COMMISSION ON MACROECONOMICS AND HEALTH
A WHO commission examining the interrelations among investments in health, economic growth and poverty reduction

CMH Working Paper Series

Paper No. WG5: 16

Title

Constraints to Scaling Up Health Interventions: Country Case Study: Tanzania

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Date: June 2001

HEALTH SERVICES MANAGEMENT REFORMS IN TANZANIA: INTERVENTIONS WHICH MAKE A DIFFERENCE IN EFFECTIVENESS.

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1. Background: Historical Review of Reform Events of The 1990s

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 was allowable for private individuals and organizations, hitherto prohibited, to own and manage health services facilities. The policy, which lays emphasis on a decentralized ownership and management of the health sector, was followed by a 1992 legislation to effect it.

In order to interpret and implement the components of the health sector policy, reference has been made to government's Social Sector Strategy (SSS) formulated in 1994. From the health services point of view, the SSS emphasizes:

a) Improvement in the preventive and basic health services;

b) Provision of basic education; and

c) Devolution of the health sector management to the district level.

In more detailed terms, the Ministry of Health (MOH) came out with the Health Sector Reform proposals of 1994 which make reference to the SSS and the health policy. The overall objective of Tanzania's health policy is, "to improve the health and well-being of all Tanzanians, focusing on those most at risk, and to encourage the health system "to be more responsive to the needs of the people" (MOH 1994).

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1.2.Tanzania's Health Services Delivery System

Tanzania is one of the poorest countries in Sub-Saharan Africa with an estimated per capita income of $100, which is far below the average of $640 for Sub-Saharan Africa. The population is estimated at 29.5 million (1999) with a growth rate of 2.8%. The country is governed as a republic divided into 20 regions (mainland) and 5 (isles), and 116 districts. The districts are further subdivided into divisions, wards (2354) and villages (9094). It has been the intention of the government to have at least one public dispensary for every village, a health centre for every division and a district hospital in that hierarchy of health services delivery system. In a bid to distribute health services equitably, the government developed a diverse infrastructure of health services facilities as summarized in Table 1.

Table 1: ***Categories of Health Services Facilities in Tanzania (Mainland)***

Facility type	Managing Authority					Total
	Government	Parastatals Organizations	Voluntary Rel. Org.	Private Profit	Other Others	
1. Consultant/Specialist	4	0	2	0	0	6
2. Regional Hospitals	17	0	0	0	0	17
3. District Hospitals	55	2	13	0	0	70
4. Other Hospitals	2	6	56	20	2	86
Total Hospitals	**78**	**8**	**71**	**20**	**2**	**179**
5. Health Centres	409	6	48	16	0	479
6. Dispensaries	2,450	202	612	663	28	3,955
7. Specialized Clinics	75	0	4	22	0	101
8. Nursing Homes	0	0	0	6	0	6
9. Private Labs	18	3	9	184	0	214
10.Private X-Ray Units	5	3	2	16	1	27
GRAND TOTAL	**3,035**	**222**	**746**	**927**	**31**	**4,961**

Source: Ministry of Health (1999): Health Statistics Abstract

The government still remains the main financial source and a dominant provider of the health services in Tanzania. If the government and parastatals are combined as public entities, then public provision comes to 60%. Therefore the phenomenon of public financed and public provided health services as a syndrome in Tanzania will still be dominant in the near future. This calls for the lower level publics, districts and communities to take charge in mobilizing resources and managing the government owned units at their own levels (and for their own well being). This is why a call for a decentralized health care delivery system is worth studying in order to examine the possibilities of replication. This study examines two such cases in order to suggest whether they can be replicated or scaled up or not.

The proposals for the health sector reform are carrying out the mandates of Tanzania's' Social Sector Strategy (SSS) 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 of the health care services. This is the essence of initiating those kinds of projects which appear to have a propensity for or promise of community involvement, communities which also promise to take over and enhance or maintain the initial project concept, principles and practice. This study has identified two such "pilot" cases, which promise some possibilities of scaling up the achievements attained. However the said projects sought to address the MOH's Health Sector Plan of Action principles.

The MOH formulated the Health Sector Plan of Action (1996-1999) that aims at the following four major areas:

● ***Organization and Management***

To devolve authority for the day to day management of the health services to the district level. In this regard District Health Boards (DHBs) would be created. These would be answerable to the District Councils, and will be responsible for the management of the health services at the district level, whether provided by the public sector or private sector investors. The District Medical Officers are administratively answerable to the DHBs.

● ***Efficiency and Effectiveness of Health Services Delivery***

Improvements are to be made to enhance services delivery - efficiency and impact of services, to make services qualitative and adequately available, to make them sustainable, equitably distributed to ensure that health care units are adequately equipped and manned in a well functioning referral system. The various vertical projects will be integrated in terms of planning at different levels and by different partners.

● ***Enhanced Sustainable Health Care Financing***

Ensuring that quality and affordable services are developed by resources as much as possible at the point of the health services unit, and ensuring that such funds are controlled by such units duly given powers to utilize the resources to improve efficiency and effectiveness. Alternative sources of financing health services is a high priority proposal.

● ***Drugs and Supplies, Management and Logistics***

Within a decentralized management, efforts are to be made to ensure efficient procurement of quality and essential drugs, medical supplies, essential equipment and systematic replenishment and regular maintenance of equipment managed at the unit level.

It is the purpose of this study to discuss some case studies which try to tackle the four critical areas of the reform. The MOH created 8 strategies as propounded in the Plan of Action (PoA) of 1996-1999 to pursue the attainment of the four critical objectives. The objectives to be achieved are as follows:

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;
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.

The above objectives of the PoA (1995-1999) were very ambitious given the fact that Tanzania remains one of the poorest countries in the world. Notwithstanding this fact, there have been various efforts to pursue the above objectives. Of interest to this discussion are the strategies for providing quality, accessible and equitable services at the district level, ensuring sustainable health care

services financing at the unit and the district level, and to redefining the managerial roles of the central, regional and district health authorities.

In the middle of the 1980s the economy of Tanzania was in the doldrums with an economic growth averaging 2% per annum or lower. These developments left the government with little option but to approach the World Bank and the International Monetary Fund for assistance. Tanzania had to embark on a Structural Adjustment Programme (SAP) starting from 1986. Even though Tanzania boasts of having an elaborate health services infrastructure, much of its sustenance has much depended on the donor community's various projects and direct financial support to the health sector. The extent of donor dependence is shown in Table 2.

Table 2: ***Government and Donor Assistance Budgetary Allocations 1996/1997***

Total Recurrent Allocations 1996/97 (Government)		74.3%
Total Development Allocations 1996/97 (Government)		4.5%
Total Development Allocation 1996/97 (Donor)		21.2%
	Total	**100%**
Budgeted use of Donor Assistance 1996/97		
- Curative Services = 19% of which:	Regional Hospitals	10.0%
	Dispensaries/health centres	9.0%
- Preventive Services (mainly vertical projects)		81.0%
	Total	**100%**

Source: World Bank, Public Expenditure Review, 1997.

Table 2 shows a situation in which the government financed the largely public health sector under difficult conditions. Donors have contributed more to the development expenditure, while

the government financing concentrated more or less on the recurrent expenditure, especially salaries and wages.

An attempt to raise funding from the consumers of the public services has been initiated by the "Cost Sharing Policy" which started on a limited scale in 1993 in Tanzania. However, its impact has been less than significant as a source of revenue for health sector development. It has scored a milestone in making Tanzanians aware of the need to pay for their own health services. Table 3 shows that the cost sharing revenue between 1993 to 1998 increased from 1% to about 5.8% of the total health sector expenditure in 1998. This positive development, albeit in a small way, serves to encourage policy makers to create other mechanisms, hence the motivation to focus on cases in which alternative financing mechanisms are experimented with.

