Feedback to TEHIP:
Selected Findings from the Policy Influence Case Study on Tanzania Essential Health Interventions Project

August 2004

Prepared by:
Terry Smutylo

Evaluation Unit, IDRC

EXECUTIVE SUMMARY

The interviews indicate that TEHIP has significantly influenced the formulation of national health policies, the delivery of district health services and the role of health research at both these levels. At the national level respondents saw the use of BoD and cost-effectiveness information as enabling health officials and practitioners to make decisions based on the actual conditions they face. The tools and approaches developed by TEHIP have influenced many of the management practices and relationships governing health policies and their implementation.

National level policy and decision-makers commented on their increased awareness of the integral role the use of evidence needs to have in managing Tanzania's national health system. Researchers noted changes in confidence and management approaches associated with the increased use of evidence for decision-making and sector reform. Donors and policy implementers were particularly aware that experience with TEHIP had demonstrated: the need for, and benefits of, coordination and cooperation among the various health sector players; that competition and confusion between organizations, districts or levels of administration could inhibit progress; and that empowered communities can take on ownership and effective responsibility for health service delivery. Communities can make good use of health surveillance data and contribute effectively to bottom-up district planning. Nationally, there were numerous examples where TEHIP-generated information contributed to determining appropriate levels of expenditure and to choosing appropriate health interventions. Two of the examples mentioned by respondents were: 1) demonstrating how to achieve significant health impacts with lower than anticipated per capita expenditures; and 2) determining the absorptive capacity of district administrations

As a player in Tanzania's struggle to combat malaria, TEHIP contributed to changing the national malaria treatment policy and provided evidence that helped sustain and focus several large scale malaria interventions in the areas where the need was greatest.

TEHIP`s work in applying information tools and management techniques to health services planning and delivery at the district level gave it national visibility. The fact that TEHIP had money to invest in the health system at the district level gave it influence and flexibility far beyond what it would have otherwise had. Changes in infrastructure, equipment and drug availability and in quality of care were seen to result from raising local contributions and the implementation of a cascade system for health services management. Moving to evidence-based management has enabled the staff in Rufiji and Morogoro to make adjustments in the scale and quality of service delivery based on both research and community feedback. Matching funding to absorptive capacity and targeting interventions based on demonstrated effectiveness enabled staff to plan more realistically and to deliver services responding to local conditions. Researchers reported that people welcomed these changes as they experienced reduced waiting for drugs and increased attention from health care staff. Local administrators unanimously expressed the view that these lessons could and should be applied in other districts.

Informants frequently alluded to the importance of creating and maintaining the capacity to consolidate and extend the TEHIP approach across the country. Stronger involvement of the

Zonal Training Centers (ZTC) was considered essential to maintaining adequate technical support and quality assurance.

TEHIP was seen by respondents as having demonstrated the value of national health research and linking it to improving health service delivery. Increased emphasis and use of demographic surveillance and operationally oriented research was cited by all categories of respondents as connected to the country's experience with TEHIP. Most interviewees identified the need for stronger central coordination in the collection, analysis and use of health surveillance information in Tanzania. TEHIP's generation and use of such information brought this into sharper focus and, in expressing concern for this, interviewees often suggested ways the various players could better coordinate and cooperate to build and utilize this important development resource.

Researchers also expressed concern over what they saw as a need to coordinate the work of those involved in the generation and analysis of national health information. Rationalizing roles among the various players and well-defined links to health sector activities would greatly increase the value of the research. There was a strong consensus that confusion persists and many remedies were proposed. These included: bringing all surveillance sites under the same management and methodological systems; making TEHIP part of the Health Sector Reform Secretariat (HSRS); creating a research synthesis and dissemination agency – or alternatively, establishing a regular, multiple fora; and the assumption of a stronger leadership role by the MoH.

Involving and sensitizing research users and policy-makers in the research process was one area frequently mentioned. Evidence-based decision-making was seen as something new to policy-makers. The researchers saw themselves as closer to development problems and as more aware of the solution-oriented research entry points. They indicated they had some way to go to sensitize policy-makers sufficiently. Overall, there is a need to cultivate the greater use of research to see policy-makers asking questions for which research can seek answers. Researchers need to think more about how to build the policy-makers' inclinations and capacities in this direction.

Interviewees were both enthusiastic about rolling-out the TEHIP approach across the country and cautious about the challenges this poses. Time, strong leadership and coordination, training and human resource development, an evidence-based, adaptive roll-out; and flexible, realistic donor policies are some of the key elements needed to move TEHIP from a district experiment to a viable, decentralized, national system.

Table of Contents

List of Abbreviations

AMMP	Adult Morbidity and Mortality Project
BoD	Burden of Disease
CHMT	Council Health Management Teams
DHMT	District Health Management Teams
DMO	District Medical Officer
GIS	Geographical Information System
GNP	Gross National Product
GTZ	German Society for Technical Co-operation
HMIS	Health Management Information System
HSR	Health Sector Reform
HSRS	Health Sector Reform Secretariat
IDRC	International Development Research Center
IMCI	Integrated Management of Childhood Illness
MARA	Mapping Malaria Risk in Africa
MoH	Ministry of Health
NSS	National Sentinel Surveillance System
NIMR	National Institute of Medical Research
RDSS	Rufiji Demographic Surveillance System
SDC	Swiss Development Co-operation
SP	Sulfadoxine Pyrinethamine
STD	Sexually Transmitted Disease
TEHIP	Tanzania Essential Health Interventions Project
UNICEF	United Nations Fund for Children
USAID	US Agency for International Development
WHO	World Health Organization
ZTC	Zonal Training Center

1. INTRODUCTION

1.1. Background on TEHIP

The Tanzania Essential Health Interventions Project (TEHIP) was a joint initiative between Canada's International Development Research Centre (IDRC) and Tanzania's Ministry of Health (MoH). It was an experiment inspired by the World Bank's 1993 *World Development Report - Investing in Health,* which proposed that, given the scarcity of health resources in low-income countries, health planning and priority setting should direct resources more strategically to where health needs are greatest. The report suggested that the use of health information tools, such as "burden of disease" (BoD) and "cost-effective analysis" to guide the provision of packages of essential clinical and public health interventions, could bring about significant improvements in health. It's prediction was that essential interventions "reaching 80% of the population could result in a 32% reduction in the BoD in low-income countries and 15% in middle-income countries." In the same year as the World Bank report was published, the Tanzanian government passed the Health Sector Reform Act in an effort to better utilize health resources, improve primary health care, increase user access and cut rising costs. This was part of a nation-wide initiative of local government reforms and included provisions for the decentralization of the health care system.

In 1993, as Tanzania prepared to implement its Health Sector Reforms (HSR) guided by the slogan *"To Plan Is To Choose"*, IDRC, jointly with several other agencies, began looking for an African country interested in hosting a project that would focus on improving the decentralized planning and management of health services. The intention to test the practicality of the ideas in the 1993 World Development Report converged with the supportive policy change environment in Tanzania, culminating in a project called TEHIP. To improve health care, *Investing in Health* advocated the devolution of responsibility to local authorities and the reform of Tanzania's health care sector fit well with this approach. Living in one of the poorest countries in the world, Tanzania's citizens could potentially benefit greatly if an approach like this was successful.

