Analysis from a Capacity Development Perspective
Project for Strengthening District Health Services in the Morogoro Region, Tanzania
Challenging the Development of District Health Management and Sustainable Health Systems

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Preface

Although the term “capacity” used in “capacity development” originally refers to the “ability,” Japan International Cooperation Agency (JICA) defines it as the ability of developing countries “to set and attain goals, and to identify and solve the development issues of their own countries”; in other words “problem-solving abilities.” JICA also regards capacity development (CD) as “the ongoing process of enhancing the problem-solving abilities of developing countries by taking account of all the factors at the individual, organizational and societal levels.”

Based on the idea that CD is a useful concept in reexamining the nature of its projects, JICA attaches importance to the systematization and accumulation of lessons and experiences for future use by continuously analyzing previous cooperation activities from a CD perspective.

JICA has implemented many technical cooperation projects and programs in the health care sector in developing countries. Recently, JICA has increased its assistance to the public health services of developing country governments, not limiting it to primary health care or specific diseases. The Project for Strengthening District Health Services in the Morogoro Region in Tanzania is consonant with this trend. This project is designed to strengthen human resources and the management infrastructure for the delivery of regional health services in line with the health sector and decentralization reforms. The project has two major characteristics. First, it has had a significant impact on CD by respecting ownership and leadership by the stakeholders in Tanzania and by serving as a catalyst for networking among the various actors involved. Second, it has achieved a complementarity of modalities by taking advantage of the sector basket fund for sustainable financing.

With the focus on these characteristics, this study report has drawn lessons and made recommendations from the perspective of CD support. These lessons and recommendations suggest viable options for enhancing the capacity of developing countries in the health care and other sectors. They also provide useful suggestions as to what should be done to coordinate the cooperation modalities of different donors under the sector-wide approach.

In this way, we hope that the lessons and recommendations obtained from this research will be further deepened through on-site practice and discussions.

Finally, we would like to express again our gratitude to all those involved in the Morogoro Health Project (MHP), who responded to interviews and cooperated in the realization of the present study.

December 2007
Hiroshi KATO
Director General
Institute for International Cooperation
Japan International Cooperation Agency
Location Map
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Summary

Background and Purpose of the Case Study

Capacity Development (CD) has been attracting attention since the 1990s. This was based on the recognition that assistance in the past did not necessarily lead to sustainable development and the achievement of development outcomes in developing countries. CD is defined as “the ongoing process of enhancing the problem-solving abilities (capacity) of developing countries by taking into account all the factors at the individual, organizational, and societal levels.”

The importance of the concept of CD is articulated in the Paris Declaration on Aid Effectiveness, which was adopted in 2005. The declaration emphasized the necessity of endogenous efforts by developing countries for capacity development and of the coordinated support for such efforts by donors. Given this, how to operationalize the concept of CD into actions has become the next challenge for both developing countries and aid agencies.

This research is one of a series of case studies designed to serve as a reference in order to reflect the concept of CD in actual cooperation activities by the Japan International Cooperation Agency (JICA). It takes up the Morogoro Health Project (MHP; April 2001 to March 2007) as a case and analyzes the experience in supporting the CD of the local government, which is crucial for improving basic social services in developing countries. In particular, the case provides useful suggestions as an example of an effective CD support, where JICA’s technical cooperation has been coordinated with Tanzania’s own efforts as well as assistance by other development partners; complementing each other with other aid modalities such as a sector basket funds; and finally lead to tangible results in achieving the objectives of the Tanzanian development policy and strategies.

This study, by analyzing the MHP as a case, is intended to extract the lessons learned in planning and implementing effective technical cooperation for capacity development. It is also intended to analyze the role played by Japanese experts in supporting endogenous efforts for CD by the developing countries.

The Social and Political Environment in Tanzania: Background to the Case Study

In development assistance for Tanzania, an important factor is that two major reforms, the Health Sector Reform (HSR) and the Local Government Reform Programme (LGRP), are being actively pursued.