Table 3: ***Revenue from the Cost Sharing Initiative in Tanzania***

	Annual Total revenue Generated in Tshs.	*% of Cost Sharing to Total Health Sector Expenditures*	*% of Cost Sharing to Total Non-Salary Recurrent Expenditure*
1993/94	26,922,752	0.9%	1.9%
1994/95	854,195,503	20.0%	5.0%
1995/96	1,078,120,352	3.34%	8.5%
1996/97	1,851,580,139	4.7%	11.8%
1997/98	2,435,157,795	5.8%	13.4%

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

Alternative financing options in Tanzania have been difficult to execute. First, asking a people previously accustomed to free health services to pay for them creates political resentments in the sense that they think that the government is probably failing to deliver free services as it used to. Secondly a lot of education has to be done 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 still needs to be improved by revenues from the cost sharing initiative itself. The cases discussed here experiment with injecting some substantial amount of donor financing so that the almost depleted government health services facilities can have the base and a start – up energy to win back confidence of the consumers.

2.0 Pilot Cases on Decentralized Health Care Delivery Supported by Donor Funds

The government of Tanzania is implementing a lot of reforms. Of importance here are the Local Government Reform Programme (focusing on decentralization in general) and the Health Sector Reform Programme (also focusing on decentralization strategies in the development and delivery of health services). For the purpose of this discussion, a successful pilot case is that which promises the potentiality of its positive attributes to be replicated or rolled over to solve similar problems in other areas. Of course the lessons of experience from such case will be useful in identifying factors which militate against replication as constraints, and how they can be dealt with. New concepts, procedures and principles tried in the pilot cases and how these have been useful or not for the purposes of replication are another set of expectations from the pilot cases.

Two cases are discussed here. The first one is an attempt to source the financing of health services at the community level. This is more or less an attempt to create a prepaid community health insurance scheme. This initially required substantial donor funding. The case has been tried in a remote Tanzanian district (Igunga), and its model has been replicated in 9 other

districts in the country. The government, through an IDA financing arrangement, offers matching funds equivalent to the members' contribution. The second pilot case is an attempt to develop capacity for the management of urban health services. This pilot case concerns the Dar es Salaam Urban Health Project (DUHP). The pilot case has used substantial (Swiss) donor funds to rehabilitate the health services delivery capacity and its management in the Dar es Salaam region.

In the following section the community Health fund (CHF) will be discussed. The case will show that there are successes and constraints to adopting the pilot even though the government has already capitalized on some of the limited successes to scale it over to other districts across the country. Another section will discuss a case of "concern with urban health." This case of the Dar es Salaam Urban Health project is supposed to ameliorate urban health systems. The pro-socialist Tanzania policy (Socialism and Rural Development) of 1970s and 1980s favoured more of the rural based public units, leaving the urban public health units to deterioration. The rationale for the positive discrimination in favour of the rural health services development was because more than 85% of the population lived in the rural areas. However there is a rapid growth of urbanization in Tanzania today. The Tanzanian rural population migration to the urban centres is putting increasing pressure on the available health services. The DUHP is therefore an important attempt to learn how the poor public urban health services can be improved by an initial injection of donor funds. The potentiality of sustaining such an initiative is also an important issue of concern. The last section will present a brief framework for organizing the initiation and management of decentralized public owned health care services.

2.1. The Community Health Fund Model: A Community – based Health Insurance Pilot

As the government of Tanzania is implementing its Health Sector Reforms, it has also explored various approaches to create and to sustain the funding of its services while at the same time trying to remain firm in its commitment to equity. The Community Health Fund (CHF) is considered a viable mechanism for providing additional funding for the health services, especially at the district and sub-district levels.

The CHF is assumed to be a mechanism to ensure increased access to health services, to empower the households (which are contributors to the fund) to participate in decision - making, and to further promote the cost sharing policy with increased community participation. In a way, the CHF is a form of a voluntary health insurance, a pre-payment arrangement for health services in the event of illnesses. It also appears 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 is flexible in another way in that it allows (in principle) contributors to pre-select a public, a private for - profit or a religious organization - owned unit from a network of existing health services 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 of such pre-selected units reserve the right to join another every year, in case they are dissatisfied with the services at the dispensary of their first choice.

At the time the Community Health Fund (CHF) was started, there were a lot of constraints facing the health services delivery as summarized in Table 4.

Table 4: ***Summary of Constraints and Interventions in the CHF***

(1) Structural Elements	2. Process/Professional/ Technical Elements	3. Drugs and Medical supplies Elements	4. Health Services management
→ Structures of Facilities were deplorable. Some had bats flying all over. → Lacked essential equipment for treatment of diseases, even simple gloves → Some units lacked beds and mattresses → Clinical officers' and other lacked decent accommodation → Units were without adequate furniture	→ Medical personnel were incompetent and issued wrong prescriptions → Attitudes toward customers were poor and rude → Bribery went with service delivery to customers → Health personnel had low morale at work → Underdosage was a common prescription → Opening and closing time depended on staff. Some units opened as late as 11 am	→ Drugs shortage was common → Drugs available at the beginning of the month → Drug shortage caused underdosage of prescription and unnecessary referrals → Drug shortages caused over crowding at the time when drugs are available → Limited services due to limited drugs and equipment → Staff have no uniform → Incompetent staff were unable to use available equipment	→ Unmotivated staff → Unofficial charges of between Tshs. 2000 to 3000 were common for services which should bear no charge → Unqualified staff were employed → Poor supervisory services → Little or no community public owned units → Limited services mix
Interventions following the Community Health Fund Initiative and by Use of the IDA Funding/Matching Funds			
→ Health services structured were repaired and rehabilitated using the IDA supported Food and Nutrition Project fund → New latrines were constructed where they did not exist → Furniture was procured → Some facilities still need water and electricity → Some housing units for clinical officers were rehabilitated	→ Transfers were effected to bringing new clinical officers and nurses with more positive attitudes → Operating hours change and work starts it 7.30 am instead of 10 to 11 am., and closing early → Clinical officers now available day and night in some units → Personnel feel motivated now with new equipment and drugs available → Now display of price lists exists at some units	→ Drugs now available throughout the month → Congestion at the beginning of the month not common as drugs availability is spread out → Many supplies and equipment purchased → Some lab work now possible, mattresses and bed sheets now available at units → Needed reagents and disinfectants now available → Staff have uniforms	→ Formal opening and classing times for units are statematic and official → Official price lists are now posted and adhered → Waiting time is reduced by the spreading of treatment for more than 8 hours and for a whole month → Orderly referral system is now being developed → Ward management committees (community involvement) participate in units management

****Specific results of the interventions are summarized in Table 11***

Source: This evaluative summary is extracted from Andrea Robles, V. Chuwa, A. Mkini, M. Mwinyi and T. Urio (1999) Qualitative Evaluation of the Community Health funds (CHF) in Igunga District, Tanzania, MOH Dar es Salaam.

The CHF was therefore meant to address the constraints and to remove or reduce their impact. It was therefore believed that providing a system of financing and mobilization was a major way towards addressing the constraints. Once the financing method had been identified, then

community involvement in sourcing and managing the funds was another strategy and a concern of the CHF management.

Table 4 also summarizes some interventions which were undertaken in some of the units which were involved in the CHF project. Some of the achievements of the interventions include, *inter alia,*

- Improvement of structural quality eg buildings were rehabilitated, new toilet facilities and new offices were constructed and water/sanitation improvement were done.
- Efforts have been made to train clinical officers and some nursing staff to have them improve their performance at work.
- With buildings rehabilitated, essential drugs now more available than before, and with equipment procured for some of the participating units, the health services personnel are more motivated to work than before the interventions.
- With the availability of drugs throughout the enteire month, congestions experienced during the first one or two weeks of the month (when drugs are available) are no longer seen in the CHF participating health services units.

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 US $ 4.40 per year. This amount covers operating/recurrent costs for personnel, drugs, medical supplies, logistics, transport and maintenance. The problem then became that of how to raise and to manage such funds to provide

the basic package (URT 1995:40). The other levels of care would need varying indicative funding as shown in Table 5.

Table 5: ***Indicative Recurrent Costs to Deliver Basic Package of Entitlements***
(1995 prices: US $ Tshs. 600)

	Tanzania Shs.	US $
Recurrent Costs per capita	2600	4.40
Per capita costs at a dispensary	3900	6.50
Per capita costs at first referral hospital	6,540	10.90

Source: URT Community Health Fund Pilot Pg. 19

The costs in Table 5 are informed by the World Bank's study ("Better Health in Africa") which uses data from several low income African countries (including some Tanzanian data) to cost a provision of basic services in a typical rural district. The assumption is that the services are provided by a well functioning first referral hospital (a district hospital in the case of Tanzania) and a network of dispensaries, which it services.

