This chapter will look at how the problem-solving ability of the health managers of Morogoro Region and its districts was enhanced by the project activities from a CD perspective. In 3-1 the respective outcomes at the individual level; the organizational level; and the policy, institutional, and societal levels will be articulated, and the section will conclude by analyzing CD challenges throughout the entire process. 3-2 will compile the features of and lessons from the implementation approach for MHP.

3-1 The Capacity Development Process and Project Outcomes

Table 3-1 separates the frame of reference for perceiving capacity into three categories: individual, organizational, and institutional and social systems. It also illustrates the form of capacity for these three categories, as well as things like tools and opportunities for expressing capacity.

Knowledge, skills, commitment and approach, soundness, and awareness were what served as indicators for the strengthening of individual capacity. The degree to which capacity was strengthened was understood through how these measures had changed compared to before the capacity was enhanced. Next, organizational capacity was judged by factors like personal assets, physical assets, and intellectual property, as well as the organizational configuration by which these three assets were utilized. The degree to which capacity was strengthened was assessed through how the elements needed for the achievement of certain objectives were enhanced, including the decision making process and management system, as well as the organizational culture and structure. The extent to which the capacity for institutional and social systems was strengthened was understood through its effect on the environment needed for the individual and organizational levels to demonstrate their capacity (enabling environment). It was also judged based on whether the decision making processes and systems, as well as their frameworks, in relation to the formulation and implementation of policies and strategies that surpass single organizations had an impact on specific structures and policies.
Firstly, the project outcomes at the level of individual capacity improvement will be analyzed. In the first half of the project, basic capacity for management was fostered through training for all of the members of the RHMT/CHMTs and by selective training. Furthermore, various individual skills were acquired and amassed by means of repeatedly conducting capacity strengthening for daily activities. These include computer operating skills, presentation ability, and coordination abilities (holding regular meetings, transmitting information to workers at the health facilities, etc.). (Refer to 2-2-3)

In the second half of the project through to the extension period, there was a drastic increase in the opportunities to present the outcomes owing to the process of generating outcomes through WGs and strengthening horizontal and vertical collaboration. The individual capacity previously fostered was further tested and imparted as the ability to deal with organizational challenges in a constructive manner. For example, one of the Morogoro Municipality CHMT members stated, “Through the MHP, health activities (= my work) has now become a lot of fun.” The capabilities of the Regional Administrative Secretary (RAS) and Acting Regional Administrative Secretary (Ag RAS), as well as that of the RHMT/CHMTs members soundly improved. This led to them to building their self-confidence, with the CPs even exhibiting changes in their countenance and attitudes. (Refer to 2-5-3)

Local health managers became capable of carrying out administrative acts such as examinations, planning, and drafting through their own ability (fostering individual capacity). The self-confidence of

Table 3-1 Means of Perceiving Capacity and its Expression

<table>
<thead>
<tr>
<th>Levels of capacity</th>
<th>Key capacity features to be developed</th>
<th>Elements on which the capacity is based at the three levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>The will and ability to set objectives and achieve them using one’s own knowledge and skills</td>
<td>Knowledge, skills, will/stance, health, awareness</td>
</tr>
<tr>
<td>Organization</td>
<td>The decision-making processes and management systems, organizational culture, and frameworks required to achieve a specific objective.</td>
<td>Human assets (capacities of individuals comprising organizations)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical assets (facilities, equipment, materials, raw materials) and capital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intellectual assets (organizational strategy, management and business know-how, manuals, statistical information, production technology, survey and research reports, household precepts, etc.)</td>
</tr>
<tr>
<td>Institution</td>
<td>The environment and conditions necessary for demonstrating capabilities at the individual or organizational level, and the decision-making processes, and systems and frameworks necessary for the formation/implementation of policies and strategies that are over and above an individual organization.</td>
<td>Capacities of individuals or organizations comprising a society</td>
</tr>
<tr>
<td>Society</td>
<td></td>
<td>Formal institutions (laws, policies, decrees/ordinances, membership rules, etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informal institutions (customs, norms)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social capital, social infrastructure</td>
</tr>
</tbody>
</table>


3-1-1 Outcomes at the Individual Level

Firstly, the project outcomes at the level of individual capacity improvement will be analyzed. In the first half of the project, basic capacity for management was fostered through training for all of the members of the RHMT/CHMTs and by selective training. Furthermore, various individual skills were acquired and amassed by means of repeatedly conducting capacity strengthening for daily activities. These include computer operating skills, presentation ability, and coordination abilities (holding regular meetings, transmitting information to workers at the health facilities, etc.). (Refer to 2-2-3)

