Chapter 2  Development and Outcomes of the Project

The process of activities in MHP can be perceived as several stages of development, as illustrated in Figure 2-1.

![Figure 2-1 Project Implementation Flow](image)

Source: MHP (2006)

First, the period from 2000 to 2001 before the start of the project can be taken up as the “project formulation period.” In this period, the point of view on how the project should be formulated amidst the political and financial backdrop outlined in the previous chapter was adjusted.

Next, the stage from April 2001 to October 2003 after the initiation of the project was brought together as the “first half of the project.” For this, an analysis was conducted on the preparatory period and the introduction period in particular. This first half period corresponds to the period in which substantial project activities such as basic management training were initiated. These activities include the establishment of offices, the formulation of a project action plan, and the creation through trial and error of ver. 1.0 through ver. 3.0 of the Project Design Matrix (PDM), which is a tool for project management, and basic management training.

In October 2003, a project mid-term evaluation survey was conducted, and from this point on analysis of the “second half of the project” was carried out. This mid-term evaluation survey represented a major transitional point for the project. That is to say that upon receiving the evaluation results, the project experts and CPs worked together to review the activity contents, with the structure of the Japanese experts being reconstructed as well. In addition, activities were worked out one after another for sustainable development such as the formation of WGs. As these demonstrate, the achievement of outcomes for the project was keenly examined and it was conducted by means of strategic activities, which is considered to have enormous significance in leading to the success of the project.
Finally, the one year period from April 2006 to March 2007 is considered as the “project extension period.” This was a period of systematization designed to disseminate and expand the project’s outcomes and lessons to the whole of Tanzania as a management model. A variety of specialized activities were designed for the sake of this dissemination and expansion, and the contribution of activity fees from local government authorities gradually grew larger. As such, dissemination activities were carried out on the basis of the independence of the Tanzanian side in a personal, financial, and operational sense.

After such transitions and alterations the project was completed on March 31, 2007. As of April 2007, a request was submitted to JICA by the Tanzanian Government for the nationwide expansion (which would target all 21 regions) of the Regional Health Administration Capacity Building Project, a technical cooperation project utilizing the lessons of Morogoro. Ahead of this request for a new project, the Tanzanian MOHSW has already initiated activities to formulate the Health Sector Capacity Development Program along with its development partners. This project has been manifesting outcomes worthy of mention in a manner exceeding expectations with regard to sustainable development.

This chapter sets out the project activities and other aspects according to the time segments described above from project formulation through to the end of the extension period. While doing so, it also reveals the manner in which the CD of the partner country was realized through a process of trial and error at these different points in time.

2-1 Project Formulation Period: Project Formulation Based on the Counterpart’s Self-reliance (August 1999 - March 2001)

MHP was formulated as a request for technical support based on the clear consciousness of the problems and ownership on the part of the Tanzanian side in the light of the progress of the two reforms of the HSR and LGRP. This is in keeping with the basic spirit of Japan’s Official Development Assistance (ODA), which is to support the endogenous self-help efforts of developing countries. At the same time, it is also an important point of departure for CD projects in terms of supporting the endogenous growth of developing countries.

2-1-1 Project Formulation Led by the Tanzanian Side

Aid coordination regarding development assistance has been vigorously debated in Tanzania, which was the third country worldwide to formulate a PRSP. As of 1999 it was already promoting the policies of the HSR, and had been looking for various development partners to provide support within a framework primarily led by Tanzania itself.

During the formulation period for this project, the Chief Medical Officer (CMO) played an important role in taking up the leadership of the HSR. The formulation of the project involved close and frequent information-sharing and consultations between the CMO and the policy advisor assigned to the MOHSW as a JICA long-term expert at the time. The CMO was a specialist in the health sector, having had experience serving as the Dodoma Regional Medical Officer (RMO). As such, he was fully aware of the problems of the weak management capacity of the local governments as a major impediment to effective service delivery. This was extremely important for the formulation of the project. In fact, from the formulation stage the CMO requested that the Japanese side, “Refrain from carrying out a project whereby Japanese experts merely bring something in with them, and that ends as soon as they leave.”

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1 From the interview with Hashimoto, the expert who acted as the former policy advisor of the MOHSW.
2 Same as above.
In terms of the Japanese experts that were to be appointed, the CMO stated, “I do not want them to just lend a hand to the health services, but rather to inform us how the region and the districts can continue to carry out their activities and services. I would like them to act as a ‘catalyst.’” As such, it was readily apparent that the CMO’s expectations for the project were for “self-reliant development by the Tanzanian side.”

What is more, the RMO for Morogoro Region said, “The objective should be defined as capacity building for those concerned with regional and district health through routine on-the-job Training (OJT), rather than classroom-style training via lectures. To begin with, an analysis of the present state will be necessary during the initial stages of the project in order to determine challenges and problems.”

In looking back to the time of the project’s formulation, those in charge at JICA Headquarters were keenly aware of how strong the Tanzanian side’s self-reliance regarding the project was from the preparatory study stage. Reviews of the project activity contents were promoted through the initiative of the MOHSW. The fact of the matter was that there was a strong conviction that the project would truly be able to make a profound contribution to the realization of health sector reforms.