In 1996 TEHIP set out to test the feasibility of an evidence-based approach to health planning in two rural Tanzanian districts. The broad objectives were: to increase and strengthen the capacity of district health authorities in Rufiji and Morogoro-Rural Districts to effectively plan and deliver essential health interventions based on BoD and cost-effectiveness; and to measure, assess and document the overall impact and lessons learned in delivering selected health interventions at the district level. More specifically the project aimed at the following objectives:

- Strengthen district level capacity in Rufiji and Morogoro-Rural Districts to plan and set priorities using BoD and cost-effectiveness analysis for resource allocation
- Increase district level capacity to effectively deliver the selected health interventions
- Assess and document lessons learned in district health planning and management

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

information systems and processes
- Measure the overall impact of delivered health interventions in terms of BoD reduction (TEHIP Project Document, June 1996: p.6)

TEHIP started to pioneer these new approaches in 1997. It drew on national research capacity to: develop and pilot test district level health planning tools; monitor trends in health care delivery and health seeking behavior; and track changes in health through demographic and health surveillance. The project worked to build the tools and capacities of the local Council Health Management Teams (CHMTs) and to expand the scale of their health interventions. In addition, TEHIP supplemented district health budgets by about CAD1.50 per person per year.

The management tools developed and used by CHMTs and TEHIP included:
- *Burden of Disease Profiles* to show health needs at the community level
- *District Health Accounts* to map budgets and expenditures
- *District Cost Information System* to identify and cost technical inefficiencies
- *District Integrated Management Cascade* to enhance decision-making and involvement within district health facilities
- *Community Ownership of Health Facilities* for more affordable rehabilitation of health facilities
- *Community Voice* to facilitate community participation and ownership in improving the quality of health services
- *Project Operations Committee Meetings* to maintain effective communications, procedures and monitoring

1.2. Methodology

Five years after TEHIP started and about six months before it was scheduled to wind up, IDRC included it as one of a series of case studies looking at linkages between research and public policy. Fifty-two interviews were conducted with TEHIP personnel, participants, partners, donors and other organizations involved with or affected by TEHIP's work. The interviews were loosely structured and flexible enough to cover issues at the depth desired by the interviewees. They were conducted mainly during a two-week period by two Evaluation Unit staff from Ottawa. Designed to provide feedback to IDRC and the TEHIP team, this report is a condensation of comments extracted from the interview. Interviewees' comments are grouped according to five categories: decision-makers; researchers; donors; national policy implementers; and local policy implementers. The purpose of this selection of material from the interviews is to contribute to discussions in the planning and design of subsequent initiatives related to or building on the TEHIP work. A fuller analysis from a policy influence perspective is included with the TEHIP case study, which is part of the larger strategic evaluation.

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

2. TEHIP'S INFLUENCE ON NATIONAL HEALTH SYSTEM POLICY

Overall, interviewees were unanimous in recognizing the significant, positive influence of TEHIP on national health policies. TEHIP's work with the district health services sites at Morogoro and Rufiji was seen as having influenced thinking and actions affecting how research and other kinds of evidence can be used to make decisions about health policies, priorities and programs. Interviewees described this influence in relation to: 1) the **processes** of health policy and program formulation, implementation and reform; and 2) the actual **content** of policies, programs and reforms.

2.1. Processes of National Health Policy and Program Formulation

Several informants reported that the MoH was frequently making choices while subject to pressures from development and other agencies regarding the allocation of resources and the selection of interventions. Demographic surveillance data, from TEHIP and other sources, analyzed and made accessible using TEHIP-developed tools, was widely credited with making available reliable, relevant and understandable information to assist with these choices. Respondents saw the use of this information as enabling health officials and practitioners to take decisions based on actual and sometimes changing, needs, capabilities and conditions within Tanzania. BoD and cost-effectiveness of interventions were the most frequently cited examples. When describing TEHIP's influence on **how** policies and reforms were formulated and implemented, interviewees mentioned: resource allocation; the generation and use of health-related information; cooperation among sectors, levels and actors; and expanding the role of communities.

2.1.1. Resource Allocation

Fostering the use of evidence in resource allocation decision-making was the most frequently mentioned benefit derived from the experience with TEHIP. This was noted particularly by policy-makers and donors.

- *We are very satisfied with TEHIP's products, they have exceeded expectations. We have information for expansion to other districts, for example, a BoD tool on which to base expenditures. (1)*

- *TEHIP outputs will enable us to deliver much better health care. Before, we did not know how to plan, how to budget. For decisions on drugs we depended on WHO and sent the same drugs to all areas. Integrated Management of Childhood Illnesses (IMCI) and malaria studies gave us insights on what was required by giving us feedback from the field. (1)*

- *MoH has changed its policies due to the TEHIP BoD profiles. The Adult Morbidity and*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

Mortality Project (AMMP) has come up with the same kinds of data. (2)

- *Latest TEHIP data shows that IMCI addresses a huge part of the BoD in the district. In general, awareness of BoD is high, but action and budgeting are not following. It is difficult for the MoH to exclude certain things. (3)*

- *The most recent multi-country evaluation of IMCI looked at the economic implications and used TEHIP data. (3)*

- *Last year a review of the AMMP project fired up the Chief Medical Officer (CMO) as it highlighted the value of triangulating data from multiple sources to get a rich data set and the unique position occupied by Tanzania in having extensive health surveillance potential. (3)*

- *Now that we have the results, the central MoH has embraced the results and is looking to use them in other districts. (3)*

2.1.2. Generating and Using Health Information as an Integral Part of the Health Services Delivery System

Comments made by **national level policy and decision-makers** suggested that TEHIP had raised their awareness of the value of making the collection and use of evidence an integral part of managing Tanzania's national health system.

- *TEHIP has made us at the MoH aware of a lot of issues: BoD; allocation of resources; improving our health research facilities; and the use of evidence. (1)*

- *AMMP has shown us that we are missing some data in our Health Management Information Systems (HMIS) - mortality at home. Our services were not reaching the household; therefore we needed to take action. A comprehensive district plan is useless if it does not go to the household. (1)*

- *From the work of TEHIP, the MoH authorities need to learn to use research to make the right decisions and policy changes. In the primary health care system, research is a very important item. TEHIP can influence the MoH to allocate more resources to research in National Institute of Medical Research (NIMR). (1)*

Researchers, donors, and national level policy implementers pointed to examples from the TEHIP experience that indicated how such evidence could be used nationally and locally.

- *TEHIP has done a lot in a short time - demonstrating the need for evidence and changes in management styles, and the political will was there for reforming the health sector. Working with TEHIP, the district team gradually became more confident in planning and resource allocation. Now we can call in community resources, involving not just health*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

people but also other players. (2)

- *TEHIP has been a reality check on our annual strategy meetings; it has helped us decide if something is feasible. TEHIP experience at the district level and with district councils has been very helpful in the formulation and design of the decision-making structures for the partnership committees. (3)*

- *MoH has requested Rufiji Demographic Surveillance System (RDSS) data for basic health indicators (fertility and birthrate) for the national health abstracts. (4)*

- *Now when the District Medical Officer (DMO) delegates a task, people are more responsive than they used to be. They are more knowledgeable and can carry on the work even when senior people go on leave. (4)*

2.1.3. Collaboration Across Sectors and Regions, and Among Donors

When discussing how evidence should be generated and used nationally, respondents often mentioned the value of, and in some areas the urgent need for, greater coordination and cooperation and among the various players - as highlighted by TEHIP's operations. Donors and national policy implementers were heavily aware of this issue.