In the second half of the project through to the extension period, there was a drastic increase in the opportunities to present the outcomes owing to the process of generating outcomes through WGs and strengthening horizontal and vertical collaboration. The individual capacity previously fostered was further tested and imparted as the ability to deal with organizational challenges in a constructive manner. For example, one of the Morogoro Municipality CHMT members stated, “Through the MHP, health activities (= my work) has now become a lot of fun.” The capabilities of the Regional Administrative Secretary (RAS) and Acting Regional Administrative Secretary (Ag RAS), as well as that of the RHMT/CHMTs members soundly improved. This led to them to building their self-confidence, with the CPs even exhibiting changes in their countenance and attitudes. (Refer to 2-5-3)

Local health managers became capable of carrying out administrative acts such as examinations, planning, and drafting through their own ability (fostering individual capacity). The self-confidence of

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20 From the interview with all of the RHTM/CHMTs.
individuals in their own abilities and their motivation were fostered, and the organizational response capabilities of regional and district health management teams were strengthened to allow them to exhibit still greater management ability at the individual level (strengthening of organizational capacity). The creation of a proactive, horizontal network between districts was initiated with the objectives of conducting cooperation and sharing burdens (developing systematic capacity). As such, the presumption is that the foundation has been laid for endogenous and active local health systems.

As a catalyst spurring on change in Tanzania’s district health managers, the project provided the opportunity to transition to CPs, as well as the means to do so in a competent sense. This originated out of a critical analysis of the conventional top-down type of management structure, in which administrative acts are carried out through instructions from the central government, such as MOHSW. This took the political background of the health sector reforms and the financial background characterized by the introduction of the basket fund through aid coordination as its foundations. In this sense, the role played by CD can be thought of as supporting the endogenous growth of developing countries by using what is termed development assistance as an agent for change.

### 3-1-2 Outcomes at the Organizational Level

**(1) Outcomes of the Organizational Capacity Improvement**

The organizational strengthening for the Morogoro RHMT/CHMTs was conducted through the individual acquirement of basic managerial capacity. This was then accumulated as organizational ability among the group activities of the WG, which brought this individual ability together. The achievement of various outcomes which extended beyond solely that of individual capacity was achieved successively by means of the organizational ability which collectively brought together this individual capacity. Such outcomes include an information transmission system utilizing wireless devices, the publication of a health information abstract, the regular publication of a newsletter, the opening of a resource center, the implementation of operational research (OPR), the creation of various manuals and handbooks, and more.

As an example, on August 18, 2006 the MHP received a letter from the MOHSW in relation to the publication of the Morogoro Health Abstract 2005/06. The letter read, “The Morogoro Region is the first region in Tanzania to publish a health abstract, and this abstract is the first health abstract within the country to rise to the level expected by the MOHSW.”

Furthermore, NIMR praised the performance of the local OPR study report, which was also the first in Tanzania, when evaluating the activities of the MHP. The institute commented that its outcomes had contributed to improving the organizational capacity of the local health administration sector as a whole. 21 (Refer to 2-4-3 (1)-(3))

**(2) Significance of Support from the Region**

The former CMO of MOHSW emphasized the fact that, “The project contributed to strengthening the organizational capacity of the district health systems in the Morogoro Region. This in turn allowed the region and districts to break out of the mold of vertically-segmented administration and resolve the health problems besetting the community as a single “team.”

As a part of the central government (MOHSW), the RHMTs principle duty had traditionally been to operate and manage regional hospitals. However, since 1999 they have additionally been furnished with the function of providing on-site guidance and management support for district health administration. As such, their fundamental duties have come to be surveying the incidence of and prevalence rates for diseases,

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21 From the interview with NIMR (Dr. Kitua).
which differ for each district within the region. They then provide technical guidance and administrative monitoring so that the districts can provide appropriate health services.