2-1-2 Project Outline

Regarding the project site, several regions (Tanga, Pwani, Lindi, and Mtwara) were proposed as candidates at the time of the survey on project needs. But at the close of consultations with the concerned parties, the end result was that the Morogoro Region, situated 200 kilometers west of Dar es Salaam, and six districts within the region were selected as model districts in the interest of model formulation.

With the goal of improving the operational and management capacity of the RHMT and CHMTs, the project established three points as outcomes. These points were: (1) improving the health management information system; (2) sharing of experiences and information by the health managers in the region and districts; and (3) improving the planning, implementation, monitoring, and evaluation capacity for regional and district health managers (refer to Appendix 5-1 on PDM ver. 4.0 for details regarding the project outline).

The project implementation period, implementation parent organizations, implementation structure, and project formulation are as indicated below.

<table>
<thead>
<tr>
<th>Implementation period</th>
<th>April 1, 2001 - March 31, 2007 (six years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation parent organizations</td>
<td>MOHSW, Morogoro Regional Government, JICA</td>
</tr>
</tbody>
</table>
| Implementation structure | - 5 long-term Japanese experts (chief advisor, health information management, health administration management, health administration planning, activities coordinator)  
- 63 CPs (Morogoro Regional RHMT and six district CHMTs within Morogoro Region: Morogoro Municipal, Morogoro, Mvomero, Kilombero, Kilosa, and Ulanga)  
- 1 CP advisor |
| Project formulation | Bilateral project-type technical cooperation |

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10 JICA, Medical Cooperation Department (2000)
2-2 First Half of the Project: Building Relationships of Trust through Trial and Error (April 2001 - October 2003)

Throughout the first half of the project there was a period of roughly 10 months in which the chief advisor was absent for reasons such as overlapping early returns to Japan by the chief advisor and experts. Over this period when the chief advisor was absent two long-term experts and one short-term expert were obliged to carry on with the activities.

Yet regardless, over this period trial and error was conducted in the form of laying the foundation for a network between CPs by determining and analyzing the current conditions in the region, reviewing CP-led project planning, and conducting training with the participation of every member. As such, over this period the sense of solidarity between the Japanese experts and the Tanzanian CPs was strengthened due to the mutual sense of urgency caused by the absence of the Japanese chief advisor. The sense of commitment and ownership by the Tanzanian side for the operation of the project was fostered, as were two-way relationships during this phase.

2-2-1 Laying the Foundation for Vertical and Horizontal Networks in Local Areas

In the first half of the project, the health information management expert’s activities included determining the current status of medical facilities in the target region and frequently carrying out routine patrol activities for each district. Through such activities, basic data on health facilities was collected, including information like the number of health facilities and the number of health care providers. Further, the adoption of wireless devices by the health facilities to improve the means of communication related to the collection of health information was examined.

The foundation for a horizontal network between districts was laid through these district visits and the installation of wireless devices and such. The Ulanga District and Kilombero District both had numerous regions where the roads were underdeveloped and traffic access was difficult, due to which the transmission of health information was exceedingly slow. However, through opportunities for routine visits to local areas it became possible for adjoining districts to exchange information with one another.

In addition, communication between the region and districts was strengthened by having the members of the RHMT travel together. Likewise, communication between the CHMTs and the health
The information network was enhanced through the introduction of wireless devices.

Therefore, this strengthening of the information network later came to serve as a foundation for the self-reliant development of a network between district health managers and organizations (refer to “2-4-1 (2) Horizontal and Vertical Collaborations in Local Areas”).

**2-2-2 Project Action Plan Formulation and Modification Led by the CPs’ Initiatives**

Generally, in cases where indicators for project activities have not been set and when reviews are necessary, it is extremely important to hold consultations among those involved in the project and establish and reestablish PDM indicators from as early a stage as possible in order to clarify the project’s outcomes and activities.

This project was no exception. From immediately after the start of the project onward, a great many opportunities were provided to confer with the CPs in order to examine the contents of activities and establish the performance indicators. On such occasions, the principle focus was placed on creating a satisfactory action plan by applying the Project Cycle Management (PCM) method and nurturing a cooperative spirit with the CPs. It took nearly two years to complete PDM ver. 3.0. However, by emphasizing the self-reliance of the CPs and with the experts playing the role of catalysts, the CPs devoted a great deal of time, set their own objectives and fostered their sense of ownership and commitment regarding the activities.11

The CP advisor (a former RMO) described the training pertaining to project activity planning and modification as follows: “The input of long-term experts capable of teaching the PCM method is required at the outset of the project. Since it is difficult to understand the PCM method and apply it to the logical framework of the project in a single workshop, I believe that the abilities of a facilitator well-versed in such method will be especially necessary from the very beginning of the project.”

**2-2-3 Implementation of Full Participation-style Training**

The basic training at the very beginning of the project was participated in by all CP members. This had the major advantage of fostering team work for resolving problems as an overall team by means of imparting every member of the team with a minimum understanding of basic management and instilling them with common capabilities.

However, because the CPs were engaged in medical services such as medical examinations and nursing as their routine work, the total participation training frequently caused stoppages of health and medical service functions. This fact came to be expressed as a concern of the CP side. For this reason, in the second half of the project activities and development were conducted in a manner whereby “selective training” formed the basis of the WGs (refer to 2-4-1 (1) Working Groups).