The Community Health Fund (CHF) contributions (usually Tshs. 5,000 or US$ 9.40 per year per member household) are pooled and managed together in a specific account. Such funds 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 illnesses or injuries are in principle paid for on behalf of the members of the CHF.

In order to ensure equity of access to health services, a village (community) council considers exempting those households and individuals who are unable to pay the required contribution.

They are given a CHF membership card. The exempted individuals will usually include the disabled, the elderly and others as determined by the community leadership in the community in which they live.

The CHF is managed under 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.

From the point of view of providers, and in a situation in which there is no health insurance, the CHF does promise to be a potentially reliable source of revenue and an expanding clientele for the health services. In this respect the District Health Board CHF management is expected to negotiate arrangements to receive and reimburse funds for services rendered by the various service providers who will have rendered services to the CHF card holders.

Participating hospitals, health centres and dispensaries are to receive an "up-front capitation grant" to enable them to render services for their expected clientele, and to agree on conditions under which referrals can be made. This capitation arrangement is expected to enable the pre-selected providers to plan for their essential needs in advance, stock up essential drugs and equipment and be prepared before the patients start demanding for services. This capitation arrangement is also expected to improve service availability at the dispensaries, and in this way congestion will be reduced at the district (level) hospital. Table 4 tried to identify the existing constraints at the CHF initial stages and how the IDA provided financial facility was used to focus on the constraints in terms of interventions.

In terms of the HSR implementation, the CHF model addresses the issues of efficiency, equity, financial sustainability, decentralization and private sector participation (HSR ideals) pretty well. This is summarized in Table 6.

Table 6: ***How CHF Principles and Operations Improve the Implementation of the HSR***

Health Reform Dimension	*Clients*	*Providers*
Efficiency	More secure access brings people into modern health system at times of need Motivation to seek curative services complemented by emphasis on preventive services	Cost-containment prompted by capitation grants. Impetus to stress preventive as well as curative care
Equity	Security of access for poor, women and children Cross subsidization of poor by rich, the sick by the healthy on an assumption that the exemption principle is effectively applied.	Will not discriminate against anyone as long as they hold a CHF health card.
Financial Sustainability	Payment of membership fees at times when people can mostly afford allows stronger and more regular contribution to cost sharing	Existence of CHF, large membership and capitation grants give providers ready access to resources, especially if subsidized by matching grants from the GOT.
Decentralization	Improvements made to facilities in close proximity to where people live. Management inputs shifted towards local level and community	Fiscal decentralization is assured through autonomous District health Boards, negotiating with CHF to honour health card benefits.
Private Sector Development	Opportunity for local and community based NGOs to provide inputs to health facilities and CHF fund management.	Capitation grants to providers prompts competition and a spur to private sector development through contracting out.

Source: United Republic of Tanzania, MOH, Community Health Fund (CHF) Design, Dar es Salaam, June, 1999

2.2 The Implementation of the Igunga CHF Pilot and the Roll – Out Districts

As described above, the CHF is a quasi-health insurance system. It was introduced in Igunga District in December 1995 covering only 26 wards. After 6 months there were indications that the participating ward health facilities were performing better than the other facilities in the same district. 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 services units. The fees were Tshs. 500 per incidence at a health centre and Tshs. 1500 for Outpatient Department (OPD) 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 DHB changed the fees schedule to be Tshs. 1000 at a dispensary, Tshs. 1500 at a health centre and Tshs. 2000 at the district hospital OPD per incidence of health services demanded. This change was backed by an enabling by-law passed by the District Council. Service users were left with an option of becoming CHF Card holders (prepayment scheme) or to face up to paying the stipulated user fees at the government owned facilities.

The introduction of the CHF model as a management intervention attempts to deal with the constraints of (according to Table 4 section (b) above):

a) Unavailability of essential drugs and supplies at the facility level;
b) Improvement of inadequate services available to the public at large;
c) Improvement in levels of sustainability in the delivery of health services and
d) Improved efficiency and effectiveness on the part of the health services personnel.

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

The main diseases affecting these districts include malaria, URTI, diarrhea, pneumonia, and STD/HIV/AIDS. These districts together have 17 hospitals, 43 health centres, 368 dispensaries and 399 health posts. Without alternative sources of financing, the facilities' service provision may be hampered by the shortage of essential drugs, medical supplies, essential equipment and logistics. These have been mentioned in official documents as major constraints facing the entire country (Health Sector Reform Plan of Action 1996-1999).

The CHF is an attempt to mobilize resources, which are to be managed in an ascending complexity of service mix and a referral system. This is summarized in Table 7.

Table 7: *CHF Basic Health Services Package*

The Dispensary (referral) ➔ level	The Health Centre (referral) ➔ level	The District Hospital level
- Curative services	- Curative services	- Curative services
- Preventive services	- Minor surgical services	- Out-patient service
- MCH services	- Limited in-patient services	- Surgical services
- Inter-sectoral general sanitary education	- Laboratory services	- In-patient services
	- Preventive services	- Laboratory services
	- Health education	- Preventive services
		- Health education

The services appear to be almost the same in the three levels of care. A leve - difference is construed by a variation in the available equipment, technology, expertise, medicines etc. so that the more complex cases are referred to the next relevant level. The CHF is expected to mobilize funds to improve the quality of services at the respective levels. It is the responsibility of the health services management to ensure that the available funds are used to meet the expectations of their clients. The clients expect the items listed in Table 7 as the minimum package once they have contributed and committed themselves as members of the CHF.

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

In Igunga each contributing membership unit paid Tshs. 5000 which was then about UDS$ 9.0 when the initiative started in 1996. Owing to the devaluation of the Tanzanian shilling the Tshs. 5000 presently amounts to US$ 6.25. With the government's matching amount of the equivalent contribution sourced from the IDA funds, it means an amount of $12.50 per member can be mobilized. If the membership drive increases and the potential members could pay, the CHF is one major alternative to financing the health care services in rural Tanzania. This observation is based on a World Bank recommendation that what is required as financial inputs to create an effective health delivery systems is US $ 12. per capita (WHO, 1996).

Since 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. They have, however, differed in the membership fees. Hanang uses a membership rate of Tshs. 10,000 (US$ 12.5 at the 2000 exchange rate), so has Songea (urban) District per membership unit, i.e. the household. Songea (rural) District is charging Tsh. 7,000 or US$ 8.75 per household per year, while Mbinga District charges Tsh. 15,000 or US$ 18.75 per household per year. The number of households which have joined the CHF is summarized in Table 8 in columns 4 through 7.

It is noted that once a CHF project has been introduced in a district, two major policy steps are taken. First, user fees become effected in a systematic way for non CHF members who seek services at the government's respective unit. Secondly, since the CHF is owned by the communities and the respective districts, relevant by-laws are passed to enable its execution.

Between 1996 and 1999 the CHF managed to mobilize membership contributions amounting to Tshs. 209,884,000. This attracted a matching government contribution of the same amount and user-fees amounting to Tshs. 94,512,746. This amount could have been much higher if the membership size were to keep on increasing systematically relative to the number of households in the respective districts. One major constraint in executing the CHF experiment is the low level of membership strength.

2.3.Observations on the Performance of the CHF

One of the major weaknesses of the health sector reform programmes is its the top-down approach. The CHF is, in one way, a top-down initiative because the idea originated at the MOH with the support of the World Bank. In another way, the CHF is a bottom-up (if its basic principles are operationalized) because it is sold to the communities at the bottom, who then

voluntarily decide to own and mange it. The main question is, however, how to make it possible for the CHF intervention to function and to score better results. Table 8 shows that the members of the CHF across all the participating districts is very low, i.e. as few as only 3% in Hanang and Iringa and less than 2% of the households in Igunga district.