- *TEHIP played a crucial role in combining the use of research information and multi-sectoral partnerships for the national Insecticide Treated Nets program. With the commercial sector involved we now have a sustainable intervention. It is hard for researchers to implement as they don't have the skills but they make an important contribution. (3)*

- *We have not gone out to the donor community to let them know about the findings - there are sensitivities about the ownership of the findings and this is a constraint. (3)*

- *In the past we were complying with US, German and British types of planning. We sat together and decided to use one particular approach. Now all the districts are reforming and want to use our type of plan. Last year's Morogoro plan was praised and cited as an example for other districts. TEHIP has helped so much that the District Health Management Teams (DHMT) in Morogoro and Rufiji are the best in the country. (4)*

- *There needs to be more coordination between all the research projects developing tools… too much confusion and competition among the districts. (4)*

2.1.4. Community Participation in Policy and Service Delivery and Reform

Respondents with responsibilities for managing or delivering health services, particularly those involved in implementing health sector reforms, saw TEHIP as having demonstrated the value of devolving ownership and responsibilities to the communities being served. In addition, TEHIP

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

was considered to have demonstrated some valuable ways of doing this.

- *TEHIP has more knowledge of what is happening in villages than MoH. People's attitudes have changed for the better in the TEHIP areas. (1)*

- *Having this tool in TEHIP has influenced the MoH to devolve ownership to communities in the districts. (4)*

- *World Vision in Morogoro is now using the community mobilization tool from TEHIP. (4)*

- *Dissemination of the tools (BoD for planning, financial accts., cascade supervision, building capacity & strengthening the CHMTs) is now important to all stakeholders. Part of this will involve AMMP and TEHIP meeting to disseminate the tools - under the guidance and policy leadership of the MoH together with the empowerment of the communities. Both local government and MoH have to agree on the guidelines. (4)*

- *Before HSR the districts received funding based on central priorities; districts had only an indirect influence. Now they give us just so much money and we decide how and where to allocate it based on our own data (HMIS), on community feedback and on information from RDSS. We are now doing our own district health plans. This district is really very unique - other districts visit here to learn (for example about our communication mobilization system, our cascade supervision, about community sense of ownership). These are due to TEHIP. (5)*

- *Research has helped us simplify and improve the planning process. Contrary to what was done before, now our planning is from the bottom-up. We have a solid plan and other departments are copying aspects of our approach... such as bringing in community participation through the "village voice" tool. (5)*

2.2. Content of National Health Sector Policies and Programs

The interviewees gave numerous examples where TEHIP-generated or TEHIP-disseminated information contributed to rationalizing health care expenditures per capita and to choices related to the selection and implementation of health interventions.

2.2.1. The Possibility of Achieving Significant Health Impacts with Much Lower than Expected Expenditures Per Capita

- *TEHIP told us that it's not what you can give but what they can absorb at the district level. (1)*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

- *TEHIP has shown us that we can have health improvements with health expenditures of much less than $15 per capita.(1)*

- *TEHIP helped us by providing evidence, with the partners, to decide how much to allocate per capita. (1)*

- *TEHIP has shown the big increase you can make in health with a small per capita expenditure on health interventions. (2)*

2.2.2. Decisions Affecting the Selection of Health Interventions

TEHIP contributed to the process of changing the national malaria treatment policy from Chloroquine to Sulfadoxine Pyrimethamine (SP). The Rufiji household data on deaths of children who had already visited a health facility and been treated for malaria helped influence the decision.

- *TEHIP has provided evidence, information on costs and impact, that helps us sustain and justify IMCI. Tanzania has to put resources into the roll out. (3)*

- *Researchers are becoming more aware of what moves policy makers. (2)*

- *We used TEHIP information in calculating costs of malaria vs GNP to influence reduction in taxes on nets. (4)*

- *We used TEHIP research to decide when and where to start our bed net marketing (the highest zones and times of transmission) (4)*

- *We used TEHIP Mapping Malaria Risk in Africa (MARA) data to influence them (World Vision, ACT, Care International, Africare) to work in the areas where the need was greatest. (4)*

- *The TEHIP MARA tool helps identify and manage the malaria risk by painting an epidemiological picture of the distribution of malaria. We use it. We have mapped two districts and are mapping five more. (4)*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

3. TEHIP'S INFLUENCE ON DISTRICT HEALTH SERVICES

Working in Rufiji and Morogoro, TEHIP's focus was on using evidence in the planning and delivery of health services at the district level. Interviewees indicated that the program has had a profound effect on both the processes and content of district health services in its two districts. The approach demonstrated by TEHIP had gained high national visibility in the health sector and was seen by most interviewees as a model that needed extension in to other districts. Several interviewees expressed the view that the TEHIP approach would be useful and relevant in other sectors.

3.1. Planning and Implementation Processes

Researchers, donors and policy implementers commented on the dramatic improvements in district health planning and service delivery resulting from TEHIP's demonstration of information tools and management processes for resource allocation, planning and implementation of health services at the district level:

- *The district health plans for Rufiji and Morogoro were the best across the country. (2)*
- *Health review teams have reported big differences between the TEHIP and other districts. (3)*
- We learned very important lessons from the two TEHIP sites and the two adjacent comparators. How improved health administration (management, planning, resource use) can support clinical services and allow spending a little more time with patients. (3)
- *In the district, TEHIP changes are very obvious in infrastructure, equipment and availability of drugs. A major contribution is the cascade system of supervision over dispensaries - people welcomed it very much, there is much less waiting now for drugs. (3)*
- *The most important lesson from TEHIP is district capacity-building in: planning; prioritizing; supervising interventions and raising funds locally. These lessons can be applied to all districts.(4)*
- *TEHIP is showing importance of capacity building in speeding up and strengthening HSR. Not many other projects are doing this. Strengthened capacity in Morogoro and Rufiji will never go away. (4)*
- *Now the budget matrix tool is something we cannot do without. Other useful innovations are: Community rehabilitation of facilities; MARA; the Cascade health services*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

management system we are using for distribution of bed nets & tablets; returning of funds; conflict resolution; and dispatching workers to outbreaks. (5)

3.1.1. Creating and Maintaining Capacity Through Training

In addition, and often linked to describing the extent and value of the improvements in the planning and management of health services in Rufiji and Morogoro, respondents frequently commented on the importance of training in creating and maintaining the capacity to support the reforms in these districts and in dissemination to other districts.