In the MHP, the RHMT and CHMTs worked together to put the WG activities into practice. This led to the strengthening of the region’s monitoring ability, as well as its capacity to provide guidance and advice to the various districts. At the same time, the region was able to share information related to monitoring and evaluation standards for district health activities with the CHMTs, which allowed for highly transparent monitoring and evaluations. (Refer to 2-4-I (2) 2))

(3) Horizontal Collaboration between Districts

Concurrent with the aforementioned vertical collaboration, the health administrative officials of each district conducted activities as a single WG transcending the district framework. The fact that this led to strengthening horizontal collaborative relations between district administrative officials is a result that deserves special mention. This horizontal network serves as a significant asset in the sense that it enabled daily exchanges of information, fostered a competitive spirit for health services, and strengthened the referral system. (Refer to 2-4-I (2) 1))

3-1-3 Outcomes at the Policy, Institutional, and Social Levels
(1) Contribution to the Millennium Development Goals

The contribution to the Millennium Development Goals (MDGs) in the Morogoro Region has been incredible. As the following figure illustrates, the region is expected to achieve the target figures for two of the goals in the MDGs by 2015. These include the fourth goal to “Reduce Child Mortality,” which encompasses the Infant Mortality Rate (IMR) and the under five mortality rate (U5MR), and similarly the fifth goal to “Improve Maternal Health,” which includes the Maternal Mortality Rate (MMR). In reality, there are a variety of different elements involved that serve as factors in this. Yet it is conjectured that the capacity strengthening of health officials through the MHP had an impact which extended all the way down to improving the capacity of workers at health facilities for providing services, thereby acting as a facilitating factor.

Figure 3-1 Infant Mortality Rate and Under Five Mortality Rate in the Morogoro Region
Chapter 3  Outcomes and Challenges from a CD Perspective

(2) Consistency with Policy

In the health sector evaluation and study reports from 2003, 2005, and 2006, emphasis is laid on the “vulnerability of the capacity of local administrative officials and the necessity of strengthening this.” As can be seen from this, the objective of enhancing local health management aimed for by the MHP was a project which was highly consistent policy-wise in its conformity to the HSR and LGRP. Owing to this, compared with the capacity strengthening projects of other development partners, this project was designed to remove the bottlenecks that were absorbing the nation’s resources. This could be considered the reason for its success in accomplishing the project objectives in a relatively short period of time. (Refer to 2-4-3 (1)-(3))

From the perspective of fostering human resources in the health sector as well, the project clearly laid out the competency required for the members making up the regional and district health administration teams, as well as the methods for fostering these capabilities. In this regard, the MHP could be called a success in that it offered a single policy proposal to allow the Tanzanian Government to draft ongoing training plans for the people engaged in the health sector.

(3) Utilizing the Health SWAp

In the MHP, the districts did not rely solely on the JICA project budget in order to carry out health activities. They also made requests via their own budget planning for financial resources from the Tanzania health sector SWAp mechanism of HSBF, executing such budget planning with accountability through their own monitoring and management. This is a result worthy of special mention from the perspective of the project's autonomous development. (Refer to 2-4-2)

The chairman of the Health Development Partners Group (Health DPG) has indicated their inclination to examine further increasing the capital of the HSBF. This would be done in a similar fashion for the Morogoro Region and other regions in the future, and to the extent that local government authorities could establish their own personal accountability.22

In other words, improving the capacity of health administrative officials and the development of the health SWAp through MHP has been recognized as exhibiting synergistic effects. This contributes to the essential process whereby the project outcomes are set in place as institutional norms for the Tanzanian health sector.

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22 From the interviews with the former and current chairmen of the Health DPG
3-1-4 Challenges from a CD Perspective

(1) Consistency with the Comprehensive Development Programs of Local Governments

The WG activities that were established through the project are important in that, after the end of the project, they are still being budgeted for and implemented as fundamental duties as part of health activities.

In Tanzania, comprehensive development programs are created at the district level via decentralization by devolution (D by D). It is essential that such programs continue to be expanded as local comprehensive development projects by means of conducting budget coordination with other sectors. When this is done, the Regional Planning Officer and District Planning Officer (RPO/DPO) play a central role as coordinators between the other sectors.

The MHP drew these planning officers into the project activities and improved their capacity for formulating the health sector comprehensive budget plans of the CCHP. Furthermore, it not only brought in planners from the region and districts, but also involved regional and district governors and administrative officials as needed in aiming for coordination across sectors in local areas. It also contributed to improving comprehensive administrative capacity in order to appropriately allocate limited resources among the local government authorities. These efforts are considered to have been immensely meaningful.

(2) Challenges for the Implementation Structure regarding Future Local Health Administration Services

Based on the outcomes of and lessons from the MHP, hereafter it will be necessary to reexamine the administrative environment in greater detail. This reexamination must correspond to the policy, instructional, and social systems, and is designed to expand the strengthening of managerial capacity out to other areas in Tanzania.

As indicated in 1-5-2, due to the decentralization by devolution process, when it comes to local health administration health activities they must be implemented based on Comprehensive Council Health Plans (CCHP) by means of the budgets from local authority ministries. The HSBF is a sector fund that works as a mechanism to provide allocations to the districts from the local authority ministries. In this manner, for the future it is envisioned that the MOHSW will play a supporting role on the technical front, while the local government will take the lead in providing services and administrative management when it comes to local health administration services.