Table 8: ***CHF Financial Position as at June 1999***

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
		Total	HH CHF MEMBERS				HH CONTRIBUTIONS (Tshs. '000)				USER FEES (Tshs. '000)				EXPENDITURE (Tshs.'000)	
SN	DISTRICT	HH														
			1996	1997	1998	1999	1996	1997	1998	1999	1996	1997	1998	1999	1998	1999
1	Hanang	19,458	0	0	611	5,079	0	0	6,110	50,790	0	0	4,090	5,901.60	1,726.5	2,930,675
2	Igunga	50,142	2,004	2,948	3,085	860	12,215	14,740	15,425	4,300	3,222.2	24,573.5	15,974	5,113.3	37,777.58	10,483
3	Iramba	58,066	0	0	2,737	398	0	0	13,685	1,990	0	0	4,455	3,909	0	4,790,096
4	Iringa	88,594	0	0	-	3,028	0	0	0	15,140	0	0	0	1,604	0	267,867
5	Kilosa	87,538	0	0	-	2,381	0	0	0	11,905	0	0	0	1,669.5	0	0
6	Mbinga	66,536	0		-	2,244	0	0	0	33,660	0	0	0	293	0	0
7	Nzega	52,421	0	0	2,171	287	0	0	10,855	1,435	0	0	1,193,246	1,707	0	4,790,096
8	Singida Rural	54,424	0	0	2,154	111	0	0	10,770	555	0	0	11,907	298.8	5,360.84	2,670.87
9	Songea Rural	67,110	0	0	698	69	0	0	4,886	483	0	0	3,391	4,599.6	0	0
10	Songea Urban	19,630	0	0	71	23	0	0	710	230	0	0	580	931	106.7	1060
	Total	563,919	2,443	2,948	11,527	14,480	12,215	14,740	62,441	120,488	3,222.2	24,573.5	4,0690,246	26,026.8	44,971.62	36,602,604
	Total Household Contributions					209,884,000										
	Matching					209,884,000										
	User-Fees					94,512,746										
	TOTAL					514,280,746										

Source: Community Health Fund Coordinating Office, MOH, Dar es Salaam

The low response rate to the CHF has been caused by, *inter alia*, the fact that the scheme promises an entitlement to basic health care service at specified facilities, only to find out that the facilities cannot deliver as expected. This is also reflected in the low absorption capacity of the districts' planning units. If we take examples of 1998 and 1999 revenues and expenditures, one notes that the participating districts managed to mobilize Tshs. 307,817,928 altogether in 1998 and 1999. Their expenditures amounted to Tshs. 81,574,224 for the two years. This is only a 26.5% level. One can assume that had the available funds been properly planned to improve the quantity and quality of health care services, the units would have attracted more members. In effect this would result into increased revenue for the CHF enterprise as well.

Another problem is that members had expected to receive a full range of services at all levels in the district referral system, including the private health services units. This has been difficult because there has to be a clear contractual frame of reference such as "a service level agreement" between the service 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 (as of the basic expectations) at the moment due to low levels of membership strength and a poor rate of contributions.

The CHF has extended some of the objectives of Tanzania's Health Sector Reform. 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. This is some starting point for a system which has been centralized and patronizing service users. For communities which had been 100% dependent on the central government to finance their

own health care, a programme which makes them to mobilize about 37% of the required revenue is not a mean achievement. The Igunga 1998 District Health Plan shows that about 55% of the revenues were a responsibility of the communities, that is, CHF and user fees combined (see Table 9).

Table 9: ***Sources of Revenue for Igunga Health Services planning (1998)***

CHF Contribution	1. Balance Brought Forward	44,100,000	
	2. Expected Contribution	44,100,000	
	Total CHF	**88,200,000**	37.4%
User Fees	1. Balance Brought Forward	20,226,212	
	2. Collection for the year	21,567,850	
	Total User Fees	**41,794,062**	17.8%
Central and Local Government Sources		95,954,554	40.8%
Donors Contribution		9,412,914	4%
Grand Total Revenue		**235,361,530**	100%

Source: CHF Coordinating Office, Ministry of Health Headquarters

The Igunga District Health Plan (1998) shows the success of a management intervention which takes a decentralization approach though strongly based at the district level, and indeed, a devolution in which communities and district authorities are expected to be empowered by the use of by-laws to create revenue sources in order to improve the health services at their own levels.

Of greater significance is the implication of the decentralization approach to improving efficiency, effectiveness and the quality of health care services. Admittedly, increased financing is a necessary condition to improve these dimensions, but it is not a sufficient condition. With improved funding, drugs can now be available throughout the month (at the dispensing

counters), so that patients do not have to congest at the health services units on those few days of the month when drugs are available. Poor quality of care has often been associated with unavailability of drugs at the health services units in Tanzania (Munishi 1991, 1997; Mnyika and Kilewo, 1991 and Kilima *et. al.* 1992). Table 10 shows how the mobilized revenues at Igunga were expended in the intervention and the possible areas meant to improve quality of care, efficiency and effectiveness.

Table 10: 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	.5
5.	CHF Social Marketing	2,269,000	1.3
	Total Expenditure	171,996,174	100.0

Source: Ministry of Health, CHF Coordination Office

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. For the year 1998 Igunga district health services' planners decided to use 61.5% of the available budget for that priority concern. It had been observed that the contents of the Essential Drugs kits supplied by the central government chain lasted for about 10 to 15 days of the month (Munishi, 1997). The kits are usually opened up on the first day of the month. This is known to the clients of health services who congest the units once drugs are available. Assured consistent supplies of drugs and essential equipment can now allow the patients to spread attendance for an entire

month. In the past health, services units had experienced stockout incidences of some essential drugs. With the CHF interventions such problems have decreased as is summarized in Table 11.

Table 11: ***Impact of CHF/User Fees on Availability of Drugs and Equipment***

		FACILITIES REPORTING ITEM NOT AVAILABLE			
		1997		*1999*	
	ITEMS	*Nos.*	*%*	*Nos.*	*%*
1.	Sterilizer	16	66.6	1	4.2
2.	Stoves	10	41.6	0	0
3.	Stethoscope	20	83.3	3	12.5
4.	Foetoscope	21	87.5	1	4.2
5.	BP machine	9	37.5	0	
6.	Scissors assorted	13	54.1	0	0
7.	Forceps assorted	18	75	0	0
8.	Microscope	19	79.2	18	75
9.	Delivery bed	5	20.8	0	0
10.	Examination bed	6	25	0	0
11.	Lovibond comparator	3	12.5	0	0
12.	Mattresses	20	83.3	0	0
13.	Mackintosh	18	7.5	0	0
14.	Kerosene lamps	3	12.5	0	0
15.	Giving set	1	4.2	0	0

Source: 1. MOH Quantitative Evaluation of CHF Pretest Igunga District Survey Data 1999.
2. HMIS District Processing Files 1997 and 1998.

According to the evaluation survey it can be observed from Table 11 that for the three years of the CHF, 83% or 25 out of the 31 items that reported as “stockouts” for more than one week before the CHF (1996) were no longer reported as a problem in the latter years. Nearly all the items reported as stockouts in 1996 had been rectified to a level of 100% in 1999.

According to a survey conducted to evaluate the Igunga project, and whose respondents were health workers and the services consumer communities, the Igunga CHF intervention has had some significant positive effects on the quality of services and efficiency in some wards such as Itumba and Intunduru.

In Intunduru and Itumba the CHF has assisted in changing the attitudes of health services personnel towards clients because they now value them as payers rather than beggars of their services. The availability of essential drugs and supplies throughout the month has motivated the health personnel as they now have some improved working gear. The working hours have increased as they now work from 7.30 a.m. to 4 p.m. instead of 9 a.m. to 12 noon in the previous time, that is, before the CHF intervention components.

This constant availability of supplies, equipment and drugs has reduced unnecessary referrals as a lot more cases can now be handled at the dispensary level.

Given that drugs are available throughout the month, and that the health personnel are now relatively more motivated (according to the survey) to attend to patient cases than before, the demand for services has increased at the health services units. With a prepayment arrangement for the health services, the propensity for the health units' personnel to solicit for bribes has been reduced as there is not much cash that has to change hands.

The value which local communities put on the CHF project is summarized in Table 12. Communities conceive the CHF prepayment arrangement as useful because it is said to make services available throughout the year, and it seems to be a way of reducing costs.

Table 12:*The Way the CHF is Perceived at the Local Level**

Community Members' Perception of CHF Benefits	*(%)*
Prepayment to all services throughout the year reduces costs	48
Health services have improved - more availability of drugs and supplies, more services, better staff attitude in general	21
Good program for the whole community but need to get rid of some current problems	15
Other e.g. Community members have a voice, assist government in cost sharing etc.	10
No benefits	6

Source: Robles *et. al.* Qualitative Evaluation of the CHF in Igunga District MOH, Dar es Salaam, 1999.