In 1994, the Ministry of Health and Social Welfare (MOHSW) initiated the HSR ahead of reforms in other sectors. The HSR was designed to devolve authority for health services to local government authorities. The goal was to have local government authorities that were closer to the citizens and to provide health services more effectively to the community by means of the decentralization of the health sector. Furthermore, in 1999 Health Sector Basket Fund (HSBF) through the adoption of a Sector-Wide Approach (SWAp) was examined and introduced as an independent source of revenues for local health services. This established the financial foundation for the local government authorities to independently plan and implement health activities.

Furthermore, the introduction of the LGRP in 2000 defined the roles of the central and local governments: the former formulates policies and the latter provides administrative services, including the planning, implementation, and monitoring of various projects and programs. Accordingly, in the health sector, local districts have come to carry out health and medical services on their own. As a result, the function of the MOHSW has changed to focus on the formulation of the policies as well as technical backstopping and support to the local authorities.
However, the solidification of the political and financial foundations for the reforms mentioned above, did not necessarily result in the expected provision of health services that meet local needs. Considering this fact, MOHSW introduced a policy that would give priority to strengthening the management capacity of the regional and district health administrative organizations. Against such a background, the MHP was started with the aim of taking the Morogoro Region as a pilot area and creating a model for region-district partnerships for better service delivery.

Progress and Outcomes of this Project

(1) Project Formulation Period: Project Formulation Based on the Country’s Initiative

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. For this reason, the CMO referred to requesting assistance from the experts: “I do not want them to just lend a hand to the health services, but rather to inform us of what can be done to have the region and districts continue to carry out their activities. I would like them to act as a ‘catalyst.’ ” The CMO’s expectation from the project was for “Tanzanian autonomous development.”

(2) First Half of the Project: Building Relationships of Trust through Trial and Error

During the first half of the project, an extensive situational analysis of the current status of the health facilities in the target region was conducted and routine visits to the districts were made frequently. The foundation for a horizontal network between the districts was laid through these district visits as well as through the installation of radio communications. In addition, communication between the region and the districts was also strengthened by having the members of the Regional Health Management Team (RHMT) supervise the network together. Likewise, communication between the Council Health Management Teams (CHMTs) and health facilities was enhanced through the introduction of communication tools.

Frequent discussions with the counterparts (CPs) were held from right after the start of the project in order to elaborate the specific contents of the activities and to establish the performance indicators. The approach of the experts was to play a facilitative role as catalysts contributing to the enhancement and sense of ownership and partnership on the part of the CPs. This led to the formulation of an action plan that was fully agreed and owned by the Tanzanian side. The CPs, who devoted a great deal of time to the above process, committed themselves to the project to the extent of setting objectives by themselves and carrying out their activities to achieve the objectives. Through this phase, a sense of ownership and commitment was fostered and strengthened among the CPs.

(3) Second Half of the Project: Establishing a Self-reliant Health Management System

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 Working Groups (WGs) were established for each outcome and they were introduced into all activities. As a result, since the RHMT members naturally belonged to the WGs, this WG-unit strategy expanded not only in the cross-district horizontal network but with the vertical lines of each operation. What is more, consideration was also given to “the utilization of
and cooperation with local resources,” including the latent human resources and organizational capabilities of universities, research institutions and other sources both within and outside the Morogoro Region.

By paving the way for WG activities and making other administrative officials and the general public aware of this as a tangible outcome, the commitments from district and regional governors were augmented. In addition, the idea of contributing various expenses incumbent on the project activities via district health budgets also came to be examined due to this. Thus, it 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.

(4) From the Extension Period through to Project Completion

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.

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. 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.

At the same time, for the experiences and activities that were organized and made into educational materials by the CPs themselves, opportunities were provided to present them externally, and a program of mutual visits to examine the feasibility of applying them in other regions was conducted. Through this, the confidence of the CPs was fostered and a foundation was laid for dissemination and expansion.

Features of and Lessons from MHP from a CD Perspective

(1) A Sustainable Health System from a Comprehensive Perspective

Figure 1 is an image of the health system that comprehensively illustrates the respective ways in which the central government, regional governments, district governments, and communities are all involved through the MHP.

![Figure 1 Sustainable Health System](image-url)
As the above figure shows, 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 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.