The improvements in the capacity of local governments have progressed rapidly as a result of the abundant support that was provided, including the MHP, SWAp, and others. Yet at the same time, the development of institutions and the strengthening of managerial capacity for regional health administration are not yet complete, with this serving as a bottleneck for the promotion of decentralization by devolution.

The Tanzanian Government has petitioned JICA for technical support for the nationwide expansion of the strengthening of capacity for regional health administration, which acts as a bottleneck for the development of the entire health system. This would be done by utilizing the experiences of and lessons from the MHP. For its part, the Tanzanian MOHSW does not just have expectations for the strengthening of capacity of regional governments as seen from the central government’s point of view. Rather, there are also significant expectations for the creation of modalities and a mechanism for regional health administration that are desired from the districts’ point of view, such as those fostered by the MHP. The formulation of projects is currently in progress in order to allow the Tanzanian government and development partners to continue working together to support this type of mechanism.
### 3-2 Summary: Features of and Lessons from the MHP

While Chapter 2 traced the time sequence for the MHP activities, this chapter will once again pull together its features and lessons.

<table>
<thead>
<tr>
<th>3-2-1 Entry Point of Support through Capacity Assessments [Chapter 1, 2-1]</th>
</tr>
</thead>
<tbody>
<tr>
<td>The reason the initiatives of the MHP had such an impact is due to the fact that an appropriate entry point for cooperation was stipulated based on the policy environment for the formulation of the project. This policy environment refers to the development strategies, health sector reforms, and decentralization by devolution in Tanzania, which were described in Chapter 1.</td>
</tr>
</tbody>
</table>

Due to the health sector reforms and decentralization by devolution, the RHMT/CHMTs have been called upon to further enhance local health activities. The RHMT/CHMTs are gradually expanding their sphere of activities in order to achieve the objectives of the MDGs, which the international community is focused on, as well as the MKUKUTA and Health Sector Strategic Plan (HSSP) formulated by the central government. Throughout which they must formulate, implement, and conduct monitoring and evaluations of the CCHP according to the needs of the communities that are faced with the actual problems. In order to preserve consistency between the needs of both parties, the RHMT/CHMTs are being called upon to extract actual health problems as “evidence” and attach the priority to problem solving.

In light of this situation, for the MHP this entry point was discovered to be in improving the districts’ capacity for budget/activity planning and service implementation. This was done by means of strengthening the region’s technical support capacity in order to enhance managerial capacity for the local health sector, which was acting as a bottleneck. In addition, by thoroughly carrying out “evidence-based planning and implementation” the project was developed as a trusted local health administration model through decentralization by devolution.
Moreover, for the case of the MHP vigorous and persistent exchanges of opinions and debates were conducted over the area to be selected and the project contents. These were carried out around the time of the needs study, and were performed by the MOHSW as well as other development partners. During the project formulation stage, suitable attention should be focused on adjustment between the concerned parties in order to determine the entry point for support.

3-2-2 Sustainable Health Systems from a Comprehensive Perspective [Chapter 1, 2-4-1 (2), 2-4-2, 3, 2-5]

Based on the capacity assessment from the situational analysis mentioned above, Figure 3-3 is an image of the health system that comprehensively illustrates the manner in which the central, regional, and district governments, as well as the community are related to one another regarding the MHP.

**Figure 3-3 Sustainable Health System**

![Sustainable Health System Diagram](source: Sugishita (2006c))

The ascending arrow on the left illustrates the process whereby the CHMT, which perceives the needs of the community and uses this as evidence, incorporates activities into CCHP while also offering up materials to the region and central government (MOHSW and PMO-RALG) in order to effect policy changes. The descending arrow on the left indicates that health-related policies and guidelines (policy making conforming to needs is required) formulated by the central government descend down to the regional governments. The regional governments provide supervision to ensure that the district governments have properly interpreted the policies, while the district governments provide health services to their communities that matches the guidelines.

It is important that both systems, those that draw out the needs from the bottom up and those that provide services from the top down, interplay and function as a sequence of systems. As a result, this ensures development whereby local health administration services can reach the residents in an appropriate manner.