- *We are now focusing on building the capacity to maintain the quality of health care, and the necessary structures and policies. TEHIP has been very important to us in this, as low capacity was one weakness identified in our HSR. (1)*

- *The Rufiji and Morogoro DMOs are resource persons for the MoH in training other DMOs. They have been called to help other districts that are decentralizing. (2)*

- *Training by the ZTCs is delivered to very heterogeneous DHMTs. Training content was focused mainly on planning and management and was influenced by local projects in various districts including GTZ project in Tanga and TEHIP in Morogoro & Rufiji. TEHIP was very active in early meetings planning the training modules. Now they have tools for district management and we are trying to integrate their model into the training…Some of TEHIP's concepts have been included in the June 2001 revisions to the training modules. (3)*

- *With the TEHIP research we saw the weaknesses in the district planning training modules and developed stronger content. In particular it provided input to modules on: use of BoD for budget allocation; financial management and accountability; mobilizing community ownership and participation. (3)*

- *The ZTCs need to look at the district health plans and help us with technical support and quality assurance. (4)*

3.2. Content and Priorities of Health Services

Introducing the BoD tool influenced the use of resources and the implementation of interventions at both the national and district levels. Interview data suggests that one factor in this success was TEHIP's ability to make financial support available. Respondents frequently expressed the view that TEHIP's contributions to the district health program budgets strengthened its influence on both the procedures and the content of district health service delivery. This, in turn, gave it credibility among national players.

- *The fact that TEHIP brought resources to districts that lacked them was showing this was*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

not a "blah blah" type of thing…It created confidence in the TEHIP people - both local and expatriate. (1)

- *The TEHIP funding to districts made a very big difference, enabled them to apply funding flexibly. IMCI and ITN would not have been possible without TEHIP. (2)*

- *The fact that TEHIP had money to invest in the health system at the district level gave it local influence and access far beyond what it would have otherwise had. (5)*

3.2.1. Resource allocation

- *TEHIP has influenced resource allocation and district health planning, for example use of BoD. Some of the Community Voice seems to have taken hold. (2)*

- *The BoD tool has helped resources flow to Malaria - helped identify it as a big problem - in CHMT planning. Before that the districts did not give much priority to malaria strategies. (4)*

- *AMMP and TEHIP experience with District Councils has helped us. We use most of TEHIP info to help us adjust our program (resource allocation according to BoD). We are now moving more into evidence-based approach in Dar, having started focusing first on service financing and management. Similar results data from TEHIP gave us confidence in our own data. (5)*

- *Support from TEHIP has empowered us to allocate funds according to problems we identify using the BoD criteria. (5)*

- *We decide how and where to allocate based on our own data HMIS, on community feedback and on info from RDSS. (5)*

3.2.2. Realistic Planning and Treatment Approaches

TEHIP's research component enabled Rufiji and Morogoro health services staff to make adjustments in the scale and quality of service delivery based on the feedback generated. In both districts, matching funding to absorptive capacity and targeting interventions based on evidence and cost-effectiveness enabled staff to plan more modestly (realistically) and deliver services more responsively to local conditions. They reported this as follows.

- *The first dramatic insight of the DHMTs was that they could not spend all their money. (4)*

- *Researchers told us we had planned too many activities and the next year we reduced our plans realistically. (5)*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

- *Feedback meetings with the researchers showed us how people think about malaria, about the facilities. This helped us find a way to influence their health seeking behavior. (5)*

- *Researchers told us some people did not attend our facilities because of the language of the health workers. We changed this and use and attendance went up. (5)*

4. TEHIP'S INFLUENCE ON THE NATIONAL RESEARCH SYSTEM

4.1. Recognition of the Value of Local and National Demographic Surveillance in the Health and Other Sectors

Just as TEHIP was seen as contributing to increased awareness of and capacity for the implementation of health sector reforms, TEHIP was also considered by informants to have demonstrated the value of national health research and how to make it more effective in improving health service delivery.

- *TEHIP and AMMP are converging in the MoH. TEHIP came along after AMMP and looked at the whole social setup related to Health Services. (1)*

- *A National Sentinel System (NSS), based on the TEHIP/AMMP experience will feed health data to the nation. (1)*

- *HSR has made the senior officials sensitive to the need for feedback; they could see the need for detailed, accurate data across the whole country. (2)*

- *MoH is much happier with NIMR now and TEHIP has helped by participating in fora and in developing thinking. (2)*

- *TEHIP could be usefully linked to the management of the Poverty Reduction Strategy Program. Demographic surveillance could be used to develop an evidence-based approach for poverty-reduction intervention and monitoring. (2)*

- *Together, both TEHIP and AMMP have influenced MoH to set up an NSS. (3)*

- *There is lots of research in Tanzania, but not all of it is being used. NIMR research is only recently is being used…doing more operational research, maybe due to TEHIP influence. (3)*

4.1.1. Coordinating Roles and Responsibilities in Generating Health-related Evidence

In a variety of ways, many interviewees expressed the view that the collection, analysis and use

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

of health surveillance information in Tanzania is not centrally coordinated nor fully rationalized. TEHIP's generation and use of such information brought this into sharper focus as a problem. Donor interviewees frequently raised this issue and four examples of donor comments are included below. Interviewees, in expressing concern for this, often suggested ways the various players could better coordinate and cooperate.

- *Research is not guided by MoH demands. It often depends on the interests of the researchers. Therefore sometimes their research is not useful. We need more funding along with some direction should be given to researchers (1)*

- *At national level, we intend to aggregate data on specific diseases. The BoD tool is very powerful for planning and monitoring and we hope to expand its use. The adoption of new tools happens slowly in the MoH. (2)*

- *Having a NSS could be a very important resource for many sectors of development. (2)*

- *Now we are collecting both AMMP and health management information. The latter we analyze locally but the NSS data is analyzed in Dar. We would like to have it analyzed here so we can get feedback earlier. (3)*

- *There are four or five major HMIS all asking for data collection from the same local persons. (3)*

- *TEHIP is a valuable contribution to national policy but the national health information system is in a shambles and the donor community does not know what to do about it. (3)*

- *Demographic surveillance takes time and needs to be done in conjunction with other information collections. (3)*

- *Data from AMMP in Morogoro and RDSS in Rufiji are in conflict (use different methods to collect and analyze) and need to be standardized. We need one system so it can apply to the whole region. (4)*

- *The current situation is that the Rufiji site and all the DSS sites in the country use the AMMP Verbal autopsy method… Also the AMMP sites now use the TEHIP Burden of Disease tool to communicate their results to their districts. The tool was designed to be robust enough to accommodate AMMP and other methods . (5)*

- *The future of the Rufiji DSS is more clear as it will be handed over to the Ifakara Centre as part of the TEHIP legacy. (5)*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

4.2. Creation and Demonstration of the Use of Tools for the National Research System

Tools demonstrated by TEHIP were mentioned frequently by researchers and donors as important to the national health research system.

- *We want to use the BoD model and the methodological aspects of GIS in Ifakara's research. (2)*

- *TEHIP is good at sharing tools. They explain and hand out at our meetings. The GIS-based approach for data entry in HMIS (clicking on icons). (3)*

- *We will be using BoD information from TEHIP and AMMP to implement interventions in nine more districts. (3)*

4.3. Generation of Information and Linking it to Policy Processes

Researchers cited ways that TEHIP influenced the connection between the health research and policy-making processes in Tanzania. There were two parts to this influence: contributing research information to specific policy changes; and, through this and a variety of other contributions, sensitizing and involving research users and policy-makers in the research process.

