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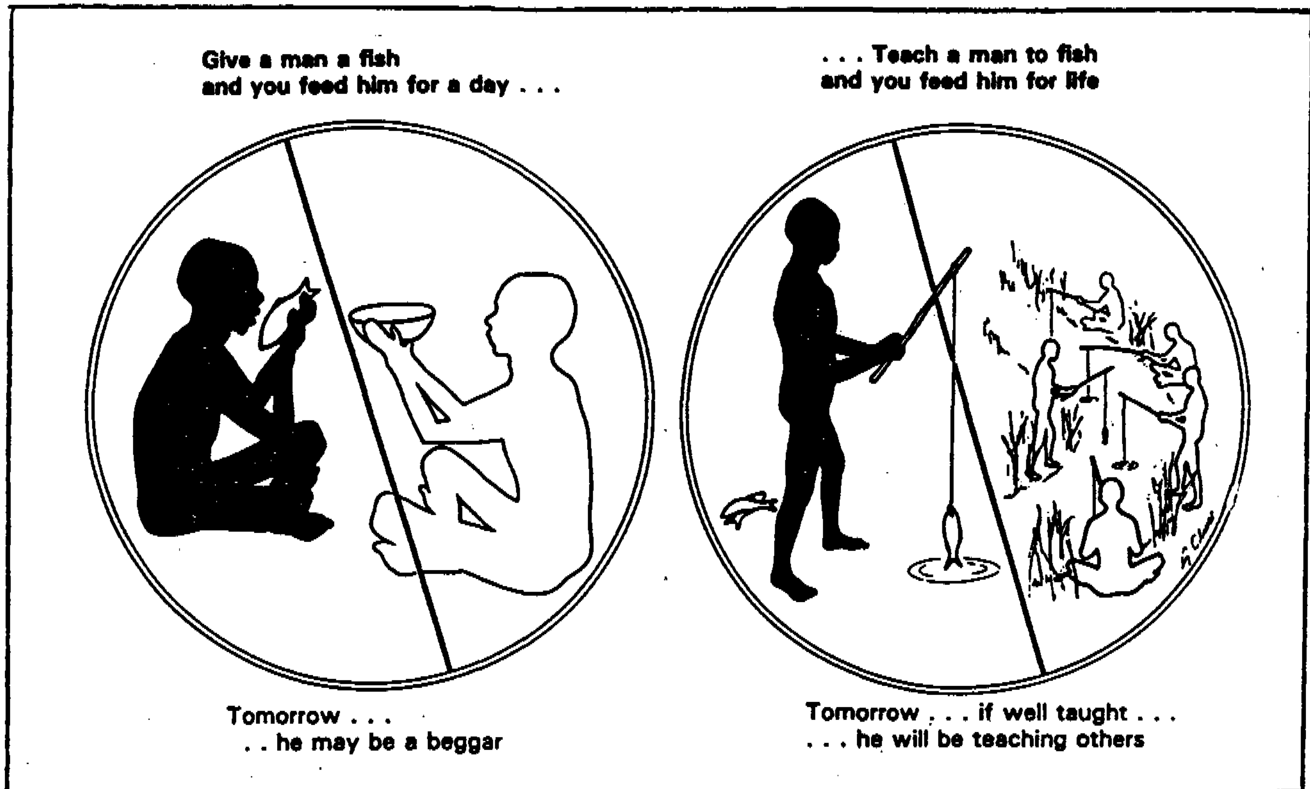
The Art of Survival

A study on sustainability in health projects



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Dar Es Salaam and Stockholm
January 1991

814-TZ91- 8950

This report is the result of two missions to Tanzania during October- December, 1990. The team consisted of Dr. Lillemor Andersson-Brolin, sociologist, team-leader, Dr. Birgitta Lorentzson, medical doctor, Mr. Ole-Memiri, auditor, Dr. Daniel Ndagala, social anthropologist, and Mrs Elisabeth Michanek, evaluation analyst, SIDA, who participated in the second mission. The views and interpretations expressed in the report are those of the authors.