The CHF is also perceived to have given the local communities a voice in the way the health services should be managed. There are some reservations which some argue need to be dealt with to make the CHF smooth. These include areas such as education and communication and the role of the government bureaucracy at the district level *vis a 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 operationalizing the CHF concepts.

3.1 The Case of the Dar es Salaam (City) Health Services

Given Tanzania's policy of socialism and rural development (TANU, 1967), during the 1970s to 1980s, a lot of development efforts were directed to the rural areas where more than 80% of the population reside. The Essential Drugs Programme for example, (EDP), which was initiated by support from the Danish government (1984 – 1993) focused on equipping and supplying the

rural based health centres and dispensaries (the primary or first contact levels). The District and the Regional Hospitals (as referral points) were not included in the programe. The EDP supplied drugs to all the government owned health centres, dispensaries, and to some of the church owned (non-profit) health centres and dispensaries provided that such NGOs applied to be in the EDP distribution plan.

One finds a situation in Tanzania, in the late 1980s and early 1990s, in which most of the urban – based 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 – based primary health care (PHC) strategy. And since the 1990s this concern has preoccupied the government of Tanzania even though not much has been done in most of its urban located (government – owned) primary health care units. It is with this background that the Dar es Salaam Urban Health Project (DUHP) was created to being to address the improvement of health services at the district level in the city of Dar es Salaam. The Dar es Salaam case can put forward some lessons of experience with regard to what can be done to improve other urban public owned health services.

The population of Dar es Salaam is well over 1.7 million with an estimated growth rate of 5%. 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. The government policy (rural bias in the provision of social services) left little allocation to the urban centres such as Dar es Salaam. Insufficient allocation of funds led to a gradual deterioration of the health facilities, it rendered the health services units

to be undeserved and congested. It also resulted into shortages of essential drugs and equipment. In short the quality of services was but poor (Munishi, Kilima and Kanji, 1992).

The establishment of the Dar es Salaam Urban Health project (DUHP) 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.
- To 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,
- To reform the system of health management which was centralized and bureaucratic, and without real authority at all levels,
- To address the problem of the health delivery practice which did not adhere to standards of PHC principles. Inadequacies in this area included e.g. the distorted referral system, and
- To extend the concept of the Essential Drugs Programme to the Dar es Salaam urban areas. (Pichette, Pierre and Mutasiwa, D, 2000).

3.2. The establishment of the Dar es Salaam Urban Health Project

The Dar es Salaam Urban Health Project (DUHP) was a strategy devised to put in place a reliable and an efficient public service delivery system. The delivery system to be developed by the project concept and design was to define and specify a **minimum package of health and related management activities** (MPHMA) in which communities would be involved. Therefore

the minimum public health and related management activities (MPHMA) comprise a concerted effort to:

(a) Specify and define systems of standardized inputs (human, material, financial, information and managerial capabilities), and

(b) To identify which resources would be needed for and by each level of service provision (DUHP1997).

The improvement of health services delivery system in Dar es Salaam was initially planned as one of the components of a World Bank supported Tanzania Health and Nutrition Project (THNP). (Pichette and Mutasiwa, 2000). The principal objectives of the THNP have been implemented since 1990, and these include, *inter alia*,

(a) institutional capacity building, policy development and formulation,

(b) manpower development and training,

(c) to develop a sustainable financing and provision of pharmaceuticals and medical supplies,

(d) implementation of a national population policy and

(e) to embark on primary health care (PHC) through reform and rehabilitation

The DUHP has already gone through three phases. Each phase has had specific constraints tasks, and achievements to deal with. The first phase, (October 1990-June 1993) was basically concerned with the rehabilitation and equipping the Dar es Salaam region's health services facilities through the rehabilitation and the provision of equipment an order to improve the health services infrastrure.

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 one 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 the Local Government Reform (for Dar es Salaam city). These major activities are summarized in Table 13.

The extension period in the DUHP (July 200 – June 2001) was intended to follow up on the other phases with a view to consolidating the DUHP's 10 years 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. It is resolved that all vertical donor projects will be integrated, and funding for a sector will be pooled under a MOH's managed "basket funding". This will enhance improved coordination and integration of the donor funded projects. This is a promising development for an increased funding level of the hitherto neglected or underfunded areas such as public urban health services delivery. That is, if the government of Tanzania decides to put priority on urban health development *a la* Dar es Salaam.

During the preparation of the DUHP the Swiss Agency for Development and Cooperation (SDC) showed an interest in co-financing the DUHP on a bilateral arrangement between the

Government of Tanzania and Switzerland. Negotiations were held and agreements were reached. The DUHP started in October 1990. The Swiss Tropical Institute became the executing agency for the DUHP.

During the three phases of the DUHP a lot has been achieved, so that it can be believed that the DUHP experience can be replicated in other urban settings in the country and elsewhere, of course with some adjustments and adaptations. What would need to be done is basically to go through what DUHP did to a large degree as summarized in Table 13.

Table 13 The DUHP's Summary of Phased Activities

1990-1993 Phase I	1993-1996 Phase II	1996-2001 Phase III
Strengthening of the district based health management and rehabilitation/construction of district health facilities	Improvement of management and planning capacities at city level of the government health system	Implementing the Health Sector Reform Program (Decentralization and Sector – Wide Approach) and devolving responsibilities to subnational levels

3.3 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 (Munishi, Kilima, Kanji, 1992; Gilson, Kilima and Tanner 1994; Gilson, Alilo and Heggenhougen, 1994 and Munishi 1997). Most of these studies pointed out the inadequacies in the quality of health services. Some of them pointed out the causes of the problems. The constraints are summarized in Table 14, but they have also been pointed out in the previous sections.

Table 14 summarises some of the major constraints identified quite early on, and which the DUHP was meant to deal with. The constraints are seen to have affected the various dimensions of quality of health services. These constraints are categorized as being of a structural type in the sense that buildings, space, state of the equipment were seen to be inadequately set for the delivery of standard and quality services. The state in which they were would not make the district hospitals effective first referral points.

The second area of constraints was in the professional practice in the sense that the processes of examination, diagnosis, prescribing and dispensing was not correctly done. Health services 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 prescribers. There were inadequate procedures for drug identification, quantification and distribution in accordance with established needs per tier or level of service. The units were also found to be unequipped or illequipped, and the existing equipment was not getting systematic preventive maintenance.

The fourth group of constraints was in the area of administrative and managerial inadequacies in the design, development and rendering 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, in line with the on going reforms (Munishi, 2000).

Table 14 : *Summary Constraints and Interventions in the DUHP*

A: Constraints on Various Dimensions before the Inception of the DUHP				
1. Structural Quality Related constraints	2. Process/ Professional Practice constraints	3. Medical Supplies and Drugs Constraints	4. Equipment and Maintenance Constraints	5. Administrative/ Managerial constraints
→ Buildings were in poor form, unrepaired, poor sanitation and inadequate preventive maintenance → Poor Staff houses in state of disrep air → Some service units lacked adequate structures for their activities, these include offices, examination rooms → Some units lacked toilet facilities or they were in a state of disrepair	→ Personnel not working within the PHC concept and principles → Unmotivated health workers who handled patients rather rudely → Prescribing, diagnosis and dispensing were poor → Lack of health information system → Lack of provision of minimum package of health services expected at health units by level, hospital or dispensary	→ Non-existence of standard drugs needs → Poor distribution of essential drugs → Poor dispensing and insensitive use of drugs by patients → Lack of standard procurement system → Some units did not have uniforms for staff	→ Poor maintenance of records of existing equipment → Inadequate equipment in the facilities → Lack of equipment maintenance system and culture → Preventive maintenance not practised → Some units lacked some essential diagnostic equipment	→ Over centralization of decision making → Lack of clear administrative relations between the unit, the district and the region → Poor or non-existence of services planning and monitoring → Non participatory administrative system → Lack of community participation
B: Interventions' Results Summarized				
→ Hospitals, health centres and dispensaries repaired and maintained → Hospital waste-management concept and practice instituted → Creation of health service stakeholders committees to address matters of structural quality and other constraints → Rehabilitation of staff houses done → Involvement of local communities in rehabilitation of public health services units	→ Advocacy of the PHC concept and practice → Definition and installation of basic standard treatment schedules in units → Definition of Minimum Package of health services expected at units → Inception of standard per - formance control → Development of standards for case management in units → Extensive training of health personnel in lthe areas and the mission of the DUHP and management	→ Adoption of MOH-HMIS → Drugs estimates needs known → Operationali-zation of an essential drugs systems for the city units → Standard guidelines adopted and used → Rational drugs use elaborated and managed → Facility level drugs budget projected → Identification of cost effective procurement system	→ Elaboration and adoption of standard equipment list for units → Extensive procurement of equipment for hospitals, health centres and dispensaries done → Identification of cost effective procurement system → Development and maintenance of inventories for units' assets and status → Introduction of maintenance teams to deal with medical equipment	→ Creation of various steering teams all at levels → Review and establishment of organization structure in line with the HSR of the MOH → Various levels of medical practitioners and general support staff have been trained in management in short courses → Adoption of systematic planning at various levels → Community involvement has been adopted and improving