- *TEHIP contributed to the process of changing national malaria treatment policy from Chloroquine to SP. (2)*

- *The Rufiji household data on deaths of children who had already visited a health facility and been treated for malaria helped influence the decision. Researchers are becoming more knowledgeable about what moves policy-makers. (2)*

- *MoH is adapting the Health Accounts tool of TEHIP for application at the national level. (2)*

- *Research institutions need to develop departments that can put research into language that can speak to each category of player. The commercial world has been able to reach its audiences - but not scientists, and they need to. (2)*

- *We have so many problems and we need somewhere to pose the research questions to the researchers and the MoH and learn how to tackle them. The Health Research User Trust Fund coordinated by NIMR is a small step in this direction (has been calling for, and funding, research proposals for 4yrs). (2)*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

- *Policy-makers are not thinking of research. Evidence-based decision-making is something new to them. In developing countries, researchers are closer to and more aware of the problems, research topics and entry points (though not always). We have to sensitize policy makers to these things sufficiently. (2)*

- *The MoH has to change its attitude about research. We (researchers) have to develop our skills to communicate with and influence them. (2)*

- *There is a need to cultivate policy use of research. Policy- makers need to make demands and ask questions for which answers can be found through research. And on the research side, we need to think of building the policy-makers capacities. (2)*

A related comment from a donor called for better standards for data collection to enhance its use at the district level.

- *We need to have better data on what the public health services are really achieving. There is too little data on performance. Consistency is lacking. Household surveys report double the treatment the HMIS is reporting as delivered. As part of the local government reform process, HMIS needs to be balanced and centrally standardized but for use at the district council level. (3)*

5. LESSONS AND OPPORTUNITIES ARISING FROM TEHIP EXPERIENCE

5.1. Clarifying and Coordinating the Roles and Relationships of the Major National Providers of Health-based Evidence

Researchers expressed concern over what they saw as a lack of action and the need to clarify and coordinate the work of those contributing to the generation and analysis of national health information. Without rationalizing the roles and relationships among the various players and without establishing well-defined links to health sector policies, they felt that inefficiencies would continue along with falling short of realizing the potential value of evidence coming from their research. Interviewees expressed a wide range of views on how to remedy the situation and there was a strong consensus that confusion persists and needs resolution. Assertive leadership by the Ministry of Health was seen as an urgently needed key step towards solving the problems of role clarity and organizational linkage and coordination.

- *There is no common house to gather, synthesize and distribute health research information. MoH's Health Systems Research Unit is weak…it does research and training whereas it should be doing health systems analysis. NIMR now has a health systems and policy analysis unit whose mandate is (or will be) to identify where further*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

research is needed and get accurate research information to researchers, policy-makers, program implementers and the public through the mass media. (2)

- *When MoH moves to create the NSS, all surveillance sites will be coordinated under one umbrella. This will be challenging and complex as the two main elements AMMP and RDSS started with different missions and mandates under different donors, and have developed different approaches. (2)*

- *There is no gold standard for data. RDSS is very different from AMMP and it is up to the MoH to bring the two together (2)*

- *In future, RDSS will be part of NSS. TEHIP needs to participate in workshops with AMMP to jointly improve the verbal autopsy tool. (2)*

- *We need more cooperation across the NSS projects, so the different sites, AMMP, TEHIP can start cooperating to aggregate across regions. (2)*

- *TEHIP could be a nucleus for informing the country on how to link researchers and health systems. (2)*

- *TEHIP could be a moving laboratory for the Policy and Health Systems Analysis Unit. (The MoH Policy and Planning Directorate is overseeing this unit. IDRC might be able to provide support with capacity building and technical support). (2)*

- *The annual reviews are driving the HSR but there are too few players represented in the annual reviews and we do not draw on some of the most relevant information such as from NSS. An evidence-based institute could make a big contribution by pulling such information together. Ifakara is thinking of starting a small clearinghouse like this for health science info. We have a proposal in to SDC for this. (2)*

Policy-makers and donors, reflecting on the issue of a coordinated research system effectively connected to policy formulation and program implementation speculated on the kinds of scenarios under which this could be achieved.

- *If TEHIP was brought closer to the MoH, it would have more influence (i.e. could correct what is wrong in the MoH District Planning Guidelines). It needs to become part of the HSRS. I would start TEHIP the same way - but <u>now</u> it should be under the HSRS. TEHIP has to break away from IDRC and be firmly embedded in the HSRS. Don't perpetuate parallel structures! Now the HSRS would be enriched by TEHIP's experience. (1)*

- *TEHIP is a rare example of the coexistence of research and intervention. This kind of operational relationship needs to continue to inform development in Tanzania. One*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

possibility for connecting policy and research would be an institution which would synthesize and summarize research results and recommend which tools to roll-out. It would need to give research information a sense of direction and ownership, with the neutrality to make it acceptable and easier to adopt. (3)

- *This new thing, operational research, is a baby. We need help to link research to policies. We have no expertise in policy analysis in the country. Many people are trying, TEHIP is not the only one, but it is very good in dissemination. Influencing people with research is important but we should not go with just one institution. We should have several systems to use. It would be too rigid to have one body. Let's have multiple fora. Let's get away from developing a structure for every problem. We need multiple visions and audiences and linkages. (3)*

5.1.1. The Need to Reconcile Conflicting Approaches to Demographic Surveillance

The following comments illustrate that much of the above confusion, as seen by policy makers, donors and policy implementers, centers around the differing and apparently conflicting approaches to demographic surveillance being taken at the Rufiji site, supported by TEHIP, and at the Morogoro site, supported by AMMP.

- *Most clear, strong research input to policy-making process has been AMMP. TEHIP is only a pilot project with a research component. (1)*

- *TEHIP and AMMP are converging in the MoH. TEHIP came along after AMMP and looked at the whole social setup related to Health Services (1)*

- *Both TEHIP and AMMP are important generators of information for policy. (3)*

- *Both AMMP and TEHIP need to pull together to make NSS happen properly. There is a need to standardize the two methodologies - if not, this could damage the (future) NSS. (3)*

- *One approach could have been to divide the field: AMMP doing surveillance and TEHIP doing capacity building. (3)*

- *NIMR, AMMP & TEHIP have mutually compatible roles and benefits. (3)*

- *Over the years friction between AMMP and TEHIP at the project staff level has yielded very annoying arguments about the tools and approaches - without sitting down and looking for consensus solutions. The MoH should have taken charge, but refused to mediate. (3)*

- *Data from AMMP in Morogoro and RDSS in Rufiji are in conflict (they use different*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

methods to collect and analyze) and need to be standardized. We need one system so we can apply it to all regions. (4)

- *We need to look at all the tools developed (with Mwanza, UNICEF, AMMP, Ifakara, and TEHIP) and assess practicality and feasibility, and then coordinate curriculum development based on the selection. (4)*

- *TEHIP and AMMP experiences are building a NSS. They are similar in some ways, but very different. (5)*

5.1.2. The Need to Involve the Regions in Health Systems Support

Researchers, donors and national policy implementers expressed the view that, up until now, a role for the regional level of administration had not been adequately defined and implemented within the reformed health sector. TEHIP, with its focus on districts, did not address this directly. However, the "systems thinking" underlying its approach raised this issue in the minds of interviewees as illustrated by the following comments.