ISN 0950
814 TZ91

Cover Illustration: From D. Morley and H. Lovel. *My name is Today*, Talc 1986

But of the
best of leaders
When their task
is accomplished
Their work is done
The people all remark
"We have done it
ourselves"

Lao Tsu, 500 B.C.

Executive summary

The rationale of the study

During the last few years donors have become increasingly aware of the lack of *sustainability* of development assistance programmes, as difficulties often arise when support is withdrawn.

In order to obtain more knowledge on the issue of long-lasting effects, SIDA and four Swedish Church denominations decided to make a study together on health care support to Tanzania. Both SIDA and the denominations have experience of cooperation within that sector. SIDA has assisted the Government of Tanzania with the construction of more than half of all rural health centres in the country. The four denominations have assisted their Sister Churches with dispensaries and hospitals.

A supposition was that Church dispensaries and the Government health centres have many similarities but differ in one respect - sustainability. Therefore the two types of health facilities were selected as objects of the study.

An exploratory study

A number of factors that generally influence the sustainability of a programme were identified. The main aim of the study was to test the relevance of these factors in the actual health care programmes. However, during the study, it became necessary to clarify and elaborate fruitful concepts to be used, before going into any analysis. Conceptual discussions and descriptions therefore make up a considerable part of the report.

In order to try to find factors that could be systematically related to sustainability four voluntary agency dispensaries were selected. Each of these dispensaries were matched with the closest government health centre which was seen as a "twin facility".

Working definition of sustainability

In order for a programme to be defined as sustainable Tanzanians should have primary responsibility for the service, the institutional capacity and commitment to carry it forward and the ability to mobilize the necessary resources to maintain it.

The programme (health facility) should consequently be both self-reliant and offer a service of high quality. Self-reliance was assessed from the viewpoints of administration, financing and the health care provided.

The data-collection

Information from as many different sources as possible was collected. *Individual interviews* were made on the local level with staff members, patients, congregation members, pastors and other church representatives, community leaders, and representatives for women's groups. Informants on district and regional levels were also interviewed. The interviews were semi-structured and adapted to the actual target group. Moreover, a number of *focus group discussions* were carried out within the community.

Systematic observations were made at the health institutions: the quality of the service, the equipment, supply, transport and the physical status of the buildings was observed and assessed. Furthermore, *statistics were reviewed, budgets and financial reports examined.*

Findings

Health care programmes run by the Government and programmes, or projects, run by voluntary agencies (VAs) differ as to both objectives and decision-making levels:

* The main goal of the government programmes is to offer service free of charge to all Tanzanians. The main goal of a sustainable health facility run by a voluntary agency is to offer service of high quality that is in great demand, and which is paid for by the patients. The main difference between the VA dispensaries and the government health centres is the curative care. The high quality at the VA health facilities attracts a lot of patients who in fact should have gone to a government facility.

* Government rural health centres are deliberately dependent on central resources. The possibilities for individual initiatives at the centres are therefore limited. If a voluntary agency dispensary is to survive, such initiatives are however necessary. Each of the VA dispensaries has its own budget, income and expenditure. The government health centres have no cash whatsoever at their disposal, and as a consequence of this they cannot even pay for minor repair of instruments, equipment or the vehicle belonging to the the centre.

These principle differences imply that *the most important factors related to sustainability are to be found at different levels.*

This is particularly valid for the financing aspects. The difficult macro-economic situation in Tanzania aggravates for example sustainability within all social sectors, and few of the government rural health centres can play the role in the primary health care programme that they are supposed to play.

The situation of the health institutions run by the churches is different. The dispensaries can best be described as small local health care enterprises with a committed staff. However, the road towards sustainability is not always easy.
In the study we found that the following preconditions have to be fulfilled:

A good reputation. The most important precondition for a VA health facility to be sustainable is a continous stream of satisfied patients. Consequently, when the patients were asked what they thought they could do for the health institution, many answered: *Tell others about the good service!*

Creating local income. All church dispensaries studied have chosen to charge patient fees, which mainly consist of sale of drugs. A precondition for having an income from the sale of drugs is that the dispensary obtains the drugs at a subsidized price from different donors as well as from the essential drugs programme. It is also necessary that the health facility buys and keeps the adequate stock of drugs. Hence, the management capability of the health facility is very important. Relying heavily on drugs for financial sustainability is however a risky matter and furthers development towards curative care.