Thus, the MHP was positioned in between these bottom up and top down approaches. Targeting regions and districts that were acting as bottlenecks, it fostered health administration management with the goal of organizational enhancement. As a result, the district health administrative team

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23 From the interview with former policy advisor Hashimoto.
accurately determined the health needs of the community, and it became possible to formulate this as a
district health planning and budgeting operation. At the same time, these activities led to the creation of a
sustainable health system by means of the acquisition of a sector basket fund positioned from the top within
the health SWAp.

By positioning the initiatives of the MHP within such holistic health systems, its alignment with health
sector reforms was adjusted. As a result, it came to serve as a move for the formulation of national health
sector CD strategies as indicated in 2-5-5.

3-2-3 Ownership

By what means was ownership by the Tanzanian side fostered? The answer to this is thought to lie in
the attitudinal factors between the parties of Japan and Tanzania for the project formation and planning,
and the strategic factors which went so far as to “set up a system in which the RHMT/CHMTs worked to
address health problems within the region as a team.”

Going into specifics, project formulation and planning led by the Tanzanian side and the catalytic support of Japanese experts will be described regarding
the former, while for the latter the formation of project activities and the utilization and activation of local
resources will be discussed.

(1) Project Formulation and Planning Led by the Tanzanian Side [2-1-1, 2-2-2]

During the MHP’s project formulation stage the CMO played a central role in clearly grasping an
awareness of the need to strengthen the management foundations for local health administration along with
the JICA Tanzania Office. As such, this case was created in a manner that utilized ownership by the
Tanzanian side to the utmost extent.

Furthermore, in the first half of the MHP the CPs were personally made aware of the project’s
objectives by attempting to have them engage in project activity plan drafting and modification in a
participatory manner. The fact of them personally getting involved in developing the project was a
motivating factor behind dramatic outcomes being produced in the project’s second half.

(2) Catalytic Support [Chapter 2]

The MHP adopted “catalytic support” as its support modality in order to foster the ownership of the
Tanzanian side.

The MHP Japanese experts carried out activities in consideration of the following points for the
implementation of catalytic support.

- Valuing an attitude of thinking and learning together with the CPs
- Trusting in and developing the latent potential of the CPs (for example, fostering basic management
capacities such as leadership, team work, communication ability, etc.)
- Providing continuous support for the process of reflecting skills learned through training in regular
duties

The Japanese experts emphasized an attitude of thinking together with the CPs and learning from
one another. This was designed to enable the RHMT/CHMTs to implement health activities independently
and actively at the local level without having to wait for instructions from the central government. Expert
Sugishita explains, “It is necessary to motivate those on the ground and to have the ability to think from the
field (field capacity) in order to conduct catalytic support. This requires not only ‘knowledge and

From the interview with the former CMO.
experience,’ but also health administration management consisting of comprehensive ‘technical ability’ as well as just enough ‘personal magnetism’ to get the partner moving.” Moreover, Fukushi, another Japanese expert, said, “In the CP growth process there are a great many things that must be overcome and numerous areas where you can’t get progress simply with a cosmetic or superficial response. This requires the resolve to honestly ‘come face to face’ with issues rather than just superficial ‘interacting.’”

Therefore, through genuine interaction CPs imbued with leadership capabilities were fostered. Along with this, teamwork was created among the CHMTs as well as the WGs, which were formed for each health issue. It can be said that these facts comprise the quintessence of catalytic support.

This posture of acting as catalysts also serves to explain the importance of the presence of the Japanese experts as foreigners. To the Tanzanians, the Japanese experts were foreigners who would return home at some point. It was precisely because they served as “catalysts” for a limited period that they were at times able to carry out an intermediary role between the various stakeholders, occasionally propose ideas from a different point of view, and “interact” by thinking together and learning from one another. Through such efforts support was provided for the self-reliant initiatives for Tanzania taken by the Tanzanians themselves.

Figure 3-4 below denotes this catalytic support in a more systematic manner, expressing this concept by means of the 5Es (Exposure, Empowerment, Enhancement, Exercise, and Excitement).

The first step is Exposure, which is designed to make the CPs recognize problems on their own and take up these challenges. Drafting plans in a participatory manner through trial and error served as exposure which fostered ownership on the part of the CPs towards the activities they would continue to address themselves.
The **Empowerment** stage aims for capacity enhancement at the individual level, such as by basic management training.

When conducting **Enhancement** to put the outcomes of individual capacity enhancement into practice, attention is paid to forming WGs and establishing a structure designed to take organizational responses. Furthermore, the utilization of local resources is conducive to the development of sustainable activities.

By means of **Exercise** underneath such a structure, one becomes conscious of the duties of one’s own organization, and examinations begin to be made into independently working out a budget that is separate from project expenses.