- *HSR is a mainstay of local gov't reform. Tanzania is committed to devolution of health services but has not defined a role for the regional level of government. (3)*

- *We still have gaps & confusion at the national level. How to bring the regional level into the system has not yet been addressed… Under the present arrangement the [funding] "basket" goes from the national level right down to the district level. (2)*

- *At first we were bypassing the regions in the HSR. We then realized we needed to train the Regional Health Management Teams too! To enable them to monitor the quality of health services, they needed technical training so they could set and enforce standards and supervise the district teams. (3)*

- *Regional secretariats could play a role in quality assurance of district plans. (3)*

- *Roles of the regional bodies and ZTCs have to be worked out. (4)*

5.2. Extending the TEHIP Approach Across Tanzania

Taken together, the interviews suggest that TEHIP has had extensive influence on many aspects of national health policy formulation and content as well as on the capacity, thinking and practice of those managing Tanzania's district level health systems. The interviewees' comments also provide evidence that the wide range of players involved with the HSR know and value highly the concepts, tools and learning models provided by the TEHIP experiment. Interviews also explored what, in the view of interviewees, needs to happen next based on their knowledge and/or experience with TEHIP. The responses can be summed up in the words, "extend", "scale-

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

up" or "roll-out". Respondents were all enthusiastically positive about possibilities they saw for applying and extending the experience coming out of TEHIP. Many expressed this in terms of their own intentions or those of others they were familiar with. Here are some examples.

- *TEHIP's BoD tool is now available for other districts to guide allocation of resources. (1)*

- *TEHIP module helps us assess district plans. The HSRS brought it forward, because it was a tool for a holistic approach. In July 2002, the Minister's budget speech to parliament referred to the TEHIP results as a factor enabling the formulation of basket funding guidelines. (1)*

- *TEHIP tools will help DHMTs to determine their programs through evidence-based planning using BoD and to mobilize local resources . (1)*

- *We are asking partners, including Canada, for help in scaling up the benefits of TEHIP's work. (1)*

- *The DMOs in Rufiji and Morogoro are acting as resource persons for the MoH in training other DMOs. They have been called to other districts that are decentralizing. (2)*

- *We are figuring out how to roll-out TEHIP tools to other districts. The human resource base will help us move forward. We need to retain a core of resource and supervisory personnel at NIMR. (3)*

- *We will be using BoD information from TEHIP and AMMP to implement interventions in nine more districts. (3)*

- *The Joint Review of HSR wants to scale-up TEHIP because it's obvious the interventions are working. (3)*

- *TEHIP has documented introduction of IMCI, we need to share this with other districts. (4)*

- *TEHIP needs to get out of the laboratory and share with other districts. (4)*

- *It is important to roll-out the tools during the reform period to take advantage of resources available for data collection. This is an opportune time because we need data at the local level. If you wait, resources may not be available. (4)*

- *This district has influenced the MoH very much. The Ministry is now very anxious to get other districts to use this budget matrix and other tools. This year's plan for Morogoro*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

is being promoted by the ZTCs as an example to other districts.(5)

- *When we share what we are doing with other districts at the regional meetings, they are envious. For example, Bagamoyo is now putting in a radio communication system similar to ours and they are using our RDSS data. (5)*

5.3. Roll-out Concerns

In equal measure to their desire to see the benefits of applying the TEHIP approach on a wider scale, interviewees identified concerns regarding the challenges a successful extension would have to overcome.

- *TEHIP has tried its best to be part of the national health picture and has worked with the district officials. It could now do more to influence other districts - not just in Morogoro, Rufiji and the central MoH. (1)*

- *TEHIP has worked with the Morogoro and Rufiji ZTCs on training components and USAID is funding two strong training centres. But it's not replicating across the country. GTZ has well-funded initiatives, and also has roll-out intentions. What we need now is a coordinated roll-out of existing, proven initiatives. (2)*

- *It is very difficult to estimate the costs of IMCI at the district level for trainers, materials and logistics, but more needs to be done to fully operationalize it. TEHIP's planning and budgeting tool is helpful but is not enough. (2)*

- *The TEHIP philosophy, approach and skills need to carry on. Most of the impact is at the local scene. We are still waiting for the upper echelons to embrace it fully. Getting this to happen is our duty now. Some senior officials know the TEHIP results (i.e. IMCI Program Manager, Director of Preventative Services), but I hesitate to say that senior officials are thinking like the TEHIP concepts in a systematic way. (3)*

- *The TEHIP approach is very good but you need more time to make it work - double the time you think. (5)*

5.3.1. Roll-out Concerns Related to Financial Resources

In addition to general concerns, many interviewees commented on the resource challenges and implications of applying the TEHIP approach more widely in the country.

- *With the extension of TEHIP we have one year to develop a proposal on how to roll TEHIP tools out to all districts. We need to abstract a useable version of Morogoro and Rufiji that fits the resources we have. (2)*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

- *TEHIP has had a good approach covering planning, local governance and households. The challenge now is how can we use this resource strategically to apply the lessons for putting the results into action. (2)*

- *Latest TEHIP data shows that IMCI addresses a huge part of the BoD in the district. In general, awareness of BoD is high, but action and budgeting are not following. (3)*

- *To roll-out we need to simplify, reduce costs and then follow up with districts and see where they may need further support. Find out what version of TEHIP is feasible under 'normal' circumstances across the country. (4)*

- *IDRC may have underestimated the training and advocacy required to institutionalize the TEHIP tools. MoH rhetoric is there but the resource commitment is not. (5)*

- *We are still working on the community voice. It is not easy. We need to expand it from our two pilot villages to others. We need more resources to work more on it. (5)*

Several of the comments on resources focused specifically on international donor agencies and the basket approach to health sector funding in Tanzania. A frequently expressed concern related to the criteria governing which items can qualify for "basket funding".

- *Donors have to be satisfied with good evaluations showing achievements of the "basket" as a whole, and with not being able to claim credit for results specifically attributable to them. (1)*

- *The "basket funding" has not functioned very well. The guidelines are very cumbersome and are not results-oriented. (2)*

- *The guidelines are too restrictive. Restrictions on equipment mean that dollars go to workshops and not to service delivery. (4)*

- *When the TEHIP project ends, the basket funds will not be able to cover what TEHIP has been doing (i.e. we can afford four to six dispensaries with TEHIP; but only two without it). The basket puts unhelpful constraints and conditions on funds. (4)*

5.3.2. Roll-out Concerns Related to Technical and Managerial Capacity

The fact that TEHIP had integrated capacity-building into its approach made all categories of interviewees highly aware of the integral role capacity-building needs to play in expanding decentralized evidence-based health care planning and delivery. **The Final Report of the Tanzania Joint Health Review, 22 March 2002** clearly reflects this awareness.

> *"The management capacity of the health department in the Local Authority is relatively weak, particularly when not supported by health management*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

projects. Geographical expansion of existing projects would cover more districts and provide much-needed support during this transition phase implementing health sector reforms." (pg.5)

" ...Successful management strengthening projects like TEHIP should extend their expertise to other regions." (pg.7)

Here are examples of interviewee comments regarding the need to build technical and managerial capacity as part of, and as support to, any roll-out.