It is also very much dependent on macro-economic development. The situation in one of the VA dispensaries could be used as an example. In 1979 90% of the running costs were covered by patient fees in that HF. In 1989 the corresponding figure was 45%. This change can be explained by increased expenses such as staff salaries and purchase of drugs.

Furthermore, the sale of drugs is very much related to both insufficient preventive health care in the surrounding community and to lack of drugs in governmental health facilities, a situation that will hopefully change in the future.

Minimizing the staff. Another precondition for a Voluntary Agency health facility to be financially sustainable is to have as few staff members as possible. The dispensary identified as most self-sufficient is in fact understaffed by as much as 40% in comparison to government rural health centres. In the long run, the staff question has to be solved by assistance from the Government through staff grants or/and seconded staff.

Promoting the staff. The trained staff at the (most) sustainable dispensary has remained there longer than at any other of the VA facilities studied.. This is explained by the fact that the staff is encouraged by up-grading, by scholarships and other incentives during studies. Stressing common values and a *"we-feeling"* are also of importance.

Adapting transport means to the financial situation. The VA dispensary that is financially self-reliant cannot afford to buy a car for referrals, out-reach activities or mobile clinics.This implies that it is only possible to keep a high service quality outside the health facility if other transport means are available. However, it seems as if missionaries have often chosen remote places, where no public transport exists. In these cases, sustainability may be reached at the expense of a deteriorated service quality outside the health facility itself.

Caution as to expansion. Financial self-sufficiency is related to a certain defined service level. When, in the case of expansion, the health facilities obtain support from abroad in the form of capital investments, such as buildings, expenses increase.

Experience shows that problems easily arise, and that support from outside is often needed for maintenance and salaries.

Skilful management. In order to fulfil the preconditions above a skilful management of the health institution is needed. If the administration does not function very well, if the person in charge does not plan and follow-up activities, the number of patients coming for curative service might decrease.

A solid and/or equal community. It is evident that there is a variation between communities as to the ability to pay patient fees, and in some of the VA health facilities the number of unpaid bills was high. This is particularly valid for transport costs for referrals to hospital.

Sometimes, there is also a variation within a community. Women for example complained about the patient fees more often than men. This was particularly the case when the women had to use their scanty resources for health care for the whole family.

A tie to the local church. A good relationship between the person in charge and the local church is another necessary precondition for a church health facility to remain self-reliant and to be able to maintain an adequate quality. For a sustainable health facility the church plays the role of safety-net in case of problems. For facilities that are not (yet) self-reliant the church has the permanent role of life-line. However, in most of the cases studied the local congregation is little involved, in spite of the fact that it is a potential resource for all the VA health facilities.

The positive policy of the government. Without the positive attitude that the authorities show towards the voluntary agencies and their facilities, these health facilities would not be able to exist.

The quality of the government health care. The situation of a single voluntary agency health facility is also very much related to the prevailing national health care context. At the moment the health care system is not functioning, and many persons who need care prefer the VA institutions and pay fees, often because they have no alternative. If the government health care is improved, the VA dispensaries will be in another situation and will have to change strategy.

Some suggested factors that were investigated did not show any clear and direct relationship with sustainability. This does not necessarily mean that there is no relationship between these factors and sustainability, but that the factors are not *necessary* preconditions.

No clear correlation was found between *planning procedures, scale of projects* or *length of time of donors' involvement* on one hand and degree of sustainability on the other. A long-term involvement may further sustainability but it may also prevent such a development and make a certain dependence permanent. The scale of a project is not directly related to sustainability, even though it seems as if a small project more easily can adapt to necessary changes than a large project. *Involvement* of the recipient country in the planning process does not guarantee sustainability unless the long-term capacity to maintain the activities is assessed. Sometimes support from

abroad in the form of capital investments is offered too generously. In this way sustainability is hampered. Further, given the actual situation within health care, the VA health facilities would not function if they were dependent on, and *an integral part of* the government health care structure.