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11 From the interview with the Kilombero CHMT.
2-3 Project Transition Period: Revision on account of the Mid-term Evaluation (October 2003 - March 2004)

In October 2003, a mid-term evaluation was conducted which served as a review of the project. Through this mid-term evaluation the performance of the project activities up to then were evaluated and the activity contents were reviewed. There were personnel substitutions among the Japanese experts, and a specific strategy designed to obtain outcomes was clearly laid out. Taking this phase as a transitional period, this report will describe the features of this period that acted as key factors for the project’s development in its second half.

2-3-1 Mid-term Evaluation

When the mid-term evaluation study team was dispatched an evaluation workshop that employed the PCM method was conducted, and the existing PDM ver. 3.0 was modified to produce PDM ver. 4.0. Moreover, the Second Joint Coordinating Committee (JCC) was held, and the study team reported that, “While delays in the project activities are foreseen, from here on it would be preferable to promote activities via greater collaboration among the concerned parties.”

There were extensive debates from the very start of the project regarding the tools for measuring the improvement of management capacity, which was one of the project goals. From PDM ver. 3.0 on, the Hexagon-Spider-Web-Diagram (HSWD) which was devised between the experts and CPs was adopted. In the mid-term evaluation as well, using the HSWD the six management capacities were clearly defined as the various capacities for schedule management, project, coordination, financial, management of human and material resources, and knowledge. The results of the measurement of benchmarks through the HSWD are as follows (Figure 2-2).

*Figure 2-2 Hexagon-Spider-Web-Diagram*

Through the introduction of the HSWD the prospects for accomplishing the project’s objectives were further clarified in the mid-term evaluation. Furthermore, while there were variations in the level of understanding of the CPs regarding the project management method, the further deepening of their understanding of this method and the PDM was achieved through consultations in the mid-term evaluation. This was enormously beneficial to the operation of the project from that point on.
2-3-2 Substitution of Experts

In this manner the project went through a period of “creating trust and laying the foundations for management.” As such, in the mid-term evaluation expectations rose for the achievement of outcomes oriented toward the completion of the project, particularly the achievement of visible outcomes and model creation. Following this, a detailed examination of the project’s implementation structure was conducted. As a result, because of the changing role of the project, four of the five Japanese experts currently serving were substituted out and a reorganization was conducted of the new experts team “in the interest of producing outcomes.” In particular, the experts for the second half of the project did not limit themselves to “interaction” meant to solely keep good relations with the other side, but drew out the others’ capacity by “coming face to face” to honestly exchange ideas with one another from time to time. As a result, the input of highly specialized human resources capable of making proposals in a tangible manner was needed.

There were concerns that the activities would be held up due to the substitution of experts. However, one expert who had a grasp of the activities and the process of trial and error with the CPs up to that point, Dr. Sugishita (in charge of health administration planning), remained on-site. Following the chief advisor’s return back to Japan, he took over the activities related to the chief advisor’s duties, thus earning the consent of those involved. On account of the relationships of trust with the CPs that were formed by the predecessors, no significant problems were observed in the relationships of trust and communication with the CPs in spite of the nearly complete turnover of the experts. Moreover, the CPs were still actively committed, and the new expert team was able to join the project activities relatively smoothly.12

2-3-3 The Mid-term Evaluation and Changing the Awareness of those Involved from the Partner Country

From the mid-term evaluation onward, while faced with several problems such as the overhaul of the Japanese experts team and the construction of the resources center13, a change came to be observed in the CPs towards adopting a more assertive attitude.

In other words, at the point where the mid-term evaluation study team reflected back over the project, having everyone involved share in the development and outcomes of activities served as an opportunity for the CPs, which had independently carried out activities, to display accountability for the outcomes of such activities. Separate from the PDM for the project, the RHMT and CHMTs each independently created their own respective PDMs. For these, a reexamination was performed on elements related to the achievement of the project, such as the activities, inputs, and external conditions for the regional and district achievement of project goals.

From the planning of to participation in project activities, the Morogoro Regional Administrative Secretary (RAS), the official responsible for the operation of the project, was changed. The CPs were compelled by this event to brief the new RAS on the project contents and build new relationships of trust between the project and the regional administration. This made the CPs recognize that little would have remained after the return home of the Japanese experts unless the CPs became able to resolve problems on their own.14

After the construction of the regional resources center was halted due to various circumstances, the Kilosa District renovated and reopened a resources center using its own finances. This serves as an example of a team from another district utilizing the lessons learned from the process of resolving the problems.

12 From the interviews with experts Tsuda and Goto.
13 Resource center held the function of assembling together health information from inside the region and widely making it available for the RHMT and general public. In addition, it also carried out WG activities and training.
14 From the interview with expert Sugishita.
Project for Strengthening District Health Services in the Morogoro Region, Tanzania

confronting them and applying them in the project. It was also acknowledged that there were numerous cases where the administrative capacity required was secured through the local network.