(2) Ownership

There are believed to be two significant sets of factors behind the fostering of ownership on the Tanzanian side through the MHP. The first is the attitudinal factors between the parties of Japan and Tanzania in which the Tanzanian side took the lead in project formulation and planning, while Japanese experts provided catalytic support. The other is the strategic factors, in which the configuration of project activities and local resources were utilized until a system was set up in which RHMT/CHMTs worked to address health problems within the region as a team.

For the “catalytic support” which constitutes the focal point of the attitudinal factors, RHMT/CHMTs did not wait for instructions from the central government. Instead, such support was characterized by an emphasis on Japanese experts and CPs thinking together and learning from one another in order to allow for the implementation of health services independently and flexibly at the regional level. This posture of serving as catalysts also serves to explain the importance of the presence of the Japanese experts as foreigners. It was precisely because they served as “catalysts” for a limited period that they were at times able to play an intermediary role between the various stakeholders, as well as occasionally proposing ideas from a different point of view. Due to their genuine “interaction” through mutually thinking together and learning from one another, CPs that were imbued with leadership capabilities were fostered. Along with this, teamwork was created among the CHMTs as well as the WGs that were formed for each health issue. It can be said that these facts comprise the quintessence of catalytic support.

Figure 2 denotes this catalytic support in a more systematic manner, expressing this concept by means of the 5Es (Exposure, Empowerment, Enhancement, Exercise, and Excitement).
As for the strategic factors, Figure 3 compiles the process for raising independently developed local health services. This combines 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.
“Management training” was basically carried out at the “WG-level,” and the different members applied the capacity that they acquired throughout their “daily activities.” Through opportunities to publicize the outcomes of this, “information sharing” was conducted with all of the stakeholders, which in turn promoted the strengthening of organizational capacity.

As a support strategy for autonomous development, “cost sharing” was facilitated for project activity expenses targeting the district governments within the project. Independent revenue sources were proactively utilized in the health basket fund which was allotted to districts through the SWAp. Moreover, the promotion of activities and collaboration with “local resources” such as universities, research institutions, and Non-Governmental Organizations (NGOs) is thought to be highly sustainable in a cost and technological sense as well. While accessing local resources, it is important that the capacity to utilize and manage local resources should be imparted to the CPs.

(3) Visualizing the Outcomes

In aiming to position project outcomes in a comprehensive manner and enforcing them through the understanding and support of the concerned parties, it is essential to visualize the outcomes and express them internally and externally to the extent possible. For the MHP, the management capacity of the various health administration teams was visualized in an easily understood manner through the six qualitative indicators of the Hexagon-Spider-Web-Diagram (HSWD).

Moreover, the outcomes from activities by the WGs were turned into visible outcomes such as “publications,” and the CPs consciously created venues to publicize these both internally and externally. This not only promoted endogeneity in the form of “backing up CPs as catalysts,” but from the perspective of comprehensiveness “acknowledgement from a wide range of actors” also served as an important component for autonomous development.

Lessons for Future Technical Cooperation

(1) Perspective of Comprehensiveness: Creation of an Autonomous Development System and Comprehensive Consideration

The three pillars of policy, financial, and management aspects are essential for the creation of an autonomous development system. Figure 4 illustrates the sort of policies that are required of each of these from the three foundations that are bolstering sectoral reforms.

Figure 4 Three Foundations of the Tanzanian Health Sector

Source: Sugishita (2006a) p. 117
Summary

From this figure, it can be seen how strengthening the policies of the government in the partner country as well as the budget support backing this up are required in order to enhance the policy and financial foundations. This inevitably entails coordination between the government and the development partners, as well as among the development partners, as a prerequisite. Strengthening the capacity of the management foundations in local areas is needed over and above the policy and financial foundations in order for the organizations and individuals of the partner country to carry out projects independently. The claim could be made that the catalytic support from the MHP contributed in this area.

When providing CD support, it is necessary to examine development visions based on assessments of the capacity on the ground from the three foundations adopting a comprehensive perspective. The outcomes of this are then used to ascertain bottlenecks and accurately narrow down entry points for support. At the same time, it is indispensable that not only the direct targets of support, but also actors who are involved in the initiatives from the three foundations be attracted from a wide spectrum and incorporated into stages such as implementation.