In general, there is *little contact between the health facilities and the local community*. Both community leaders and women's groups expressed a will and interest to assist when necessary, if they were contacted. They consider however the government health centres as belonging to the government and the VA dispensaries as belonging to the "mission", "missionaries" or "the church", and did not want to interfere, if not asked.

The church dispensaries studied have no continous contact with the local communities and do not involve the local congregations as much as they could.

One *suggestion* for the future is therefore to involve both the local community and the local congregation more in the activities of the health facilities. It is also suggested that VAs invite representatives of the local governments, both on local and district level, for advice and exchange of ideas about the activities at the health institutions. Another suggestion for the future is that the VA health facilities discuss and elaborate alternative sources of income in addition to sale of drugs.

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1. Background

1.1 The issue of sustainability

During the last few years, donors have become increasingly aware of the lack of observable *sustainability* in development assistance projects. Activities which have received financial, material and technical assistance for many years often experience serious difficulties when this support is withdrawn. (OECD, 1989) More and more donors are now discussing how the assistance programmes could achieve long-term improvements and achieve a lasting impact.

1.2 Why the Tanzanian health care sector?

SIDA suggested a study and concluded that the health sector in Tanzania could be suitable, as Swedish support to the health sector in Tanzania has been carried out over a long period both by SIDA and by Non-Governmental Organizations (NGOs), primarily four Swedish church denominations. As the two types of cooperation are different, it was supposed results would differ as to sustainability.

The SIDA assistance has taken various forms: financial, technical, and human resources have been transferred to the Government of Tanzania. The cooperation rests on agreements, signed after negotiations, and generally spanning over a period of three or four years.

The four Swedish denominations, *Church of Sweden Mission, The Swedish Evangelical Mission, The Swedish Holiness Mission, and The Swedish Pentecostal Mission* support their Sister Churches, which are *The Evangelical Lutheran Church of Tanzania (ELCT)* and *The Pentecostal Church Association of Tanzania (PCAT)*. The relationship is perceived as a deep, reciprocal relationship between sisters, and the Swedish denomination supports the Tanzanian sister church as long as, and whenever, she needs assistance. Such a relationship has no time limit, even though the Swedish churches try to reduce the dependency, and it is not uncommon that it lasts for forty, fifty years. Assistance to a health institution can have the same time span, as it continues as long as the sister church expresses need for it.

2. Aim and methodology

2.1 Aim of the study

The principle aim of the study was formulated by SIDA and the four Swedish denominations together as increasing the knowledge of circumstances contributing to, or hindering, successful sustainable development assistance. (See further appendix 1) Even though the study is limited to support within the health care sector, efforts were to be made to find general concepts and to identify general obstacles and options for projects and programmes in generating sustainability.

During the study it turned out that there was a lack of adequate information. The descriptive part therefore came to demand more time than planned. Before being able to analyse *why* a health institution is or is not sustainable, it was necessary to find out *whether* it is or is not sustainable! Furthermore, the necessity of clarifying and discussing relevant concepts became more pronounced. These circumstances made the study more exploratory than intended from the beginning. The study should therefore rather be looked upon as a basis for discussion than a document for decision-making.

2.2 Rural Health Facilities (RHFs) in focus

In order to be able to make a comparison between the SIDA support and the support from the Swedish Churches fairly similar activities or projects had to be chosen. Closest to hand was support to health facilities. (HFs) SIDA has supported the Tanzanian Government by constructing more than one hundred rural health centres (RHCs), i. e. about half of all existing government-managed RHCs. These health centres had been evaluted in 1986, and information from that study was considered to be relevant.

The Swedish denominations support seven hospitals and 49 dispensaries in Tanzania. The dispensaries were assumed to be more or less equivalent to government health centres, and it was decided to focus the study on the church dispensaries, having government rural health centres as points of reference and as a basis for comparison.

Each of the four Swedish denominations selected one dispensary to be included in the study. One criterion was that it should be "as much Tanzanian as possible", but as adequate data were not always available also practical reasons were considered.