In the second half of the project, concrete CD outcomes emerged that represented the fact that the trial and error in the first half of the project had borne fruit. By establishing cooperative structures between the region and districts, a sense of ownership was fostered that allowed them to deal with challenges on their own. Moreover, by improving its health planning capacity, the Tanzanian side became able to budget activity expenses for the project by using the HSBF, thereby strengthening its cultivation of ownership on the financial front.

2-4-1 Establishing Collaborative Structures between the Region and Districts (1) Working Groups (WG)

Every CP had rotated their participation in all activities for three and a half years since the project was launched. After October 2004, however, cross-district WGs were established for each outcome and they were introduced into all activities. This WG-unit strategy was aimed at stipulating outcomes and objectives and managing activities smoothly and efficiently.

As shown in Table 2-1, seven WGs were formed that were suited to the project’s outcomes. Each WG was comprised of seven people (one from the RHMT and one from each of the six CHMTs were elected, respectively). Those recommended were made the WG leader, and would participate in WG projects as a district representative.

<table>
<thead>
<tr>
<th>No.</th>
<th>Outcomes</th>
<th>Working Group (WG)</th>
</tr>
</thead>
</table>
| Outcome 1 | "Rebuilding the health information system" | - Health Management Information System (HMIS) WG  
- Communication (TWINS) WG  
- Internet Homepage WG |
| Outcome 2 | "Sharing and restoring experience and information" | - Newsletter WG  
- Health Information Resource Center WG |
| Outcome 3 | "Strengthening health problem analysis, planning, implementation, and M&E capacity" | - Operational Research (OPR) WG  
- Monitoring and Evaluation (M&E) WG |

Moreover, “selective training” was conducted suited to the formation of the WGs. The major goal of “selective training” was not merely to arrange it so that medical facilities and offices would not cease to function. It was also meant to “foster the skills and sense of responsibility of the selected participants” for specific issues. In addition, it had its basis in the judgment that there were numerous benefits for efficiency and effectiveness, such as reducing the costs related to items such as daily meeting expenses.

The WGs did not just undergo training and carry out tasks in workshops designed to produce tangible outcomes. Instead, they would “repeat” the actual activities of the WG in the form of On-the-Job Training (OJT) at the workplace of various members. Furthermore, they were also requested to set up training plans for each WG as necessary and incorporate these into budget planning.15

15 From the interview with expert Sugishita.
(2) Horizontal and Vertical Collaboration among Local Governments

In the second half of the project, the horizontal connections between districts as well as the vertical connections between the region and districts were strengthened as described below.

1) Horizontal Collaboration

In the project’s first half, the situation in each district came to be commonly shared owing to the routine visits to the districts by Japanese experts (refer to 2-2-1). In addition to this foundation for the local network, in the project’s second half the cross-district horizontal network was further strengthened due to the initiation of WG activities. For example, a member of the Kilombero District CHMT remarked to the effect that, “Before the MHP was conducted we were largely unaware of how health activities were carried out in other districts. But now we have the chance to collaborate with members from the CHMTs in other districts through the WG activities and can determine the state of health activities in other districts. And you can tell just from asking anybody that a shared awareness has been reached within the districts.” From this statement it can be seen how horizontal collaboration was strengthened through communication between the WG members. Moreover, the holding of region-district regular joint meetings (quarterly), exchange visits between districts, and other activities have strengthened horizontal collaboration at multiple levels.

2) Vertical Collaboration

For WG activities, since RHMT members also act as constituent members of the WGs, vertical lines of each operation were expanded in a freer manner. In other words, through collaboration among the region and districts for the achievement of shared objectives, the vertical relations consisting of the formation of a network between the CHMT and RHMT teams was strengthened. The outcome that resulted from expanding their relations surpassed the “manager - subordinate” relationship.

In their keynote address at the annual international science conference sponsored by the Tanzanian National Institute for Medical Research (NIMR) held in Arusha in March 2007, the MHP’s CP advisor announced the final outcomes and lessons from the project. Also at the conference, the former CMO of the MOHSW made the following remarks.

“The MHP has intensively strengthened the managerial capacity of health managers in the
Morogoro Region and districts. The conventional system was a vertically-divided, one-way administrative system in which the central government and its branch agencies of the regional governments would lead and supervise the district governments. However, a new administrative system was introduced in which district governments erected a horizontal network centered around regions. Strengthening teamwork, with the region and the districts acting as one, this also laid the foundation for a local health administration in which the region and the districts compete against and mutually help one another out in a form of friendly rivalry. This has led to the raising of an endogenous and sustainable administrative system. This is the most amazing aspect of the project, and was a groundbreaking accomplishment in a traditional and centralized Tanzania.”

**Figure 2-3 Vertical and Horizontal Collaboration**

Source: MHP (2007)
Chapter 2  Development and Outcomes of the Project

(3) Utilization of and Cooperation with Local Resources

The project gave particular consideration to “the utilization of and cooperation with local resources,” including latent human resources and organizations of universities, research institutions, and other sources both within and outside of the Morogoro Region in its second half. The purpose of this was to ensure continuity and for sustainable development.

This stems from a proposal from the RMO to JICA, which had been examining whether or not to dispatch short-term experts from Japan to the project site. The proposal suggested that it would be possible to utilize academic institutions capable of providing business training services on the ground. Another contributing factor was that Mzumbe University had conducted tailor-made business training jointly with the project.