When this is done, various different schemes, such as policy advisors and development studies, will be devoted to the multilevel organizations of the partner country, such as the central and regional governments, as well as government agencies for planning and implementation. This should be done on account of the limitations that are present at the project level, and will likely result in making it possible to further expand project outcomes. From this perspective, the strategic formation of a “JICA program” is sought.

(2) Perspective of Endogeneity: Peripheral Support Emphasizing the Self-reliance of Developing Countries

For the sake of supporting the CD of the partner country, consideration must be given to mechanisms to foster a sense of ownership on the part of the partner country through the support process. It is necessary to specifically clarify the extent to which the counterpart side is willing to make commitments in a policy, financial, and personnel sense to the project from the project formulation stage. If this cannot be elicited from them satisfactorily, then a resolution to go so far as suspending the cooperation is necessary.

Cost sharing with the partner country will not be achieved easily; it is something that should be examined from the project formulation and implementation stages over a medium- to long-term time frame. When performing this, it goes without saying that the project should be positioned upon the policy foundations of the partner country. It is also necessary to call attention to the significance of activities and their outcomes that are sufficient to convince the developing countries to bear the financial costs.

(3) Systemization and CD Support Period for the sake of Positioning Self-reliant Initiatives

Starting during the project implementation period, it is essential to systematize the project outcomes from a policy-wise institutional point of view, and also to give rise to a cycle of strengthening self organization. The purpose of this is to set in place initiatives from the project as independent efforts of the partner country after the end of cooperation from JICA.

When considered from the partner country’s program orientation, developing partners should think about support on the basis of a medium- to long-term outlook. However, this is not necessarily the same as implementing CD support projects over a long time frame. In the event that CD demonstrates enhancement of the self-reliant problem-solving abilities of the partner country, then consideration must be given to somehow transitioning to self-reliant initiatives by the partner country without support, on the premise that CD support from the development partners has a definite end point.
Introduction

1. Background and Purpose of the Case Study

In recent years, growing importance has been attached to capacity development (CD) in international efforts towards increased aid effectiveness and the achievement of development results. CD has been attracting attention since the 1990s. This was based on the recognition that assistance in the past did not necessarily lead to sustainable development and the achievement of development outcomes in the developing countries. CD is defined as “the ongoing process of enhancing the problem-solving abilities (capacity) of developing countries by taking into account all the factors at the individual, organizational, and societal levels.”

“Problem-solving abilities” refer to the “ability to set and achieve objectives” and the “ability to identify and resolve development issues.” The first feature of the concept of capacity development (CD) is the emphasis on the developing countries’ ownership and leadership in solving development problems by themselves. Secondly, by defining capacity as “problem-solving abilities,” the CD concept lays stress on the endogenous nature of CD. This means that capacity is not something to be transferred from outside, but rather something that continuously develops through the endogenous efforts of the developing countries themselves. This is based upon reflections which concluded that a large proportion of past assistance has undermined the existing capacity of the developing countries and attempted to make a simple transfer of the technology, knowledge, and systems of the developed countries from the outside. Under the concept of CD, the development partners are required to provide assistance in such a way that it fully utilizes the existing capacity of developing countries and supports their endogenous efforts by operating as a “catalyst.” The third characteristic of the CD concept is the understanding of capacity as aggregate of diverse elements and of CD as a dynamic process of change through the interaction of these elements. It is recognized that successful efforts to promote CD require attention not only to capacity at the individual and organizational levels, but also to the policies, institutions, and systems that serve as the enabling environment which influences the behaviour of the individuals and organizations.

The concept of CD as mentioned above has been elaborated through a series of studies by the United Nations Development Programme (UNDP) and discussions at such international fora as the Organisation for Economic Co-operation and Development’s Development Assistance Committee (OECD/DAC). The concept is now internationally accepted; and the importance of CD is widely recognized by developing countries and donor countries alike as a means for the improvement of aid and development effectiveness. In particular, the importance of CD is highlighted as a critical element in achieving development objectives and is clearly specified in the Paris Declaration on Aid Effectiveness, which was adopted in 2005 by more than 100 countries. The declaration articulated the necessity of endogenous efforts by developing countries for capacity development and the need for coordinated support from development partners for these efforts. Given this, how to operationalize the concept of CD into actions has become the next challenge for both developing countries and aid agencies.