The nearest government health centre to each of the selected church dispensaries was included as a "twin institution". *Certain* comparisons were made between the church dispensary and its "twin". The short time the team visited the government health centres did not however allow any ambitious comparison. We could state that the situation for the government RHCs has not changed very much since 1986, when a thorough evaluation was made. (L. Andersson-Brolin et al, SIDA 1987). For comparisons we would therefore like to propose that the readers consult the earlier evaluation as a complement to this study.

In summary, the studied health institutions are few and cannot be considered representative in a statistical sense.

All four Swedish denominations work in remote and different areas and to reach the dispensaries implied many travel days. Once at a dispensary, the team therefore made use of all opportunities also to contact other health facilities in the vicinity and to interview interested parties. (see appendix 4)

2.3 Data-collection

The information in this report has mainly been collected during two periods of field work during 1990. (Oct 12-30, and Nov 25 - Dec 13)

In order to avoid systematic biases, the team tried to combine different methods and to collect information from many differing sources.

Individual interviews or interviews in small groups were made with all staff members, patients, congregation members, pastors and other church leaders, community leaders, community representatives, women's groups, informants on the central level in the sister churches, representatives of local governments and Ministry of Health, district and regional medical officers, missionaries, researchers, and SIDA programme officers. These interviews were semi-structured and adapted to each target group.

Focus group discussions were carried out within the community, and *in-depth interviews* made with mothers visiting the health facilities, in-patients and their relatives. On an average 50-60 persons were interviewed for each church dispensary.

Moreover, *systematic observations,* using prepared schemes, were made at the health facilities of the quality of: the service, supply, equipment, transport, and the physical status of the buildings. *Statistics* were reviewed, and the *budget examined* by the auditor in the team.

2.4 Limitations of the study

We would like to point out that *the study is exploratory*. The ambition was to find general factors related to sustainability. However, the reality turned out to be different, and the phenomenon of sustainability both more rare and more complex than previously thought. The investigation should consequently be considered as a series of case studies raising issues to be analysed more deeply in further studies.

Furthermore, as in most studies carried out during a short time period, there are many possibilities of mistakes and misunderstandings. Both reliability and validity of the findings may therefore be questioned.

3. Some key concepts

3.1 Sustainability

The origin of the concept sustainability is not clear. It does not exist in ordinary English dictionaries and seems to have been created rather recently. Since the Norwegian Prime Minister Gro Harlem Brundtland used it in connection with a conference on the environment in 1987 the concept has appeared in different contexts, and is often used by international aid organizations.

It is obvious that the concept sustainability is perceived very differently. The recipient countries often consider it a failure when a donor leaves a sector, or finishes the cooperation after the termination of an agreement. On the donors' part, help to self-help has however long been an important guideline for assistance.

According to an OECD document sustainability is "survival of projects and programs after an initial period of investment - financial, physical, or technological" (OECD, 1989). *"Bärkraftighet"* has been mentioned as the corresponding Swedish word. The concept refers to the continuation of projects and programmes after the termination of assistance from an external donor. "A development programme is sustainable when it is able to deliver an appropriate level of benefits for an extended period of time *after* major financial, managerial, and technical assistance from an external donor is terminated". (OECD, 1989, p.13)

The OECD group states that a programme need not be totally supported by local resources in order to be defined as sustainable. The objective of development assistance is not necessarily to make a country self-sufficient but self-reliant. Circumstances may call for co-operation in solving special problems that threaten post-project operations, such as short-term technical consultations, or commodity support.

The sustainable programme is characterized by the developing country having *the primary responsibility* for the activity, *the institutional capacity and commitment* to carry it forward, and *the ability to mobilize the necessary resources* to maintain it. (OECD, p 16)

The above-mentioned definition has a correspondence in reality. Sometimes the concept of sustainability is, however, used very vaguely and contains probabilities. A project can *be supposed* to have great chances of survival and of achieving sustained development activities, and thereby be defined as "a sustainable project". Using the concept like this, implies a *judgment of expected outcome* in the future. The final result, a successful, i.e. a sustained development, is not yet at hand.