Thereupon, by independently acquiring learning from this exercise, the work is improved and visible outcomes begin to appear, through which **Excitement** is created. This represents a self-reinforcing system and process whereby the CPs are instilled with self-confidence which they mutually share among themselves, by means of which they begin receiving exposure to still more challenges.

The above describes the 5Es, but the MHP goes further by adding the new E of **Enforcement**, which is designed to make the outcomes resulting from such support sustainable. As is written in 2-4-3 (4) and 2-5 on the initiatives in the extension period, changes occurred in order to organize the experiences from the MHP and develop them into policy and institutional frameworks. The purpose of this was to turn the initiatives of the MHP into a model that was sustainable and would be disseminated out to other areas. Comprehensive ownership on the partner’s side was fostered through this CD process.

The 5E process also thinks highly of the ownership on the partner’s side, and is consequently time consuming and largely non-apparent at the outset. However, CD is realized by having this process of trial and error by the CPs serve as a foundation for them to resolve challenges on their own.

The Regional Nursing Officer (RNO) expressed and evaluated catalytic support in the following manner.

“**Catalytic support means providing close support together for forward-looking change.** In this not only must the Japanese experts act as catalysts, but the regions must act as catalysts for the districts, and the districts must be catalysts for health facilities. As a representative of the region, I would like to personally continue to provide ongoing support for the districts through this.”

A staff member of the Morogoro Municipality CHMT described the effects from catalytic support in the following manner.

“Following the occurrence of a chemical reaction, a catalyst essentially remains unchanged. Yet I know that the Japanese experts as ‘catalysts’ themselves changed through our project. They learned about issues like cultural differences in the procedure and protocol for administrative duties in Tanzania and recognized our respective division of roles. As this was occurring, through a tug-of-war of sorts we stimulated each other, grew, cooperated, and built relationships of trust.”

(3) Organizing Activities Enabling Organizational Capacity Development from Individual Capacity Improvement [2-4-1 (1), 2-2-3]

For the fostering of ownership, not only an attitude like that described above, but also strategic aspects of activities that are meant to change specific behaviors of the CPs are essential.

Figure 3-5 offers a graphic illustration of the organization of four activities that serve as capacity development models conducive to organizational capacity development from individual capacity improvement. These are understood to be time-oriented development: (1) basic applied management training; (2) working groups (WGs); (3) practical applications for day-to-day work; and (4) providing opportunities to share information.

To begin with, after working to “improve managerial capacity” by training every member, “WGs” were
formed for each health challenge by selected leaders, and activities designed to determine tasks were initiated. Then “applied management training” was carried out for the members belonging to the WGs, after which the WG members would pass on the abilities that they had personally acquired to the team. These would be reflected throughout “day-to-day work,” and the teams would carry out problem solving as a whole. In this way the strengthening of organizational capacity was facilitated. What is more, the WGs themselves were expected to act as a team for the achievement of visible outcomes, with a mechanism created for all of the stakeholders to “share information” through opportunities to present these outcomes.

Training for every member related to basic management contributes to the development of individual capacity. On the other hand, by clarifying where the responsibility for leadership lies in response to each group’s mission, the WG activities strengthened their ownership as members of an organization, rather than the capacity of scattered individuals. This contributed significantly to improving the capacity of the overall organization. The “applied management training” was given a different character from the training for every member in the sense that it was implemented in a manner that was responsive to the mission for each individual for selected members. (Refer to Box 3-1)

By putting the capacity acquired through management training and the WGs to practice in day-to-day work, such capacity took hold among the RHMT/CHMTs, which thereby developed their organizational response capabilities. Furthermore, such experiences and lessons serve as outcomes which offer encouragement to a wide range of concerned parties, both domestically in Tanzania and internationally. These have been disseminated via mutual visits to other regions and organizations, presentations at international conferences, exhibitions of the tangible outcomes, and other such opportunities.

**Figure 3-5 Capacity Development Model**

Source: Sugishita (2006c)

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**(4) Utilization and Activation of Local Resources as a Foundation for Technical Support [2-4-1 (3), 2-4-2]**

Financial backing from independent revenue sources is important for the self-reliant planning and execution of health activities. As was mentioned in 2-4-2, this project promoted cost sharing of the expenses for project activities with the district governments in consideration of the sustainable development of the activities after the end of the project. The health sector basket fund that was allocated to the districts
The MHP had 63 “official CPs,” which is a large number compared to other projects. Providing training targeting every CP would have taken up considerable time (scheduling) and cost a great deal of money. It is necessary to fit elements like the time, participants, and contents into the framework for training while constantly thinking, “Will the anticipated outcomes be worth the investment?” When it comes to training methods, the most suitable method according to the objective must be selected on the basis of their respective advantages and disadvantages from the diagram below.