- *Challenge is how to put what is in TEHIP into the ZTCs so they can be institutionalized in the other districts. (1)*

- *The challenge now is to build the local capacity to take up the tools in the other 120 districts. Building the capacity of the CHMTs: If you can do it in Rufiji, you can do it anywhere! (1)*

- *We are still reviewing plans manually but the tools from the TEHIP program could speed things up. (1)*

- *Building capacity will take some time. IDRC leaving suddenly has considerable risk of undermining gains - need a slow withdrawal to phase out. (1)*

- *We still need the involvement of IDRC to take us to a full roll-out. (1)*

- *Can the TEHIP tools do the same job outside of the experimental sites? Capacity is a crucial factor.(3)*

- *We are figuring out how to roll-out TEHIP tools to other districts. The human resource base will help us move forward. We need to retain a core of resource and supervisory personnel at NIMR. (3)*

- *Latest TEHIP data shows that IMCI addresses a huge part of the BoD in the district. In general awareness of BoD is high, but action and budgeting are not following. It is difficult for the MoH to exclude certain things. (3)*

- *Management capacity at the district level is an important area that TEHIP has attended to. (3)*

- *MoH is very receptive to good evidence and open to influences. It doesn't have the capacity to do its own research, whereas Ifikara's research is well recognized. (3)*

- *The big cost with IMCI is the initial training. Once the system is in place and people are*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

trained, it doesn't cost much. (3)

- *When TEHIP dissolves we will lose database and data management… both key resources. (4)*

- *Planning on the basis of BoD was readily accepted, but the capacity and practice was not there to do it. (4)*

- *Training for wider adoption of TEHIP tools will not exist after TEHIP closes. For example, the level of information technology literacy necessary for the financial tool is very low in many districts… it is not sufficient to a full roll-out. (4)*

- *Getting the human resources in place, trained and employed, is a central challenge of the HSR. If there is no capacity, the plans for expansion will have to be scaled down. (4)*

- *Here in Rufiji we have needs for better immunization coverage (improved cold chain), more training for new staff, some scarce drugs, infrastructure and improved HMIS info to supplement the RDSS info. (5)*

- *IDRC may have underestimated the training and advocacy required to institutionalize the TEHIP tools. MoH rhetoric is there but the resource commitment is not. (5)*

- *For the cascade supervision system our district workers are not fully formed, we are still working on it and can complete it without TEHIP. We now need no help from TEHIP for facilitating the CHMTs and IMCI training. For STDs our training is now internal and we only periodically need outside technical input. For RDSS we are not yet self reliant for training. (5)*

5.4. Transition from Experiment to a National System

While the interviews indicate that TEHIP was perceived as having done excellent and influential work, there was also considerable concern over what would happen next to build on this success. To overcome the concerns identified in the foregoing sections, many interviewees saw the need for more pilot work to build a broader base for providing technical support and to demonstrate how to make the changes given the extent of the constraints and limitations. Overall, interviewees were of the opinion that adequate information had not been developed to answer many important questions pertaining to the feasible and effective extension of the TEHIP tools to full national coverage. Although we did not ask the question specifically, most interviewees spontaneously saw a desirable role for TEHIP, along with other important national institutions, in taking Tanzania to the point of being ready for a full roll-out. As evident in the examples below, donors were particularly prolific in expressing concerns and making suggestions about roles for "TEHIP" in the post-TEHIP era. In addition, their comments also included a few suggestions for addressing specific issues that were perceived as important.

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

- *TEHIP should be in a position to advise how to extend this elsewhere - not drop out of the picture completely. (1)*

- *TEHIP has influenced MoH thinking on health services funding and planning but has not been adequately applied - it should have automatically been integrated as a part of the wider system.(2)*

- *I have heard that TEHIP has been very good from a classical pilot project perspective but are the results replicable without all the special attention? (3)*

- *The TEHIP elements to replicate are capacity-building in administration, planning and management. The problem is actually using the plan. TEHIP has apparently solved the problem of reconciling plan and budget, but I am skeptical about rolling this out in 9 districts. It needs a further pilot without all the extra support. (3)*

- *There are things that TEHIP is not doing. For example we need to look at changes in organizations and systems as a technical issue. (3)*

- *TEHIP has worked with the Morogoro and Rufiji ZTCs on training components, USAID is funding two strong training centres. But it's not replicating across the country. GTZ has well-funded initiatives, and also has roll-out intentions. What we need now is coordinated selection and roll-out of existing, proven initiatives. (3)*

- *TEHIP and the MoH need to sit down and decide how to expand. (3)*

- *The challenge is how to go from district project to national level system… As soon as technical support to the district stops, you have to give up on quality. (3)*

- *Expanding to the national scale, there is not the technical support that was available for the two TEHIP districts. What is the minimum package of technical support necessary for all districts? And, given that feedback capacity at the district level is very weak, how will the quality of services be monitored? (3)*

- *Replication of TEHIP tools on a national basis is possible and would be practical, useful and effective. However, TEHIP hand-holding cannot be rolled out nationally… technically, it is too labor intensive. (3)*

- *TEHIP has not done its job yet. It needs to show us how to scale up at a reasonable cost. (3)*

- *TEHIP tried a new intervention package and made sure it was exposed at all levels. But I am worried about whether it will carry on. We may need a handover development*

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

phase. (3)

- *I see TEHIP having an input into health care in this country. I would be very proud; you have done your job. But what if, after June, nothing more happens? How to perpetuate and roll this out to have it multiplied in other districts? This thing must be sustained. (3)*

Clearly, the tools and approaches developed through the TEHIP project are considered valuable resources for researchers, policy-makers, health officials and practitioners in Tanzania. The use of evidence to guide health care interventions and to make policies and practices more effective and efficient has been documented and analyzed. Improvements in people's health and the health services available to them, as seen in Morogoro and Rufiji, could be extended across the country. Exactly how to do this has not been fully established by TEHIP, but an excellent start at introducing changes across the national system has been initiated, the direction mapped and the first steps taken. Influencing the nature and extent of involvement of health workers, communities, researchers, training institutions and ministries and donor agencies will require strategies beyond the scale of those demonstrated in this project. From the feedback offered in this report, two basic conditions are seen by health system actors as essential but lacking. To implement evidence-based health care interventions on a national scale, there needs to be strong leadership and comprehensive follow through from the Ministry of Health, along with sustained, practical financial support. Many informants, familiar with the substantial national and international appreciation of what this project has demonstrated, expressed puzzlement at the lack of initiative on the part of the Ministry of Health and on the part of international donor agencies to implement TEHIP's very effective interventions on a national scale.