The Japan International Cooperation Agency (JICA) has actively taken part in international discussions on CD and has also made efforts to reflect the concept of CD in its assistance, having established CD as the objective of its technical cooperation. As part of such efforts, it has published a report entitled “Towards Capacity Development (CD) of Developing Countries Based on their Ownership (2006),”
which describes the relationship between the concept of CD and JICA’s cooperation. In addition, it has conducted a series of case studies designed to serve as a reference in order to reflect the concept of CD in its assistance. This study takes up as one of its case studies the Morogoro Health Project (MHP; April 2001 to March 2007) and analyzes the experience in supporting the CD of the local government, which is crucial for improving basic social services in developing countries.

In Tanzania, Health Sector Reform (HSR) has been promoted as a national policy since the middle of the 1990s, and the decentralization of health services has been advanced. Furthermore, against this background, as a part of efforts under the Sector-Wide Approach (SWAp), Health Sector Basket Fund (HSBF) was introduced to ensure independent revenue sources for the local health services. This allowed the reinforcement of the financial foundations to promote decentralization under the HSR. However, it has been gradually recognized that the weak human resources and management capacity have impeded the efforts of local governments to fulfill the responsibilities transferred to them from the central government and provide effective health services.

The MHP has been carried out, through a pilot project in the Morogoro region, to establish a model to strengthen the comprehensive capacity of the local governments to plan, implement, and manage public health services that meet the needs of the community. The main target of the project was the district governments that deliver health services, and the regional government, which plays a guiding and supervisory role with respect to the district governments.

Comprehensive CD support for local government authorities is a new area of assistance for JICA, so it came down to a trial and error situation. Furthermore, at the time that the MHP was initiated, the concept of CD described above had not yet been established internationally. Therefore, the cooperation was not necessarily carried out with a full awareness of the CD concept from the beginning. However, the end result was that MHP turned out to be an excellent CD initiative in a number of ways. These include factors such as: (1) the emphasis on country ownership and leadership; (2) the support for endogenous efforts in a facilitative manner; (3) the comprehensive approach to CD; and (4) the establishment of a sustainable system through cooperation with a diverse range of actors and networking.

Furthermore, in the MHP, the CD support was conducted (1) based upon the Tanzanian development policy and strategies, (2) being coordinated through the country’s own efforts as well as assistance from other development partners, and (3) in a way that complemented other aid modalities such as the sector basket fund. Thus, it produced tangible results in achieving the objectives of the development policies and objectives. The importance of such issues as alignment, coordinated support, and complementarity are emphasized internationally to enhance aid effectiveness. Given this situation, the experience of the MHP is considered to have provided many useful suggestions as an example of CD support.

This case study, by analyzing the MHP, is intended to extract the lessons learned in the planning and implementation of effective technical cooperation for capacity development. It is also intended to analyze the role played by Japanese experts in supporting endogenous efforts for CD by the developing countries.

2. Methodology of the Case Study

For this case study report, reference was made to the outcomes of the field study prepared by a consultant. The analysis and writing were carried out jointly by the Research Group of the JICA Institute for International Cooperation, the Health Administration Team (Group Ⅳ) of the Human Development Department, JICA Tanzania office, and a consultant.

The following members were involved in carrying out this case study.
As shown in Table 0-1, the framework for this case study is comprised of “Basic Analysis Perspectives” and “Points of Analysis.” It was conducted by reviewing the processes from project formulation through to implementation and evaluation in chronological order and extracting factors which may serve as lessons.

