

Making Plans for Success — The Tanzania Essential Health Interventions Project

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A mother and child await their turn at a health clinic in rural Tanzania. (IDRC Photo: Peter Bennett)

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Women cradling babies sit along wooden benches outside the health clinic in Mvomero, a small rural community in Tanzania. Inside, Mr Y.E. Kapito gently examines a baby to determine why he has a fever and to assess other health problems. Kapito's quick reference guides are brightly coloured wall charts that describe childhood illnesses and treatments.

Kapito is seeing more patients these days; he estimates that the number has almost doubled in a year. But he hears of fewer child deaths. "It's been six to eight months since I have heard about a child dying," he says. Samuel Hassain, who brought in his flu-stricken grandson, remarks, "Things have improved. People have faith in the services. They are treated well and get diagnosed properly."

Mvomero is in Morogoro District, one of two districts that are the testing ground for the Tanzania Essential Health Interventions Project (TEHIP), a joint initiative between the International Development Research Centre (IDRC) and the Tanzania Ministry of Health. Since 1996, TEHIP has been piloting innovations in planning, priority setting, and resource allocation at the district level, in the context of the reform and decentralization of Tanzania's health care system.

Both Kapito and Hassain have clearly seen changes in their community and their impressions are borne out by some important data sources. Child mortality between the late 1990s and early 2000s appears to have declined between 30 and 40% in Morogoro District — from about 35 annual deaths per 1000 children under five years of age to around 20 deaths/1000. This data comes from the Ministry of Health's Adult Morbidity and Mortality Project, which operates a sentinel Demographic Surveillance System (DSS) in partnership with the Morogoro District Council.¹

Marshalling the evidence

The use of such data is at the core of the TEHIP approach, both for planning health interventions and measuring their impacts. Typically, health plans for Tanzania's 129 districts reflect several influences, including the status quo, political and development agendas, and even just plain intuition. In contrast, Morogoro and Rufiji districts set priorities and allocate their health care resources based on local sources of evidence, namely the problems that cause the most deaths and illness at the household and community levels. The results: both districts have significantly improved their health systems, service delivery, and the use of health interventions.

As the TEHIP project comes to a close, the challenge now is to apply its lessons to the rest of the country. It's a challenge that has been embraced at the highest levels of the Tanzanian government.

"The entire political fabric of the country is ready for takeoff," says Anna Abdallah, Tanzania's Minister of Health. "The problem now is how do we scale up to make sure that the health plans in our country are being planned with evidence."

Investing in health

TEHIP grew out of the World Bank's *World Development Report 1993: Investing in Health*, which suggested that providing packages of essential health interventions to 80% of the population of low-income countries could substantially reduce the burden of disease. Tanzania, then undergoing health sector reform, was in a good position to test a new approach to improving health care.

The World Bank was very good about saying what was wrong and what the solution would be, but didn't say anything about how to do it," says Don de Savigny, TEHIP's research manager. "TEHIP tackles the 'how' questions."

TEHIP focuses on three activities: it develops simple tools and strategies to build the capacities of local health authorities to plan and use resources more strategically; it supports research, carried out by Tanzanians in multidisciplinary teams, to evaluate impacts; and it provides untied "basket" funds that the two districts can spend to implement their plans. This extra money, which amounts to less than US\$1 per person per year, currently comes from a pool of donor funds targeted for health care.

Planning in Morogoro

With more than 520,000 people, Morogoro is one of the largest districts in Tanzania. Living in remote and often inaccessible terrain, most of the population depends on agriculture. The town of Morogoro, the district's administrative centre, sits under the Uluguru Mountains. Their roller coaster outline is a reminder of the difficulties faced by the Council Health Management Team (CHMT) in providing health care to people. "I could use a helicopter," jokes Dr Harun Machibya, the District Medical Officer.

The CHMT includes a pharmacist, nurses, a health management information specialist, and health officers responsible for programs on malaria control, reproductive health, tuberculosis, leprosy, HIV/AIDS, and mental health. Together, they have developed annual health plans that are now judged by the Ministry of Health to be among the best in the country.

This was not always the case. "Before the inception of TEHIP," says Dr Machibya, "the District Medical Secretary would sit in an office with an accountant and add 10% to 20% to the previous year's budget. So it was not a plan in the real sense, but a budget. Now we can prioritize more comfortably because we have concrete, reliable information from the population at large."

Household surveillance

This information comes from the sentinel DSS — what de Savigny refers to as the "evidence engine." The DSS records births, deaths, causes of death, and migrations in and out of the area. Such regular monitoring gives health planners a more complete and up-to-date picture of a population's health problems.

Raw data, however, is not enough to guide decision-making. As part of its tool development program, TEHIP "added value" to the DSS data by re-packaging it into a user-friendly format for district planners. An automated tool translates complex information into easy-to-read graphs, tables, and charts to produce an intervention priority profile. At a glance, planners can now see the causes of the burden of disease in their districts in terms of how they can be tackled through interventions. After interventions have been put into place or re-focused, the same tool can help to assess the impact on the population's health.

Statistics thus become meaningful to stakeholders without a technical background. "When you can digest a huge amount of information into one picture, the information jumps off the page," says Graham Reid, TEHIP's project manager. For example, malaria was shown to be responsible for 30% of life lost because

of death and debilitating disease. As a result, the Morogoro CHMT increased spending on malaria prevention and treatment from 5 to 25% of its budget.