Source: Various Reviews and Reports of the DUHP

The interventions were carefully planned and executed to address most of the constraints. At the end of the DUHP a lot has been realized as summarized in the table. Hypothetically if such concerted efforts were done for the other urban centres in Tanzania (facing almost the same constraints), then this would result in some important and remarkable improvement in Tanzania's urban health system.

What can be realized from Table 14 are the numerous constraints facing Tanzania's urban public health services managers, and in this case in Dar es Salaam region. The table just identifies a few of the constraints and the achievements realized from some interventions. Indeed the listed constraints are not as attended to in the other urban centres of Tanzania as they are in the Dar es Salaam region following the Swiss support for the DUHP. This means that the experience of Dar es Salaam can be scaled up or replicated in other Tanzanian urban centres with some adaptations. A major constraint though not listed in the table is the financing of such initiatives.

On the other hand one should not assume that the DUHP has been able to deal with all the constraints in the Dar es Salaam region's health services delivery system. There are several areas of "unfinished business" These include:

- 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 attributes of bureaucratic hang – over of some seasoned administrators of the old centralized system who are suspicious of the envisaged (decentralization) change implications.
- Given the low level of funding by the government, the employees in the public owned health services 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 such communities taking up responsibilities to mobilize funds for the public (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 ows to the fact that the government's and the community's own financial contribution have been relatively small compared to the donors' contribution (see Table 15).

3.4 Financing the Dar es Salaam Urban Health Project

The implementation of the DUHP has meant a lot of financial commitments, but more so with the support of the Swiss government grant which has offered about 74% of the funding over the three phases as shown in Table 15. Initially the Danish government contributed to the DUHP to a tune of Swiss francs 1,800,000 or 4.8% over the period.

Table15: ***Financing the DUHP 1990 to 2000, Direct Project Related Funds (CHF or Swiss Francs)***

Contributor	1990-93 PhaseI	1995-96 Phase II	1996-200 Phase III	Total	%
Swiss Development Cooperation (SDC)	7,014,276	8,323,944	12,160,000	27,498,220	73.9
BAWI: Swiss Government Balance of Payment Assistance	3,000,000	2,000,000	n/a	5,000,000	13.4
DANIDA	1,800,000	N/a	N/a	1,800,000	4.8
Tanzania Government	968,319	756,330	1,196,145	2,920,794	7.9
Total	12,782,595	11,080,274	13,356,145	37,219,014	100%

Source: DUHP files and reports, various years.

What can be noted from Table 15 is the relatively large contribution by the principal donor (SDC) which amounts to 73.9% over the period. The statistics do reveal only the project related commitments, with items like salaries and wages and other non-project expenditure being met by the government of Tanzania, and unrecorded here. The donor's funds were necessarily needed to create improved conditions for efficient and effective delivery of health services, and to ensure continuity even after the project life. The project outputs such as new structures, rehabilitated structures, new equipment etc are of a permanent character, if only a preventive maintenance system plus new management culture are developed and maintained.

Towards the end of the first phase one notices an increased commitment by the Tanzanian government in a gradual phasing in to take up some of the donors' financial responsibilities. The supply of essential drugs started to become a responsibility of the Tanzanian government starting from 1997/98 financial year as shown in Table 16.

Table 16: Specific *Expenditure Patterns in the DUHP, 1996 to 2000 (in Tshs)*

Expenditure	1996/97	1997/98	1998/99	1999-2000	Total	%
Training and Operating costs	64,567,519	166,774,355	84,972,000	198,316,000	514,629,874	11.0
Construction	147,122,232	452,845,826	420,453,000	32,004,000	1,052,425,058	22.5
Drugs and Supplies	448,593,220	305,207,449*	174,865,800*	377,160,000*	1,305,826,469	27.9
Transfer to Districts' Recurrent Accounts**	257,970,110	151,179,917	334,223,000	161,436,000	904,809,027	19.3
Administration Cost	164,683,229	135,827,250	139,077,000	141,059,000	580,646,479	12.4
Equipment	23,487,280	89,302,033	149,145,000	60,101,000	322,035,313	6.9
Total	**1,106,423,590**	**1,301,136,830**	**1,302,735,800**	**970,076,000**	**4,680,372,220**	**100**

Source: DUHP, Audited Accounts reports.

* Government of Tanzania injection into the direct project's recurrent expenditure

** This is account No.6 which is directly controlled by the District Medical Officer for the non-project commitments

Table 16 shows that a substantial amount of the project fund (22.5%) were spent on construction and equipment in order to create an improved working environment for the delivery of health care services for the Dar es salaam region. The concern with drugs and supplies took even a bigger chunk of the funds (28%) of the project's available funding for the period in order to ameliorate the almost depleted drugs and equipment in government owned urban health services delivery units in Dar es Salaam. It is important to note that the drugs and supplies expenditure category was financed by the government of Tanzania to a tune of 65.6% for the period of 1997 to 2000.

What can further be noted from Table 16 is the gradually decreasing expenditure trends for some of the commitments, with the exception of training and drugs and supplies. This can imply some level of attachment by some of the DUHP's components. During 1998/99 more of the project funds were now remaining, and they were integrated into the District Recurrent account under the management of the District Medical Officers. This is a positive indication of a phasing out

project, and one that is likely to be harmonized as an integral part of the regular health services delivery system, as well as one which promises high chances of sustainability.

3.5 Extension of the Dar es Salaam Urban Health's Initiative

The extension and further application of the DUHP may have its financing sources more diversified than now. These include a multisectoral or a Sector – Wide Approach (SWAP) which has created a funding opportunity under the MOH's Health Sector Reforms' "basket funding" facility. Various donors can contribute to the basket in order to fund an integrating health sector, instead of single donor managed projects. The MOH then allocates and manages the pooled funds.

The second supplementary source is the implementation of Tanzania's cost sharing policy. There is some potential promise in this alternative as shown in Table 17.

It is hoped that once the Sector Wide Approach (SWAP) has been adopted and accepted, with its basket funding facility fully controlled by the MOH, then the government of Tanzania will be able to increase its funding level to margins which will enhance and sustain the DUHP initiatives, not only for Dar es Salaam, but for the other urban centres as a whole.

Table 17: Response *Rate in the Cast Sharing Policy in Dar es Salaam*

Sources of Cost Sharing Funds Collection	1999-2000 Projected Revenue (Tshs)	1999-2000 Collected Revenues (Tshs)	Rate of Collection %
Kinondoni Municipality Total	235,172,500	231.250,070	98.3%
Mwananyamala (District Hospital)	82,987,500	90,561,950	109.1%
Other Levels Collection	152,185,000	140,688,120	92.4%
Ilala Municipality Total	152,185,000	147,767,081	94.9%
Amana (District Hospital)	89,166,670	82,253,060	92.2%
Other Levels Contribution	63,018,330	65,514,021	103.9%
Temeke Municipality Total	151,071,080	126,592,872.7	83.8%
Temeke (District Hospital)	91,687,500	79,131,900	86.3%
Other Levels	59,383,580	47,460,972.7	79.9%
Grand Total	538,428,580	505,610,023.7	93.9%

SOURCE: Dar es Salaam Urban Health project Office files

Observations from Table 17 indicate that there is a very positive response to the cost sharing policy with rates of collection of projected revenues ranging from 83% to 100% during the year 1999/2000. The poorer performance municipality has been Temeke. The apparently better performing municipalities seem to derive strength from their populations' (perhaps) high income levels. The high income altribute here is related to the fact that Ilala occupies the central business district in the city centre, while Kinondoni has most of the high-income residential areas in the city. These explanations are plausible but they are yet to be substantiated by tangible income distribution data.