**Box 3-1 Separate Use of Training Methods According to Objective**

The MHP had 63 “official CPs,” which is a large number compared to other projects. Providing training targeting every CP would have taken up considerable time (scheduling) and cost a great deal of money. It is necessary to fit elements like the time, participants, and contents into the framework for training while constantly thinking, “Will the anticipated outcomes be worth the investment?” When it comes to training methods, the most suitable method according to the objective must be selected on the basis of their respective advantages and disadvantages from the diagram below.

**Comparison of Training for Every Member and Selective Training in the MHP**

<table>
<thead>
<tr>
<th>Training for every member (concerted participation from members of the same team)</th>
<th>Example of actual training</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Points of consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPR basic training, etc.</td>
<td>Improves the basic abilities of every member</td>
<td>Offices would be short-handed</td>
<td>A single training period is under 5 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enables problem solving (group work) of each team</td>
<td>High cost of training</td>
<td>Training conducted over 2 sessions (3 teams + 4 teams)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Team building</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training for every member (phased participation by members of the same team)</td>
<td>PC skills, etc.</td>
<td>Improves the basic abilities of every member</td>
<td>Members of the same team unable to discuss amongst themselves during training</td>
<td>Training participation periods (out of 2-3 sessions) adjusted because of individual schedules</td>
</tr>
<tr>
<td>(63 people total)</td>
<td></td>
<td>Offices can operate</td>
<td>High cost of training</td>
<td></td>
</tr>
<tr>
<td>Selective training</td>
<td>ORP upper level training, etc.</td>
<td>Training on advanced subjects for those responsible for the teams</td>
<td>Persons targeted limited to only some of the responsible parties</td>
<td>Requires multiple lectures and scrupulous planning and coordination</td>
</tr>
<tr>
<td>(Around 14-20 people)</td>
<td></td>
<td>Fosters sense of responsibility of the participants towards challenges</td>
<td></td>
<td>Requires DSA for weekend that falls in the middle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 day training possible from a budgeting / schedule standpoint</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Created by expert Fukushi, June 2007.

under the SWAp was actively used as an independent source of revenue for the districts. An important factor in the background to this promotion was that a sense of financial commitment for project activities was developed in the CPs themselves through their management of the WGs and the like, with this being conducive to ensuring independent sources of revenue.

Furthermore, as described in 2-4-1 (3), the facilitation of activities and collaborations with local resources like universities, research institutions, and NGOs is thought to be highly sustainable in a cost and technological sense as well. The purpose of this is to enable ongoing technical support on the ground with regards to the holding of basic and applied management training. When formulating the project, discovering technical local resources within a certain range adjacent to the project area at the earliest stage possible (until immediately after the commencement of activities at the very latest) is an extremely important task. For the future, Tanzania will disseminate and expand this model for the strengthening of local health administration management out to the entire country on its own. When this is done, it is
anticipated that these local resources will be able to act as catalysts for the strengthening of individual and organizational capacity.

The “CP’s capacity to utilize and manage local resources” is as important as accessing them. For the second round of OPR management in the MHP, the Morogoro municipality CHMT searched for and found a university lecturer on its own and commissioned the lecturer to provide consulting for just the necessary areas at a low price. Budget support-type assistance takes the position that “work that you cannot do yourselves should be consigned to a local consultant for a fee.” The MHP, on the other hand, aimed to “impair the CPs with the ability to handle issues on their own with the use of a local consultant” (sustainable pay-per-performance system). The MHP’s success will demonstrate the significance of the technical cooperation in this project as well as the validity of complementarity with budget support.

Figure 3-6 brings together the aforementioned factors that contributed to the fostering of ownership on the partner’s side based on catalytic support. This includes the configuration of activities for realizing CD, as well as providing the supporting foundation from local costs and resources used to carry out these activities in a sustainable manner.

The former RAS from the Morogoro Region described this CD process in the following way.

“CD is like building a house. When building the foundations for the house you spend an enormous amount of time and money, and you start to feel like you just squandered your money. But when the house is finished, you realize that even though you can’t see the foundations, it’s extremely important to have them for the house to stand firm.”