Such a definition is not very useful in an empirical study, as the concept has to be "operationalized", i. e. it has to be transformed into measurabale indicators, and divided into various dimensions.

3.2 Handing over - Taking over

During the preparation of the study it was suggested that the act of handing over of a dispensary should be used as the main indicator of sustainability. The dispensary was assumed to be both self-reliant and self-sufficient when this act took place.

However, it gradually turned out that the concept of handing over is impaired by at least two obscurities.

Firstly, the very concept of handing over was questioned by representatives of the Evangelical Lutheran Church. These state that the initiative for all projects lies in the hands of ELCT, which turns to sister churches all over the world for possible assistance to implement the proposals.

Secondly, it was found that, in the cases where a dispensary had been "handed over" this was but a formal act. The sister church becomes the *owner* of the buildings, but this does not affect the responsibility patterns in the daily work at the health facility or the character of the cooperation between the Swedish denomination and the sister church. External assistance tends to continue after the handing over.

Taking the mentioned obscurities into consideration the concept of *handing over* or *taking over are not very fruitful* in a study like this, and other indicators of sustainability had to be created.

3.3 Self-reliance, quality and sustainability

During the field work we found out that external assistance is still very common within the Volontary Agency health facilities. The concept of sustainability consequently had to be examined in order to become a useful working tool, and we decided to break it up into two concepts: *self-reliance and quality.*

Self-reliance was used to describe the degree of Tanzanization in relation to foreign influence. When looking at the health facilities we found that it was fruitful to split up this concept in different aspects. An institution could be self-reliant as to *human, material and/or financial resources:* In some cases only the medical staff is Tanzanian, in others both the medical care and the administration is in the hands of Tanzanians. Some church health institutions receive funds from abroad, others do not.

Health facilities where Tanzanians have the main responsibility were defined as self-reliant, and the Government rural health centres are consequently self-reliant by definition as they are an integral part of the health care sector.(but see also 3.5)

The *quality* aspect is important. Self-reliance is only a necessary, not a sufficient precondition for a health facility to be sustainable. In this connection an interesting question is how the quality of the service is related to self-reliance. Does for example self-reliance mean that the quality must decrease?

3.4 Missions, missionaries and church health facilities

The health facilities owned by Tanzanian denominations are generally erroneously called mission dispensaries, mission health centres and mission hospitals not only by the public, but also by patients and even by staff. Officially, the churches are called *Voluntary Agencies (VAs)*, a name that has also been chosen in this report. Furthermore, the abbreviation *VAHF* has been used for *Voluntary Agency Health Facility*.

3.5 Projects and programmes

When observing and analysing sustainability it is important to distinguish between two levels, i. e. to decide the *unit of analysis*. In the case of a health facility one can look at the institution *per se*, and one can look at it as a part of the whole health care structure. The comparisons made in this study are mainly on the health facility level, and the outcome of the analysis might have been different if another level had been chosen. (A sustainable health institution within a vulnerable structure may have both a positive and a negative impact on the overall structure)

Parallelly it is difficult, sometimes even irrelevant, to compare the SIDA support to the health sector as such, with the support from the Swedish churches to a couple of health facilities. SIDA has supported Tanzania in constructing rural health centres that were supposed to play an important role in the overall, national plan for primary health care for all Tanzanian citizens.

Even though the church dispensaries now take a great responsibility within the national health care structure providing health care to many, these health care projects were initiated in connection with mission work. They are responses to local people's needs, and not results of an overall, national plan.

4. Factors related to sustainability

According to the terms of reference, the study should concentrate on identifying factors which contribute to, or hinder, sustainability. (p.2&3) Earlier experiences have shown that some factors are of particular importance for the sustainability of a programme, and SIDA suggested that the following aspects are used as the starting-point of the study.