A major message coming out of the DHP is the need to have the structural quality dimension improved before the other dimensions. This calls for priority investment and sequencing the programme. Once this has been done, then the other areas of investments should be given priority. One can see that the DUHP is gradually phasing out major investments into building and equipment. This leaves more money to the other dimensions such as skills improvement training, preventive maintenance and other recurrent costs. The detailed expenditure of the

DUHP priority expenditures over the period of 1993 to 1995 (phase I) give data for this observation with expenditure details in Table 18.

Table18: ***Expenditure Pattern in the Execution of the DUHP (in Tshs)***

Priority Expenditures	**1992/93**	**1993/94**	**1994/95**	**Total**	**%**
(a) Capital Investment	30,713,381	9,756,228	298,863,188	427,141,797	56.3
(b) Equipment and Furniture	14,397,315	9,748,250	12,394,639	36,450,204	4.8
(c) Vehicles and Equipment	4,796,800	2,283,348	3,677,241	10,757,389	1.42
(d) Recurrent Costs	3,968,074	31,852,480	78,247,962	114,068,516	15.0
(e) Operating Costs	28,869,231	36,444,468	75,552,678	140,866,777	18.6
(f) Technical Assistance	973,980	18,307,781	10,630,557	29,912,318	3.9
TOTAL	**83,628,781**	**196,201,955**	**479,366,262**	**759,197,001**	**100%**
Swiss Government	146,270,014	26,141,643	746,885,915	921,297,572	96.3
Tanzania Government (Direct Project) costs		19,000,000	16,000,000	35,000,000	3.7

Source: DUHP Files (Audited Accounts) for Phase I

Notes:

(a) Capital expenditure means rehabilitation of hospitals health centres and dispensaries, construction of office space, workshops and news facilities.

(b) Equipment and furniture means to equip offices, health centres etc.

(c) Equipment and vehicles means purchase of workshop equipment and vehicles

(d) Reccurent costs means expenses on training and monitoring

(e) *Operating costs means expenses on auditing, office expenses consumables for vehicles and maintenance of health facilites*

As it appears in Table 18 most of the funds (56.3%) in the first phase went into capital expenditure, that is, to rehabilitate and to repair the three district hospitals of Amana (Ilala municipality), Mwananyamala (Kinondoni municipality) and Temeke hospital. Additionally, more funds were expended to rehabilitate the Dar es Salaam region's health centres and dispensaries. Workshops and some offices were also constructed to improve the working environment in which services are delivered. During the given period the Tanzania government could contribute only 3.7% to the initial direct project funding One should not fail to recognize how this donor contribution has made a lot of difference, without which perhaps the government of Tanzanian would been have much constrained to do what was executed in phase I.

The implementation of the DUHP was according to some, timely investment phased in a manner to create enabling conditions for the next stages. The expenditures during the second phase put more emphasis on the procurement of drugs and equipment as it is shown in Table 19. Once the buildings and equipment were put into an acceptable operating environment for health services delivery, then concern with drug and medical supplies followed.

Table19: ***Expenditure Pattern in the Execution of the DUHP 1996-97 Phase II (in Tshs)***

	1996	**1997**	**Total**	**%**
(a) Drugs	448,593,220	-	448,593,220	33.5
(b) Capital Investment	269,201,163	147,122,232	416,323,395	31.1
(c) Equipment and Furniture	24,958,675	23,487,280	48,445,955	3.6
(d) Vehicles and Equipment	1,698,553	-	1,698,553	0.1
(e) Recurrent costs	35,988,841	64,567,519	100,556,360	7.5
(f) Operational costs	92,995,281	164,648,229	257,678,510	19.2
(g) Technical assistance	18,645,766	47,937,137	66,582,903	5.0
Total	**443,488,279**	**896,390,617**	**1,339,878,895**	**100**

Source: DUHP files (audited accounts), various years

It needs to be clearly noted that the Government of Tanzania continued to shoulder non contract and non project items such as salaries wages, insurance, fringe benefits etc. Otherwise the contribution directly to the project was insignificant in nominal terms.

The 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% of the actual expenditures of the DUHP funds. The rehabilitation, maintenance and construction continued to consume a substantial

amount of the DUHP funds, that is 38%. The third most priority expenditure was training which claimed about 14% of funds as shown in Table 20.

Table 20: The *DUHP Expenditure Pattern (Tshs) for 1998*

(a) Capital Investments	452,845,826	38.4
(b) Drugs procurement/distribution	305,207,449	25.9
(c) Recurrent costs (training)	166,774,355	14.2
(d) Operating costs	135,824,250	11.5
(e) Equipment	89,302,033	7.6
(f) Short term consultancies	28,354,831	2.4
Total	1,178,308,744	100.0

Source: DUHP files (Audited accounts)

It is obvious that much more money was spent on rehabilitation and construction. This focused on the improvement of both the structural quality and user-perceived quality dimensions. An improvement in the service units' infrastructure can be positively and partially related to motivating the health services providers because the working environment will have been improved. Health Service users will plausibly perceive some level of satisfaction because there will be more space, more cleanliness and improved waiting and treatment rooms.

The third most import expenditure department is the training of health services personnel. The training was not only in diagnostic or treatment procedures but also the adherence to acceptable standard treatment procedures. In addition the health services managers were given doses of management skills in order to implement what has been referred to as a Minimum Package of Health and related Management Activities (MPHMA).

In short the DUHP has resulted into the creation of elements and concepts like the MPHMA and practical experiences which can be regarded as some critical determinants for the development of Tanzania's national urban PHC strategy. The DUHP experience can also become scaled to suit a smaller urban setting than Dar es Salaam. 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. What the DUHP has done is a structural and functional rehabilitation of the Dar es Salaam public health delivery system ,starting from 1990. The inter-government agreement between Switzerland and Tanzania has contributed a lot to what is seen in Dar es Salaam as a significantly changed and improved public health services delivery system. This is more than wanting in other urban centres which are probably in worse conditions than the Dar es Salaam public health delivery system of the late 1980s and early 1990s.

The scaling up of the DUHP may have to bank on donor financing facility like the "basket funding" arrangement in which donors contribute project - allocated funds to a pooled account to be managed by the MOH. The basket funding can be an opportunity to scale up the DUHP to other urban centres in Tanzania in order to develop an MPHMA for the other urban centres.

Another supplementary funding option is the cost sharing funds which the Dar es Salaam shows a positive response rate of more than 90%. The DUHP used a lot of participatory approaches to have the consumer communities sensitized and in involved. This is one more lesson which can be emulated by the other urban centres wishing to draw upon the DUHP experience.

Both the CHF and the DUHP concern themselves with the creation of mechanisms for raising funds at the local level and especially at the level of service consumption. The two cases have a lot questions to be raised when it comes to participation of the intended communities at the level of planning and resource mobilization because the two cases have been a top – down initiative with the donors assisting with the funding. There are alternative approaches as summarized in Table 22 for consideration and a framework of organizing the initiatives.

Even with the criticisms, which can be raised against the CHF and the DUHP approaches, they set examples, concepts, principles and promises for scaling up the initiatives to other districts. Table 21 shows that out of the 563, 919 households in the 10 CHF districts only 22,995 households or 4% were members of the CHF. This is by all means a small portion of the intended population of households. This is perhaps due to the approaches or due to short period they have been in place against established ideologies of service delivery, given Tanzania's government commitment to render free health services to the population.