**Figure 3-6 Process for Strengthening Capacity that Enables Autonomous Development**
3-2-4 Coordination with Other Development Partners [2-5-5]

The positioning of the MHP’s initiatives within the entire health system has been described previously. As was mentioned, the fact that comprehensive CD support could not be implemented solely through support by JICA alone had been recognized by not only the project experts, but also those on the Tanzanian side. For this reason the contents of the request by Tanzania, which is a country in which aid coordination is advanced, were altered. The request changed from a stand alone-style project approach to project-type assistance that provides support through mutually supplementing other assistance modalities, such as budget support-type assistance based on a programme based approach.

In the case of the MHP, the goal was to position technical cooperation from the policy background of the health sector reforms, and also to acquire the expenses for the WG activities based on CP ownership from the sector basket fund. In terms of these two points, the MHP could be labeled as technical cooperation that produced development outcomes through mutually complementing other modalities in a manner consistent with the health sector program of Tanzania as a whole.

Figure 3-7 illustrates the complementarity between MHP, which is a technical cooperation project, and budget support regarding Tanzania’s health administration CD. This illustrates the fact that the foundation for the budget framework was laid through budget support, the foundation for local health management was established through a technical cooperation project, and that a model was created.

**Figure 3-7 Complementarity between JICA’s Technical Cooperation Projects and General Budget Support**

Source: Miwa (2007)
3-2-5 Visualizing the Outcomes [2-3-1, 2-5-2, 2-5-3]

(1) Setting Indicators to Measure the Outcomes

As can be understood from the characteristics above, it is important to visualize the outcomes to the extent possible and express them both internally and externally. This is essential in working to position the project outcomes in a comprehensive manner and institutionalizing them with the support and understanding of the concerned parties.

For the MHP, self-diagnoses were performed for the management capacity of the CHMTs through six indicators (schedule management, project management, coordination ability, finances, management of human and material resources, and knowledge) by means of the HSWD. This was designed to visualize the improvement of management capacity, which was considered to be difficult to measure qualitatively, in an easy to understand manner in the form of quantitative indicators.

This HWSD is characterized by “an evaluation by oneself, for oneself.” Having the CPs hold numerous consultations among those concerned with the project and establish monitoring indicators in line with the actual conditions themselves was immensely important in terms of fostering ownership. In other words, not stopping at monitoring that simply collected indicators, but rather conducting activities like the holding of emergency meetings and working out countermeasures by the CPs based upon fluctuations in the indicators resulted in autonomous activities. In this sense, creating independence for the establishment of indicators was exceptionally important in terms of the development of management.

(2) Creating Opportunities to Present the Outcomes

In the MHP, the CPs were able to actively express the fact that they felt a sense of achievement from accomplishing outcomes, as well as self-confidence in their own abilities. This was achieved by setting up venues for them to express this, including stakeholder conferences, donor conferences, public health forums, and international conferences. It has been indicated that consciously creating such opportunities is thought to have resulted in promoting endogeneity in the form of “backing up the CPs as catalysts.” Furthermore, “acknowledgment from a wide range of actors” also represents an important element in the self-reliant development from the perspective of comprehensiveness.

Simultaneously, providing the CPs with opportunities to present the outcomes on their own also led to the establishment of local networks with central government officials, health and medical facilities, responsible parties among other development partners, and more. It also had the effect of expanding the foundation for support. With this serving as the motive behind various stakeholders acknowledging the CP’s capacity, it became possible to secure the resources to support the self-reliant development of the project in a more comprehensive context.

In this manner, the fact that the CPs consciously worked to create opportunities for others to assess the outcomes of their activities is considered to be important for a CD project from the perspective of both endogeneity and comprehensiveness. What is more, monitoring and evaluation, comments, and more were provided by monitoring and evaluation teams, and related embassy officials from Japan and visitors from other projects. Such activities are felt to have been effective in actively providing encouragement to the CPs from the Japanese experts, since they served as opportunities to revise activities and to present the outcomes of these activities.
(3) Publishing Tangible Outcomes

For MHP, goals were set by framing the outcomes from activities by the WGs as visible outcomes such as “publications.” The names of the CPs themselves were listed in these publications as the authors, which was an effective incentive as a reward for the CPs’ hard work. In addition, these publications could be picked up and referred to at any time, and were thereby immensely gratifying in that they strengthened the CPs’ self-confidence and allowed them to contribute to their teams the use of these publications (Morogoro Municipality CHMT member). Moreover, producing publications was persuasive with respect to upper-level officials such as the DED and made it easy to request the expenses for CPs to participate in WG meetings (WG member). As such examples show, the creation of publications was an effective means of fostering self-reliant development through visible, concrete outcomes designed to win the understanding and cooperation of the related parties over to the project activities.