The project had already collaborated with various universities, including Muhimbili University (Dar es Salaam), Mzumbe University (Morogoro Municipality, business management training), the University College of Lands and Architectural Studies (UCLAS, Dar es Salaam, GIS training), the National Institute for Medical Research (NIMR, Dar es Salaam), and Ifakara Health Research and Development Centre (IHRDC, Ifakara). These were centered around WG activities in particular, and served to erect and strengthen the on-site support structure sustaining technological development after the completion of the project.

2-4-2 Cultivating Ownership on the Financial Front

When facilitating independence and autonomous development on the partner's side, it is essential that financial ownership be ensured with regard to the budget for project activities. This project analyzed how the budget for activities like those of the WGs should be shared with the Tanzanian side, and in what manner the HSBF should be utilized as a source of revenue for this.

(1) Budgeting Activity Expenses

By paving the way for the WG activities initiated through the project and making other administrative officials and the general public aware of this as a visible outcome, these project activities gradually came to be recognized as essential health activities of Tanzania's local government authorities. In particular, the commitment of district and regional governors to WG activities increased. Contributions from district health budgets for various expenses related to the project activities (including Daily Subsistence Allowances: DSA) and the districts' own health activities (first annual meeting with workers at health facilities in the Kilombero District) became possible.

As illustrated below, it is understood that the net burden gradually increased after October 2004, which was when the WGs were formed (Table 2-2). In addition, Figure 2-4 shows how Tanzania's net burden of expenses in the final year of the project (extension period) exceeded JICA's net burden from the first and second years of the project's implementation.16

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16 There were delays in the start of expenditures, and it is believed that the actual amount of expenditures fell below the budgeted amount.
At the district health administration level, a certain procedure had to be followed for the ongoing participation in WG activities. This process entails CHMT members first explaining the importance of WG activities to the District Medical Officer (DMO). The DMO would then explain this to the heads of various sectors within the district, such as the District Executive Director (DED) and, upon receiving approval, the expenses would then be subsidized. The project provided training and OJT on matters such as this type of financial management and activity planning, how to write proposals, and more. Owing to this, it became possible to perform such budgeting relatively smoothly. In particular, as they were forced to seek their main source of funding through the HSBF, they were not given approval for anything less than an excellent budget plan for their activities. As a result, a positive cycle gradually took shape in which their motivation to participate in activities served as the motivation for them to acquire managerial abilities. This fact is of extreme importance in terms of ensuring the continuity of the project.

In this manner, through negotiations on issues like cost sharing for project activities, a successive cycle of practice in drafting, formulating, implementing, and monitoring and evaluating the Comprehensive Council Health Plan (CCHP) was repeatedly carried out. This resulted in sound improvements to the CHMTs’ capacity for formulating the CCHP, as well as the budget formation capacity of the local health administration sector.
Box 2-1 Schemes for Sustainable Training Participation

For their participation in seminars and workshops related to their work, the participants were provided with a Daily Subsistence Allowance (DSA). Tanzania has advised Development Partners (DPs) to establish certain standards in paying a DSA in cases such as where its government employees take part in training. Examination of these standards is conducted among the Development Partners Groups (DPG), and agreement is reached between the Tanzanian Government and the DPs. Furthermore, official notification is provided to each DP so as to ensure that these standard amounts for payment are being observed. Yet this standard amount equates to a large amount from the point of view of the salary standards for Tanzanian government workers. Because of this, there are participants whose interest is in receiving the DSA from training and seminars in every sector, as well as cases in which people place a greater priority on receiving the DSA rather than the knowledge gained through attending the training and seminars. The dilemma of the DSA and ownership on the partner’s side is a pressing issue for the DPs that conduct training and seminars. On the other hand, for those receiving the DSA the question of whether or not to take in extra income on top of their salary, which is not especially high, is a similarly compelling problem. Such maneuvering related to the DSA causes some degree of trouble for those concerned with the project on the ground in terms of creating mutual relationships of trust.

In the MHP, the Japanese experts initially used the DSA as an important incentive in order to teach the CPs that all training, including management training, is important for improving their basic managerial capacity. However, there is a limit to how many times training participants can be compelled to continuously take part in training based solely on the appeal of the DSA. On this account, it was necessary to consider the content of training that would lead to changing their consciousness so to enable them to experience the benefits of participating, even if the regional and district budgets have already been appropriated. However, accompanying the progress of the project activities, particularly the development of the WG activities, up until then the DSA had served as a major motivating factor for participation in these activities, but this gradually came to change. There was a shift towards motivation through the activities themselves, which would lead to their own capacity development and personal growth (enjoyment). A recognition had begun to take hold among local administrative officials that the outcomes from the project activities were important to the Tanzanian local government authorities. Therefore, the DSA and travel expenses came to be budgeted into district health budget plans in order to ensure continuity after the end of the project. In this manner, the budget appropriations for the DSA were able to take off as a part of the routine affairs of the Tanzanian side.