Table 21: ***Status and Rates of Revenue Sources Between 1996-1999 for the CHF Initiative***

1 District	*2 No. of Households*	*3 CHF Members*	*4 Rate Tshs.*	*5 CHF Contributions (TShs)*	*6 User fees Contributions (TShs)*	*7 Matching Funds (Tshs.)*	*8 Total (Tshs.)*
1. Igunga	50,142	(933) 8%	5,000	47,983,000	46,680,000	46,680,000	141,343,000
2. Nzega	52,421	(2458) 4.7%	5,000	12,290,000	2,900,246	12,290,000	27,400,246
3. Iramba	58,066	(3,135) 5.4%	5,000	15,675,000	8,364,000	15,675,000	39,714,000
4. Singida (R)	54,424	(2,265) 4%	5,000	11,325,000	12,205,800	11,325,000	34,855,800
5. Hanang	19,458	(5690) 29.2%	10,000	56,900,000	9,991,600	56,900,000	123,791,600
6. Songea (R)	68,110	(767) 1.1%	7,000	5,369,000	7,990,600	5,369,000	18,728,600
7. Songea (U)	19,630	(94) 0.5%	940,000	1,511,000	940,000	940,000	3,391,000
8. Iringa	88,594	(3028) 3.4%	5000	15,140,000	1,604,000	15,140,000	31,884,000
9. Mbinga	66,536	(2244) 3.4%	15,000	33,660,000	293,000	33,660,000	67,613,000
10. Kilosa	87,919	(2381) 2.7%	5,000	11,905,000	1,669,500	11,905,000	25,479,500
TOTAL	**563,919**	**(22995)**	**-**	**209,884,000**	**94,512,746**	**209,884,000**	**514,200,746**
	100%	**4.1%**	**-**	**40.8%**	**18.4.%**	**40.8%**	**100%**

Source: Ministry of Health, CHF Coordinating Office, Dar es Salaam

Even though the CHF membership was only 4% of the intended households, this small portion of the population managed to raise Tshs. 209,884,000 out of the Tshs. 514,200,746 collected to fund the health services. This substantial contribution (of 40.8%) cannot be ignored. If one were able to raise the membership size for the CHF from 4% to, say 25%, of the households, and each household contributing the calculated average of Tshs. 9,127.38, then the 140,980 households (presumed members or 25%) would be able to raise Tshs. 1,286,778,032.40. This is more than two times the total amount contributed by the households members, user fees and matching/donor funds contribution (see Table 21). It implies that the contribution rate could easily be lower in order to make the scheme more affordable and the donor funds could be

withdrawn without any constraints on sustainability in the financing of the health services in the like – districts.

4.1 Reflection on the Case for Interventions and Approaches

The purpose of studying the two cases in Tanzania is to examine those underlying problems or constraints to an efficient and effective health services delivery system. The cases are important as they are contextualized in a decentralizing (community participatory approach) administration which also calls for the health sector reforms to take on board a decentralization policy. Another context is the fact that the cases are seeking to experiment in very poor communities, with an endeavour to expect the local populations to shoulder some services' financing responsibilities once the initial donor funding has created the minimum conditions. It is expected (for both cases) that once the donor supported projects. Come to an end, the communities of users and the local administrative authorities will sustain the units in a manner will guarantee the sustainability of the interventions that would have created an improved system of health services delivery.

The Igunga and the roll-over districts' Community Health Fund (CHF) intervention is an attempt to create understanding, responsibilities, and a participatory system which will work to create a community revolving fund or a voluntary community health insurance scheme. Even though the percentage of households joining the scheme is low, it has created a sense of understanding of the need for local communities to take up responsibilities for their own health. It has also created some administrative system geared at collecting and managing a common fund for the health services in the community.

The efforts of the Dar es Salaam Urban Health Project (DUHP) were to source some funds to create

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 now brings up public concerns for urban health investments. Urban health has not received the due priority policy attention it requires. The case of the DUHP points out lessons of experience on strategies to rehabilitate Tanzania's government urban health services.

The DUHP has created a reorganized system, a much needed infrastructure, it has embarked on promotive services at the units' levels, and it has created the culture of health services planning, monitoring and evaluation; and it has also motivated more community participation in committees and the cost sharing drive. In short the DUHP has offered to the Tanzania's policy makers a need to concern itself with urban health policy development. The use of the strategies and the DUHP model can be scaled up to other Tanzanian urban centres with some adaptation.

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 are meant to show how an injection of donor funds can make a positive difference in effective health services delivery. The cases show some attempts to phase out the donor funding and to put responsibilities on communities. Some limitations to this effect have been pointed out. Something has to be done about the approaches to developing and executing the intervention projects. Table 22 summarises the major points and possibilities when the interventions are top-down or bottom – up on a continuum of possible actions. What needs to be attended to is how to make the communities own and sustain the interventions.

4.2 Reflection on the Approaches

The interventions have in many ways tried to work within the context of Tanzania's Health Sector Reform policy drive 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 programmed series of interventions.

The initiatives of the two cases have taken on a project approach, meaning that the funding has to come to an end at some point. One wonders whether the achievements of the interventions will become the responsibilities of the local administration the way they have been intended. If this is effected one wonders whether the level of funding and service quantity and quality so far achieved will be sustained after the donors' with drawl of funding. To some extent the funding sustainability are seen to be achievable to some level to guarantee the minimum package if concerted efforts are made to educate the health services consumers, and if the quality of services will be sustained to a level to satisfy the contributors' expectations.

The donor-funded projects in Tanzania have been vertically conceived and executed. The initiators, funders and managers have often been the donors' programme officers or/and the MOH headquarters' personnel. One can conceive of four approaches to create and manage health services interventions as summarized in table 22.

Table 22: ***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
1. Programme Conceptualization	• The Donor alone or with minor input from the headquart ers of the MOH conceive and put up a proposal • Some MOH consultant or expert put up a proposal	The Donor/the MOH headquarter experts or consultants conceive project which are sold to communities at the subnational level. The communities are solicited to support the initiative as funding will be available and they will benefit	Local/subnational level communities perceive a health services problem and need. They create some project seeking the support of the central government or other benefactor	Local/subnational leadership and communities take responsibilities to design and manage interventions in partnership with experts at the relevant level of service
2. Programme Designing and Planning the execution	• Domain of donor and/or central government personnel • Subnational levels are on – lookers and passive recipients of the supply-driven approach	• Expertise of the donor/central government is mobilized and plans are produced taking on board the wishes of the subnational communities where necessary • Central government principally does the execution • Some donors execute own projects	• Subnational concepts and plans are prepared and support is sought from the central government • National level resources are used to facilitate the planning and execution of locally planned initiatives	• Subnational levels plan their own interventions though answering to national health policy mandates • They manage, monitor and review the implementation of such interventions
3. Programme Management and Control	• Centralized management and accountability relations • Reeviews are centrally made and alterations are made with little or no consultations with subnational levels	• Management systems are created by the central government authority in consultation with the subnational authorities and communities • Subnational representatives are accommodated on the centrally created communities	• Subnational management structures and authorities are rationalized by the central government authorities • Central government representatives/experts are accommodated on locally created management authorities	• Within an integrated government health system subnational responsibilities are known and the subnational authorities execute interventions falling within their mandates
4. Programme Financing	• Basically donor funded, or • Basically central government funding availed • Combination of the two is a possibility	• Basically donor or central government funded • Subnational authorities are given lesser financing responsibilities	• Substantial amount of financing an intervention is mobilized at the local level or consumer level • Central government may be called to assist in large scale interventions, especially those in the category of public goods	• Finances are almost entirelly sourced at the sub-national/service utilization level eg by cost recovery • Finances are locally operated, monitored and audited • Service – level decision – making for expenditure
5. Programme Sustainability Chances	→ It lasts as long as there is central government or donor support for funds and technical staff	→ Partnerships between central and local authorities can enhance sustainability → Obscure responsibility for sustainability at subnational level	→ Increased chances for sustainability and integration into subnational planning processes	→ Much enhancement of chances of sustainability

What is summarized in Table 22 are the different scenarios. Levels of subnational 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 columns indicate traits of dependency and centralization.

The projects' interventions are closer to the left approaches the ideal right hand approaches. The interventions are more likely to be sustainable the closer the approaches move from the left hand traits (of Table 22) to the right hand side traits.

With limited funding ability and expertise at the subnational level, one can envisage a possibiity of "top-down and bottom – up supported" scenario in Table 22. This has been the case with the two projects discussed. This scenario has some limitations in that the subnational partners are slow in assuming responsibilities. It is also a supply driven approach rather than been demand driven like in the cases of scenarios C and D. A major challenge is to create those interventions which are bottom-up derived and top – down supported (scenario C), and better still, those interventions which are conceived, financed and managed at the subnational level, while at the same time contributing to universal health services' principle and national health policy concerns such as primary health care and preventive services.

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