB. For the moment, the ZTC should be seen as a potential beneficiary/client of D3CB. In due course, ZTC could play a role in assessing proposals and assisting clients/beneficiaries in developing proposals.

2. “Modalities of support for the three main approaches”, i.e. (a) comprehensive (generic) support for management, (b) support for specific demands, and (c) innovative approaches.

→ We propose that, for the time being, support be provided upon explicit requests from clients and approval of written proposals (according to set guidelines). That would cater for (b) and (c).

Generic support could be considered at a later stage, once the Technical Advisor Public Health is in place (in Mwanza). Areas to support would be:

- planning for HRD (in view of the human resource crisis)
- adherence to standards of medical practice and continuity of care
- management of information for decision making and M&E
- governance
- partnerships
- training in participatory operational research (health systems research) in combination with any of the above topics.

3. “The cost range for the different types of support.”

→ We are still in the process of collecting information on the consultancy and training fees that the various providers charge. This information will be summarised in the final report.

4. “Advice on how experiences gained in the Lake Zone can be utilised nationwide.”

→ It is too early to decide on sharing experiences beyond the Lake Zone on a large scale. Meanwhile, though, HSPS could do the following:

- a. Make the D3CB menu and the self-assessment tools available through the website. We recommend that the tools be translated into Kiswahili.

- b. Keep a database of the list of resource institutions as potential providers of D3CB support (incl CVs of relevant experts); and make this information available through the website.
- c. In due time, put a list of the approved D3CB projects on the website, and include summaries of completed projects.
- d. Take the opportunity to make some publicity for the D3CB approach at relevant national forums: e.g. the RMO conference at end of Sept 2004 and the DMO conference in May 2005.

Although HSPS will not actively promote D3CB in other parts of the country, it will be possible to fund project proposals from districts outside the Lake Zone.

Recommendations and issues for follow-up by HSPS

- a. Briefing of key government staff:
 - a.1. In the Ministry of Health: Director Planning (Dr Njau), Coordinator District Health Services (Dr Kalinga), PPP coordinator (Mung'ongo), Training/Continuing Education Dept (Dr Amos Mwakilasa), ...
 - a.2. In PO-RALG: → to be followed up by Hans Olsen
- b. HSPS could assist RHMTs/CHMTs in reviewing/updating their needs and priorities for capacity building after one year. For this, the self-assessment tool (and the tool for prioritisation) could be used and the results/scores of the Aug/Sept 2004 workshop could be used as a baseline. HSPS may consider facilitating peer reviews, which would imply that districts/CHMTs/RHMTs review each others' needs and priorities.
- c. Before doing (b), however, a review of the D3CB experience in the Lake Zone may be considered, e.g. after some 9-10 months, so as to assess the progress made. This review would include (i) an assessment of the quality of the proposals received at that moment, (ii) a review of ongoing and completed projects, (iii) the identification and analysis of any problems that may impede progress in D3CB.

Leon Bijlmakers
Godfrey Swai
Ahmed Hingora

Dar es Salaam, Sept 7th 2004

ANNEX F: DEMAND DRIVEN DISTRICT HEALTH CAPACITY BUILDING – FRAMEWORK AND MODALITIES

Separate document, submitted in October 2004