In project activities, a shared recognition was reached with the CPs to the effect that the “WGs are worthwhile and enjoyable.” The various RHMT/CHMT members felt that their own managerial capacity was improving due to the WG activities. The fact that the members “came to enjoy working” and “came to perform their tasks with confidence” had a positive influence on their colleagues. In the second half of the project it became commonplace for the members to take part in training and the WGs through out-of-pocket expenses even when payments from the districts were delayed. It was no longer the case that they were attending training and performing activities in order to receive the DSA. Upon entering the second half of the project, as a result of eventually raising their own capacity, the feeling that “we can contribute to improving the quality of local health services” was shared among the RHMT/CHMTs. Furthermore, the message that with “No Commitments, Nothing Moves” had taken hold.

(2) Utilizing the Health Sector Basket Fund (HSBF)

As the preceding section indicated, the WG activities were not merely project activities, but rather were regarded as activities of the districts themselves. Because of this, a request was made by the Tanzanian side to examine working out their own activity budgets. It also became possible for project activity expenses to be allocated in district health budget planning and for the HSBF to be used as an independent revenue source for local health. While Japan is not a contributory country to the HSBF, it did make full use of the HSBF as a budget support framework in its project activities. That is to say, this demonstrated that Japan’s technical cooperation could build mutual complementarity with the budget support of other development partners.

17 In Tanzania it has become common practice to pay the DSA on the first day of training, even if there are multiple training days. Through MHP, measures were taken such as having those who did not attend the remainder of training refund the DSA after it was provided.
Furthermore, from the point of view of effectively utilizing budget support, it strengthened the financial foundations required for the provision of local health services. Yet despite this the background, a low budget implementation rate and fewer effects from budget support occurred due to the lack of appropriate budget planning and executing capacities. By aiming to enhance to the basic capacity of the CHMTs for planning, implementation, and monitoring and evaluation, the MHP raised the quality of district health budget planning and created mutual complementarity with budget support. It raised the efficiency of support to the Tanzanian health sector as a whole, for which the MHP as a process for technical cooperation received little in the way of harsh criticism. On the contrary, during a DAC assessment mission conducted in March 2003, the project was favorably assessed by the donor community in the sense that the MHP indicated how projects should be patterned in the future.

2-4-3 Manifesting Project Outcomes

WG activities are tied in to the outcomes of project activities in the sense that the outcomes of activities by the respective WGs complement each other.

(1) Outcome 1: Rebuilding the Health Information System

The Health Management Information System (HMIS) WG enhanced its system for routine visits and guidance. Doing so facilitated its collection of information on health facilities (scale, operating structure, number of doctors, number of hospital beds, geographic and positional relationship, etc.) at the regional and district levels. The HMIS WG also regularly published the Morogoro Health Abstract and achieved other such visible outcomes.

The Communication WG methodically prepared the system design for a Two-Way Information Network System (TWINS) and installed wireless devices and the like in remote medical facilities. Doing so allowed them to guarantee communication across all of the districts, collect health information, carry out a patient referral system and health education activities, and more. In particular, this had the effect of enabling them to collect health data from health facilities that are inaccessible during the rainy season, as well as providing cautionary advice on cholera and other infectious diseases via the wireless devices in a timely manner.18

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18 From the interview with the Morogoro Municipality CHMT.
(2) **Outcome 2: Sharing and Restoring Experience and Information**

The Resources Center WG carried out a variety of activities for the systematic management, use, and integration of the health information and materials that had previously been scattered and dispersed. In the second half of the project, district health information resources centers were established by the two local government authorities of the Kilosa District and the Morogoro Municipality through the self-help efforts of these district government. As the first such attempt in Tanzania, this drew an enormous response. Moreover, by periodically issuing newsletters, the Newsletter WG contributed to the sharing of health information between local health facilities while also being of service in health education activities in remote areas.

Furthermore, a number of interactive activities were also carried out, including the holding of region-district joint health meetings once every six months, the holding of regional health stakeholder meetings, and mutual study visits between districts. These activities served to strengthen the network channels between the RHMT and CHMTs, which in turn deepened their self-confidence and fostered a positive spirit of competition by promoting the sharing of information and experiences. Gradually, aspects such as voluntary cooperative activities among the districts for the resolution of problems began to be noticeable (refer to subheadings 2-4-1 (2) 1) Horizontal Collaborations and 2) Horizontal Collaboration).

(3) **Outcome 3: Strengthening Health Problem Analysis, Planning, Implementation, and M&E Capacity**

The Operational Research (OPR) WG made it possible for local health managers, who were CPs of the project, to carry out their own health research activities. The objective for this was to have them extract evidence from among health issues by using their research capabilities, and then to reflect this in local health planning. Such research activities in particular were developed as activities for regional and district health administrations as a whole. This was acknowledged as having fostered team work among the RHMT and CHMTs, while raising the management capacity of each of the administrations. What is more, the “Operational Research Report” and “Operational Research Management Handbook” were issued with the intention of sharing the research outcomes and methods with the MOHSW and health managers in other regions.