* Financing of the project
* Management of the project
* Methods of planning and the commitment of the recipient country during the planning
* Length of time of donors'/counterparts' involvement
* Appropriate level of technology
* Degree of adaptation to the existing health care structure
* Scale of the project
* Special characteristics of cooperation between Churches
* Local participation
* External factors outside the control of the project

In the terms of reference no explicit hypotheses are formulated. It is said that "the team shall attempt to establish connections between the mentioned factors and sustainability" and "to test and attempt to verify to what extent the factors have affected sustainability in the health care projects" (Terms of reference, p 4).

In the case of sustainable projects the actual factors could theoretically be looked upon as necessary preconditions or contributing factors. The main questions would then be: Which factors are necessary? How much of the success (sustainability) can be explained by factor X? By Y etc?

In the case of projects that are not (yet?) sustainable, the most relevant question would be: Have the factors (circumstances) X, Y, Z prevented development towards sustainability? If yes, how? What preconditions are missing, and what changes seem to be necessary in order for a HF to develop towards survival?

However, before going into an analysis of reasons for sustainability the very existence of sustainable health programmes in Tanzania had to be investigated.

5. The process towards self-reliance

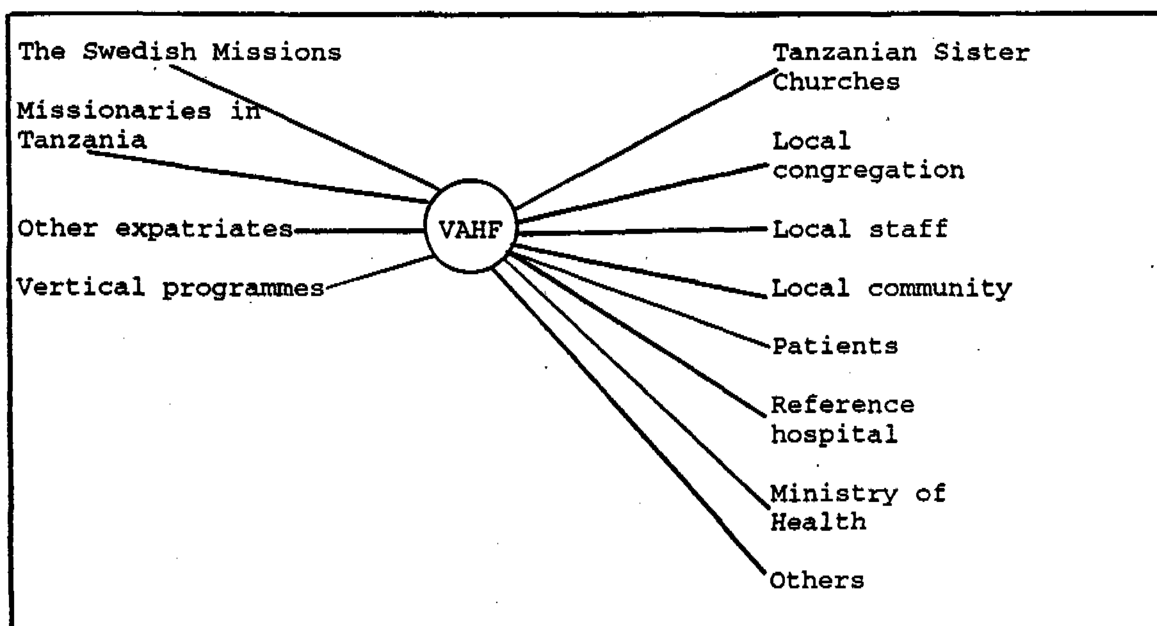
5.1 A theoretical frame of reference

As earlier mentioned a sustainable project is characterized by the developing country having the primary responsibility for the activity, the institutional capacity and commitment to carry it forward, and the ability to mobilize the necessary resources to maintain it.

This implies that the economic, administrative and professional responsibility is no longer in the hands of foreign donors or cooperation partners - a development towards self-reliance has taken place. In this process a number of *actors* participate, whose roles gradually change. The actors have *resources* (knowledge, money, material, equipment, transports etc) at their disposal. Institutions have their *policies* which guide their initiatives and activities. Persons and groups have their *expectations, values and attitudes* that guide their behaviours and their use of resources.

The actors supposed to be involved in the church dispensaries are to be found in the figure 5.1 below.