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

ANNEX A - Interviewee List

	Respondent Category
(1) Dr A Mzige Director, Preventive Services Ministry of Health PO Box 9083 Dar es Salaam Cell: 0741 410 531	1
(2) Ms M Mwaffisi Permanent Secretary Ministry of Health PO Box 9083 Dar es Salaam	1
(3) Dr A Hingora Health Sector Reform Secretariat Ministry of Health PO Box 9083 Dar es Salaam Tel: 0744 222 261 Email: ahingora@moh.go.tz	1
(4) Mr E Manumbu Director, Policy and Planning Ministry of Health PO Box 9083 Dar es Salaam Email: emanumbu@moh.go.tz	1
(5) Dr G Upunda Chief Medical Officer Ministry of Health PO Box 9083 Dar es Salaam Tel: 0744 222 268 Email: glupunda@moh.go.tz	1

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(6) Dr SK Pemba Ag Director, Human Resources Development Ministry of Health PO Box 9083 Dar es Salaam Email: spemba@moh.go.tz	1
(8) Dr Mohammed Amri Disease Prevention and Control Officer World Health Organization (WHO) Luthuli Road PO Box 9292 Dar es Salaam Email: amri@who.or.tz	3
(9) Dr M Meshak UCLAS PO Box 35176 Dar es Salaam Cell: 0741 240 261	4
(10) Dr A Kitua National Medical Research Institute (NIMR) PO Box 9653 Dar es Salaam Email: nimr@costech.gn.org	2
(11) Mr F Shleimann Regional Technical Advisory (Health) Danish Embassy Ghana Avenue PO Box 9171 Dar es Salaam Tel: 2113887 / 0744 784424 Email: finn.s@inet.uni2.dk	3

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(12) Dr A Kimambo Tanzania Public Health Association (TPHA) PO Box 7785 Dar es Salaam Tel: 2131441 Email: tpha@muchas.ac.tz	4
(13) Dr WC Mwambazi Country Representative World Health Organization (WHO) Luthuli Road PO Box 9292 Dar es Salaam Tel: 2113005 / 2111718 Email: mwambazi@who.or.tz	3
(14) Dr J Miller ITN Director PSI – Tanzania TEXCO Building 4th Floor, Pamba Road PO Box 33500 Dar es Salaam Tel: 2117879 / 2117372 / 2116312 Email: jemiller@twiga.com	4
(15) Dr A Mwakilasa Head, Continuing Education Programs Ministry of Health PO Box 9083 Dar es Salaam Tel: 2137496 Email: amwakilasa@moh.go.tz	4

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(16) Mr M Mapunda Coordinator, Health Sector Basket Funding Ministry of Health PO Box 9083 Dar es Salaam Tel: 0741 326 378 Email: mmapunda@moh.go.tz	1
(17) Ms L Loughran Health Officer USAID Dar es Salaam Tel: 217537	3
(18) Dr R Poutiainen Head, Health Unit UNICEF PO Box 4076 Dar es Salaam Tel: 2150811 / 15 Email: skimata@unicef.org	3
(19) Ms S. Sijaona Permanent Secretary Ministry of Land and Human Settlement Development PO Box 9132 Dar es Salaam Tel: 2113165 Fax: 2124576	1
(20) Dr I Semali Institute of Public Health Muhimbili University College of Health Sciences (MUCHS) University of Dar es Salaam	2

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(21) Dr. El Malangalila World Bank PO Box 2054 Dar es Salaam Tel: 2114575 Email: emalangalila@worldbank.org	3
(22) Dr D Mtasiwa City/Regional Medical Officer of Health City Commission P.O. Box 63320 Dar es Salaam Tel: 2112535	5
(23) Dr. A Chiduo Former Minister of Health P.O. Box 34224 Dar es Salaam Tel: 2630637 Mobile: 0748 668 668	1
(24) Dr P Kamuzora IDS Dar es Salaam	2
(25) Dr A Mwita National Malaria Control Programme P.O. Box 9083 Dar es Salaam Tel: 0741 339 713 Email: nmcp@twiga.com	4

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(26) Dr R. Mandike National Malaria Control Programme P.O. Box 9083 Dar es Salaam Tel: 0744 295 323 Email:nmcp@twiga.com	4
(27) Dr A Unwin Ministry of Health/National Malaria Control Programme P.O. Box 9083 Dar es Salaam Email: nmcp@twiga.com	4
(28) Dr. Y Ipuge Head, Diagnostic Services; Coordinator, Hospital Reforms; National Coordinator, PMTCT Ministry Of Health PO Box 9083 Dar es Salaam Tel: 0748 264 219	1
(29) Mr Paul Smithson Head, Health DFID (British High Commission) P.O. Box 9200 Dar es Salaam	3
(30) Dr C Kibassa National IMCI Coordinator Family Planning Unit Ministry of Health PO Box 9083 Dar es Salaam Tel: 2152976/7/8 Mobile: 0744 270 741	4

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(31) Mr Fissoo District Executive Director (DED) Utete, Rufiji District	1
(32) Dr Mkikma District Medical Officer (DMO) Utete, Rufiji District	5
(33) Dr E Mwageni TEHIP Field Station Manager, RDSS Ikwiriri, Rufiji District	2
(34) Dr I Mwinge Medical Officer, I/C Hospital Council Health Management Team (CHMT) Utete, Rufiji District	5
(35) W Mapuga District AIDS Control Coordinator Council Health Management Team (CHMT) Utete, Rufiji District	5
(36) IM Mtitu ITNS Coordinator Council Health Management Team (CHMT) Utete, Rufiji District	5

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(37) Dr D de Savigny Research Manager TEHIP Luthuli Road PO Box 78487 Dar es Salaam Tel: 2130627	2
(38) Dr G Reid Project Manager TEHIP Luthuli Road PO Box 78487 Dar es Salaam Tel: 2130627	5
(39) Dr Ndawi Director PHC Institute - Zonal Training Centre (Iringa)	4
(40) Dr Machibiya District Medical Officer (DMO) Morogoro (Rural) Morogoro	5
(41) Dr H Kitange Coordinator – NSS Morogoro (Rural) Morogoro	2

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(42) Dr P Kilima Regional Coordinator, Anglophone Africa International Trachoma Initiative (ITI) 7th Floor, NSSF Building Morogoro Road PO Box 78834 Dar es Salaam Email: kilima@trachoma.or.tz	1
(43) Ms J Mahon Health Advisor SDC 79 Kinondoni Road PO Box 23371 Dar es Salaam Tel: 2666220 Email: jacqueline.mahon@sdc.net	3
(44) Mr A Buluba Senior Program Officer (Health) SDC 79 Kinondoni Road PO Box 23371 Dar es Salaam Tel: 2666220 Email: arnold.buluba@sdc.net	3
(45) Dr Y Hemed AMMP Tel: 2153388	2
(46) Mr A Kabgire Program Manager Local Government Reform Program 120 Kilmani Road (Kinonodoni) PO Box 105081 Dar es Salaam Tel: 2666524 Email: Igrp@raha.com	4

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.

(47) Dr S Ndeki Principal Centre for Educational Development in Health – CEDHA (Arusha) PO Box 1162 Arusha Tel: 0741 510919 Email: CEDHATZ@habari.com.tz	4
(48) Dr Z Premji Muhimbili University College of Health Sciences (MUCHS) PO Box 9372 Dar es Salaam Tel: 2153419	2
(49) Dr F Njau Head, Health Sector Reform Secretariat Ministry of Health PO Box 9083 Dar es Salaam Tel: 2120624	4
(50) Ms D Timmermans First Secretary Health, HIV/AIDS, Water and Sanitation Royal Netherlands Embassy Dar es Salaam Email: dia.timmermans@minbuza.nl	3
(51) Dr H Mshinda Ifakara Research Centre Morogoro District	2
(52) Conrad Mbuya TEHIP	2

Key to Respondent Categories:
1) Policy and decision-makers; 2) Researchers; 3) Donors; Policy implementers – 4) national, 5) local.