In the M&E WG, the members were fostered as facilitators for district health planning and activity monitoring by means such as M&E facilitator development practice and PCM training. Furthermore, primarily providing technical support for CCHP enabled health planning and appropriate budget management. In addition, it also issued the “District Health Management Handbook.” This handbook was designed to share these lessons with other health managers, and to be used as a reference for the formulation of health plans and other matters.
2-5 Extension Period through to Project Completion (April 2006 - March 2007)

During the extension period, proactive efforts were taken in order to establish project activities in the Morogoro Region in a sustainable manner. Initiatives were also taken to disseminate and expand the project’s outcomes and lessons acquired over the six year period to the surrounding regions. To be precise, logistical and coordination capacity were strengthened for the sake of sustainable management, the activities of the MHP were systemized, and educational tools were developed. On top of this, the project outcomes were announced and shared, reflection of the experience from the MHP in other regions was examined, and collaboration with other development partners was explored.

2-5-1 Strengthening of Logistical and Coordination Capacity for the sake of Sustainable Management

In order to ensure an autonomous operational structure for the activities on the Tanzanian side after the completion of the project, logistics and coordination capabilities were strengthened so that those involved could continue with activities like those of the WGs on their own. In addition, training and the like was also conducted in order to ensure the continued maintenance of equipment.

To be specific, the CPs elected people to positions such as the Chairperson, Coordinator, Secretary, and so on themselves. In addition, assigning the task of completing the “WG Coordinator Guide Package” to the Tanzanian side enabled them to demonstrate independent management for WG activities. The tasks carried out by the project to date, including schedule coordination among the members, issuing official letters, and budget control, were compiled as part of this guide package.

For machinery maintenance as well, the fact that previously the maintenance and upkeep of equipment was entrusted to others was reconsidered, and training for people to manage this was conducted with the cooperation of Mzumbe University. Furthermore, a Maintenance Manual was created, and OJT was carried...
out to so that the Tanzanian side was able to conduct maintenance and upkeep for all of the equipment, not just the provided equipment.

2-5-2 Systemizing MHP Activities and Experiences and Developing Educational Tools

The establishment of project activities in the Morogoro Region and their modeling and systematization for diffusion and expansion to other regions were explored by the concerned parties.

In particular, the MHP's feature of its “catalytic support” regarding the involvement of Japanese experts (described in detail in 3-2) was extracted and systemized.

Moreover, activities such as the development of educational materials and publications that compiled experiences, outcomes, and lessons from the activities were also actively carried out. Specifically, the MHP Summary Booklet, Operational Research Management Handbook, District Health Management Handbook, Morogoro Health Abstract, multimedia educational materials, and others were edited and published as tangible outcomes through the leadership of the WGs.

For example, information such as that on the concrete steps taken by the CPs, checklists that could be used immediately in the form of templates, and detailed indications of resources and agencies has been recorded in the OPR handbook, which has been made to be extremely easy to read. The names of the people who took charge of the writing are recorded in each chapter of this handbook, which allows people from other regions to inquire of the specific author directly should they have any questions.

For the CPs, the sense of accomplishment and self-confidence gained through the experience of providing these sorts of visible outcomes served as a far greater motivation than that provided by any monetary reward.

2-5-3 Demonstrating and Disseminating the Project Outcomes

The project laid the groundwork to foster the self-confidence of the CPs and for dissemination and expansion. It did this by systemizing activities and experiences and converting them into educational materials, while at the same time having the CPs themselves actively take opportunities to publicly present these to the outside world. More precisely, the project provided support so that the CPs would have the greatest possible number of opportunities to disseminate such outcomes on any occasion from domestic meetings such as stakeholders meetings and JCC, all the way to venues for international conferences.

Through such opportunities to disseminate the outcomes, the CPs can catch the attention of the health managers of other regions, top government officials, those associated with university research institutions, and others. These chances were thus beneficial in the sense that they had the potential to widen their personal networks. As a typical example, the outcomes of the project were selected for the keynote address at Tanzania's international conference on healthcare held in March 2007 immediately before the completion of the project. The outcomes were presented by the former health director for the Morogoro Region before participants from around the world. During the presentation's question and answer session, the CMO, who had played a leading role in the project, commented to the effect that, “This is one of the two most successful health projects in Tanzania.” All of those concerned with the MHP felt encouraged by this.

The presentations to those outside Tanzania offered ideal opportunities in which the CPs were able to convey their leadership to the outside world. For the CPs, not only those in the upper levels, but the Front Line Health Workers (FLHWs) as well felt the significance in their having achieved such outcomes. They also carried out activities in order to extend the project outcomes to healthcare facilities (distribution of handbooks, holding seminars to disseminate research outcomes, etc.). In Tanzania, where harmony is especially prized, having one's leadership acknowledged by others is profoundly meaningful.
2-5-4 Reflecting the Experiences from the MHP in the Health Sector in other Regions

In light of the evaluation at the end of the project, the vision of transferring the outcomes and experience of the MHP to other regions began to be earnestly explored during the project’s extension period.

In particular, the activities and experience that had been systemized and made into educational materials as described above were shared with other regions, and a program of mutual visits was conducted to examine the feasibility of applying them in other regions.

An RMO, six DMOs, CP advisor, and four Japanese experts (a total of 12 people) visited the Kagera Region RHMT. There they exchanged opinions with the purpose of building horizontal and vertical collaboration in health management in local areas. Located on the west bank of Lake Victoria, the Kagera Region was the quickest region in Tanzania to introduce and implement the HSR from 1994. Furthermore, with the experience from the Testing the Health Sector Reform (completed in 2004) through the support of Danish International Development Assistance (DANIDA), the region is claimed to be the most successful within Tanzania in terms of independently developing its managerial capacity.