For this study, information was collected and analyses were performed by reviewing the literature, such as related reports, materials, publications, as well as conducting interviews with the concerned parties on both the Tanzanian and Japanese sides and by other means. The field study itinerary (February 3 - March 2, 2007) can be found by referring to Appendix 1, while the interview lists can be found by referring to Appendix 2 and 3, respectively.
Table 0-1 Case Analysis Perspectives and Points

<table>
<thead>
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<th>Basic Analysis Perspectives</th>
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<tbody>
<tr>
<td>Did it have consistency with the SWAp within the framework of bilateral technical support and development aid coordination? Was it somehow harmoniously positioned as a CD project in the health sector while placing value on the independence of and autonomous development by the Counterpart (CP)? Was it implemented effectively and efficiently and achieve outcomes?</td>
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<th>Points of Analysis</th>
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<tr>
<td>1. Project Design</td>
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<tr>
<td>1) Was the project positioned and formulated with the objective of reforming the health system in a manner consistent with the SWAp?</td>
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<tr>
<td>2) How were the responsibilities and roles of the Tanzanian stakeholders coordinated in the project amidst the changing relationship between the central and local governments due to decentralization?</td>
</tr>
<tr>
<td>3) In what manner were the project design and implementation structure created in response to the changing policy environment and unique regional characteristics of the partner country during the project implementation stage?</td>
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| 2. Process of improving CD (endogeneity / comprehensiveness) in the project |
| 1) Through what process were the attitudes, ownership, and so on of concerned officials in the partner country (central, local governments) fostered in this project? |
| 2) In what manner was the implementation process for this project, which was arranged as catalytic support, evaluated from a CD (endogeneity) perspective, and is there the possibility of sharing this as a valid approach? |
| 3) What sort of schemes were employed to assess the aforementioned changes? (establishment of indicators, etc.) |
| 4) What sorts of schemes were there for the planning of the project activities on the Japanese side? |

| 3. Challenges for systematization (including performance reviews and future prospects) |
| 1) How were business models for the sustained delivery of services established throughout local areas through CD projects in the local health sector? |
| 2) What should be done to enable Morogoro’s experience to be applied to other regions? |
| 3) How will Morogoro’s experiences be systematized through the central government? |
| 4) How should an independent, sustainable structure be established to provide feedback on the outcomes from this case by combining SWAp and decentralization policies? |
| 5) In the future, how should the attention of other development partners be called to the initiatives from this case? How can it be harmonized with the initiatives of other development partners? |

| 4. Role of major actors in overall project activities |
| 1) How were the departments in charge in the JICA headquarters, JICA Tanzania office, Japan embassy in Tanzania, other health experts active on the ground, the domestic support committee, and others involved in project management? Were there any points or issues devised for things like the implementation, monitoring, and evaluation of CD projects? |
| 2) How were local resources utilized in order to ensure the operation and continuity of effective CD projects? |
| 3) What sort of transitions did the catalytic support from Japanese experts undergo over the four stages from the project’s initial stage, to its mid-term, completion, and extension periods in order to foster the ownership of the Tanzanian side? |
| 4) In what manner were Japanese experts and the JICA Tanzania office involved in ensuring financial autonomous development via cost sharing with the Tanzanian Government (local municipal governments, etc.) |
| 5) What were the CD effects of technical cooperation by way of cooperation modalities? |

Source: CD Case Study of the Morogoro Health Project (MHP), public tender documents
3. Composition of this Report

This report is composed of four chapters in total.

Chapter 1 gives a general outline of Tanzania’s HSR and Local Government Reform Programme (LGRP) as the background to the formation of this project. It will describe how the mechanism for providing local health services has changed and what responses the Tanzanian Government has taken.

Based on the political background mentioned in Chapter 1, Chapter 2 follows up on the process of how the project was requested, formulated, and implemented, and will reveal the manner in which a method of trial and error was carried out between the Tanzanian side and Japanese experts.

Chapter 3 will take up the implementation process delineated in Chapter 2 and reexamine it from a CD perspective. This chapter will organize subjects like the outcomes and challenges at the individual, organizational, institutional, and social levels, as well as features of this case project and schemes put into practice by it.

Finally, based on the lessons in this implementation process suggestions and proposals for the implementation and operation of future technical cooperation will be compiled in Chapter 4 from the perspectives of “complexity” and “endogeneity.”

Source: Created by the Authors