A little goes a long way

The TEHIP “top-up” — the dollar from the basket funds on top of what the government allots the district — goes toward implementing the health plan and delivering the interventions selected by the CHMTs. Leading the list of new priority interventions is the Integrated Management of Childhood Illnesses, an approach that focuses on the well-being of the whole child. In doing so, it addresses five major childhood diseases: malaria, pneumonia, diarrhea, measles, and malnutrition. Other interventions also target malaria, such as insecticide-treated bednets and drugs to prevent malaria in pregnancy.

In the early years of TEHIP support, the districts could not absorb all the extra funding. “Our skills were still inadequate,” says Dr Machibya. TEHIP basket funds were therefore used to improve the teams’ ability to plan and prioritize. Equally important was building up capacity in such areas as administration, accounting, financial management, communications, and the reconstruction of run-down health care facilities. Computers were introduced to replace the big ledgers that were a legacy of colonial years.

A good set of tools

The concept of developing a “management cascade” came out of these capacity building strategies, to solve problems faced by the CHMT in personally supervizing all the district’s health facilities. With 97 widely dispersed facilities in Morogoro, regular visits were physically impossible.

In the cascade system, supervision is delegated to staff at selected health facilities. Morogoro has 12 cascade centres that are linked by radio to the CHMT. Each centre is responsible for a specific group of dispensaries. Supervisors use motorbikes — and a boat in the case of coastal Rufiji district — to cover their territories. The cascade is also used for delivering drug kits and bednets, collecting reports, and implementing national campaigns, such as immunization programs.

With health services improving in the district, communities are now willing to contribute to the process by repairing or even rebuilding dilapidated dispensaries. The district council has transferred ownership of many of these facilities to the communities, giving people more of a stake in the health care system. “It is a breakthrough,” says Dr Machibya. “Previously, people asked for help even when a lock was broken.”

Government endorsement

TEHIP has developed a manual that helps guide community-led efforts to rehabilitate health facilities. Both the manual and the cascade are part of a series of TEHIP tools that have been adopted by Tanzania’s Ministry of Health. [See related sidebar: [Retooling Health](#)] The government has started to introduce the cascade to other districts and is poised to do the same with the facility rehabilitation tool. It is also training districts to use two TEHIP-developed tools that are key to the planning process — one that generates the burden of disease profile and another that integrates this profile with the district’s budget. Armed with these tools, planners can allocate resources according to health priorities. The goal is to have all the districts using these tools by the 2004 planning cycle.

Other donors are also supporting the use of TEHIP tools. The United Nations Foundation, for example, is funding the “roll-out” of tools in 11 districts.

The process of extending the tools nation-wide is thus underway, says de Savigny, but it is going more slowly than desired, due to a shortage of both financial and human resources. “Taking anything to adequate scale is a major hurdle, whether it’s treated bednets, anti-retroviral treatment, human resource development, or health system change,” says de Savigny. “Scaling up is a generic challenge in Africa.”

It’s a problem with potentially fatal consequences. For example, the July 5, 2003 edition of *The Lancet* reported that, in the 42 countries which accounted for 90% of child deaths in 2002, 63% of those deaths could be prevented through the “full implementation of a few known and effective interventions.” The wider adoption of TEHIP’s tools and its approach to strengthening health care systems can help focus support on the interventions that make a difference. The success of Morogoro and Rufiji districts, where child mortality has declined substantially, is showing the way.

“We have the tools to make a difference,” says Dr Gabriel Upunda, Tanzania’s Chief Medical Officer. “Let’s get them to the other districts... let’s get them to the world.”

Coming in the summer of 2004: *In_Focus* on TEHIP

IDRC will publish a book on TEHIP and a companion Web site — which will include the full text of the book — in the summer of 2004. To be notified when the *In_Focus* on TEHIP is published, [subscribe](#) to our free electronic mailing list on health. This list is only used to advertize IDRC events and publications.

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Sidebar

Retooling Health

TEHIP has developed or refined a variety of powerful planning tools and strategies. These tools provide the evidence that enables CHMTs to better set priorities and allocate health resources as part of their planning process. The tools also help to build the planning and administrative capacities of the CHMTs.

The "tool box" includes the following tools and strategies:

- District Burden of Disease Intervention Priority Profile
- District Health Accounts
- District Cost Information System
- District Health Service Mapping
- Community Voice Strategies
- Strengthening District Health Management and Administration
- District Integrated Management Cascade
- Community Ownership of Health Facilities
- Regional District Health Management Meetings

Short descriptions of each of the tools can be found in [TEHIP in Action](#) on the TEHIP Web site. In addition, two-page briefs are available on the [District Burden of Disease Profile](#) and the [District Health Accounts](#) tools. Selected briefs on some of the other tools are under development.

(1) A DSS is way to continuously monitor a population by collecting data at the household level within a geographically defined area. A sentinel DSS site is representative of a much larger group than that under surveillance. The DSS area in Morogoro is the sentinel site for the entire Region and similar districts in other Regions. [For more information on demographic surveillance, see related *Reports* magazine article: [Vital Statistics](#).]