The Morogoro Region RMO and DMOs were spurred on by the high level of capacity of the Kagera Region’s RHMT overall, and the MHP reaffirmed that the fact that, “We learned not what, but how.” Furthermore, through repeatedly presenting the outcomes achieved through their own project in the Kagera Region, the RMO deepened their self-assuredness.19 “Before coming to the Kagera Region, I thought about what the Morogoro Region could possibly have that had not yet made it to Kagera. But upon actually visiting, I feel confident in what we have accomplished so far. It is clear that Morogoro measures up to Kagera.” This comment succeeded in increasing awareness of the project outcomes.

In addition, aside from the exchange visit program, the CPs from the MHP are expected to disseminate the activities from the MHP through being transferred to other regions. Before the end of the extension period, the DMO from the Morogoro District, who was a CP, was appointed as the RMO of the Mbeya Region, due to which it is anticipated that activities such as those of the WGs will begin in the Mbeya Region. Similarly, the DPO of the Kilombero District who was also a CP was appointed as the assistant director of the Coordination Bureau in PMO-LARG. It is anticipated that these persons acquainted with six

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19 Sugishita (2006d) p. 9
years of MHP experience will further strive for enhancement of the human resources of local administrations through the central government.

2-5-5 Exploring Collaboration with the Initiatives of other Development Partners

A project to strengthen district health management capacity (Tanzanian Essential Health Interventions Program: TEHIP) was implemented in the Morogoro District through support from Canada’s International Development Research Centre (IDRC). In particular, a cascade method referral system was established. On this account, CPs from other districts visited Morogoro Region as part of their MHP activities. Training is conducted for workers at health facilities designed to teach them know-how on this cascade method, as well as budgeting within a district health activity budget plan.

What is more, in the Kilosa District the dissemination of a Community Health Fund (CHF) had been promoted through the support of the World Bank. Owing to this, different CHMTs visit the Kilosa CHMT and learn about the Kilosa District’s CHF activities and procedures for initiating activities.

In this way, the CPs are not bound by which development partner they receive support from, but rather mutually learn from one another regarding health service delivery. As such, this demonstrates how having the CPs personally incorporate various donor initiatives into the CCHP as new activities and carry out budgetary allocations that are intended to strengthen the organization of the CHMTs.
There is no right answer when it comes to management. This case can also serve as an example in terms of how it was handled at that time. But it is extremely important to gather lessons from previous precedents.

What I felt was most unfortunate about this case was that, from what I gathered from my contact with the CPs, they had made snap decisions to attend the WGs based solely on whether the districts would share the costs. “Why am I participating in this WG? What sort of impact will this have on things like the organization I belong to, the community, and other regions?” With this in mind, I shared my distress with my supervisor, but was only told that I should express enthusiasm for taking part in the WGs. In fact, there was another CP who I had a discussion with, who said, “I somehow managed to raise the DSA from my district, but there are meetings that run until immediately before I depart. Since I won’t make it by using public transportation, would you let me ride together with you in the project vehicle?”

Finally, as a result of consultations with the DMO (who was this CP’s boss) and for reasons such as measures against an outbreak of disease in their district and the delayed implementation of the basket fund, it was confirmed that the district could not share the DSA for this CP. Due to a reexamination of the project, priority was placed on having the CPs learn the importance of management (consultations and negotiations with bosses and supervisors, budget implementation procedures, independence), more so than the progress of tangible outcomes. Yet the conclusion was that the project would not provide the DSA for this CP. In the end, he was the only one of seven CPs slated to participate who missed the opportunity to take part. However, learning from this experience, for the next WGs the DSA was raised from the district budget without a hitch, and he was able to participate.

This was not the only case. Through honest discussions (coming face to face) concerning cost sharing with the district, I feel as if I became able to see not only the individual, but also the organizational and institutional courses. This is an aspect I never would have been able to see had the costs for the project been borne unilaterally. In the organizations that the CPs belong to (CHMTs), does frank communication exist where subordinates are able to consult with their superiors over anything? Are the district health budgets being fairly apportioned? Are the basket fund and budgets from the national government being implemented smoothly? Is the DED, who holds final decision-making authority for district budget implementation, cooperative when it comes to promoting health activities and reforms? Do the district accounting systems facilitate rapid budget implementation procedures? Moreover, does the region (RHMT) determine the circumstances in each of its districts, and is it furnished with the capacity to support the districts and achieve health objectives? And on and on, with each of these a step toward organizing and institutionalizing which is not readily apparent.

Cost sharing is only one example of project management. A catalyst elicits the true feelings of the partner in each and every daily setting which requires management. It incorporates notions that this is all for the partners, organizations, social institutions, and for the health of the people, and then throws this back to the partner. Perhaps things such as the self-reliant development of individual CPs and CP organizations are not particularly desired if the project is only to be used for its own convenience. The achievement of outcomes after the end of the project is not the only thing that is expected. In addition, by facing the partner country and honestly “coming face to face” while the project is ongoing or rather, from the project formulation stage on – it is almost certainly possible to wish body and soul for true self-reliance on the part of the partner country.

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