Fig. 5.1 Actors involved



In the case of the SIDA supported rural health centres a corresponding model was elaborated. (See further appendix 5). The figures were then used as a frame of reference when questions such as the following were analysed:

Who has participated in the planning of the HF? Who is now participating? From where have the resources come earlier? From where do they come now? Who is responsible for the administration, the medical service? Has there been a change during the past years? Who is now doing what? Is there a difference from before? What expectations and attitudes do different actors have as to responsibility and participation?

In summary, the figures were used as tools when we tried to find out if there is a development towards self-reliance, and if this also means that the quality remains the same. Sustainable facilities could be compared to non-sustainable facilities, church dispensaries with Government health centres. Differences and similarities as to material and non-material preconditions and obstacles could be traced.

6. Service at the health facilities

6.1 The service rendered

The following table gives an idea of the range of the services rendered. The figures are from annual statistics and are rounded off to the hundred. As the aim of the study is to find general tendencies rather than assessing individual facilities, health facilities have throughout been given a letter instead of the actual name. A, B, C and D are dispensaries supported by the Swedish denominations, while the rest are government health centres. Of these G is an urban centre.

Table 6.1 Attendances during 1989

HF	Out-patient dep (OPD)	Antenatal	Children	Deliveries	In-patients	Est average daily out-patient attendances *)	Number of staff
A	51.000	6.400	11.300	500	1.890	229	15
B	16.900	2.900	7.900	200	2.500	92	22
C	30.300	3.900	13.900	800	4.500	160	15
D	40.000	3.900	21.300	600	(800)	217	21
E	24.500	3.700	14.200	300	1.000	141	20
F	55.200	?	?	700	?		27
G	32.000	4.800	8.400	250	-	151	46
H	25.000	1.000	4.700	100	400	102	22

*) The number of out-patients have been divided by 300

As can be seen there is a distinct variation between the health facilities as to the character of the service. One has no in-patients while one has 4.500 during a year. The estimated number of daily out-patient attendances varies between 92 and 229.
The variation of number of staff is also prominent, and there is no clear correlation between size of staff and number of patients.

6.2 Catchment area

According to the government health care structure all health facilities should have a well-defined catchment area. A health centre in the rural areas is supposed to serve a

population of around 50.000 and a dispensary about 10.000 persons.(For further information on the health care structure in Tanzania we refer to the prestudies and to the SIDA evaluation, 1987)

Three of the VA dispensaries studied perceived that the authorities had defined a planned catchment area for them. In some cases two different catchment areas had been indicated: One for curative and another one for preventive care, depending on other sevice in the vicinity. All three dispensaries identified areas with about 13.000 inhabitants as the planned catchment area. The fourth dispensary has no officially defined catchment area but is very well aware of the *actual* catchment area.

A general impression is that the VA dispensaries have taken over the responsibility of the government health facilities within a pretty large area and that *their actual catchment areas are larger than the identified areas.* It is particularly true for one dispensary, where as many as 73% of the outpatients and 70% of the children come from outside the defined catchment area. (See further table in appendix 5)

A conclusion from these observations is consequently that the sustainability of a VA dispensary is not independent of the surrounding and the performance of health facilities in the vicinity.

7. Degree of self-reliance

7.1 Three viewpoints

As was indicated in the introduction, we cannot take it for granted that all the church dispensaries studied are self-reliant, even though they belong to a Tanzanian church or to the Government. Instead, this was something to be examined before entering into an analysis on factors related to sustainability.

The degree of self-reliance was assessed from three viewpoints: administrative self-reliance, professional (medical) self-reliance and financial self-reliance.

If the administration is in the hands of Tanzanians the dispensary was defined as self-reliant as to administration. When it comes to the medical aspect the same is true for a dispensary without medical expatriates. Parallelly, we considered a dispensary financially self-reliant if the finacial resources are local. A health facility that is self-reliant in all three respects was defined as *mature*. As earlier mentioned the government health centres are self-reliant not as individual health facilities but as integrated parts of the national health care structure.

7.2 A continuum

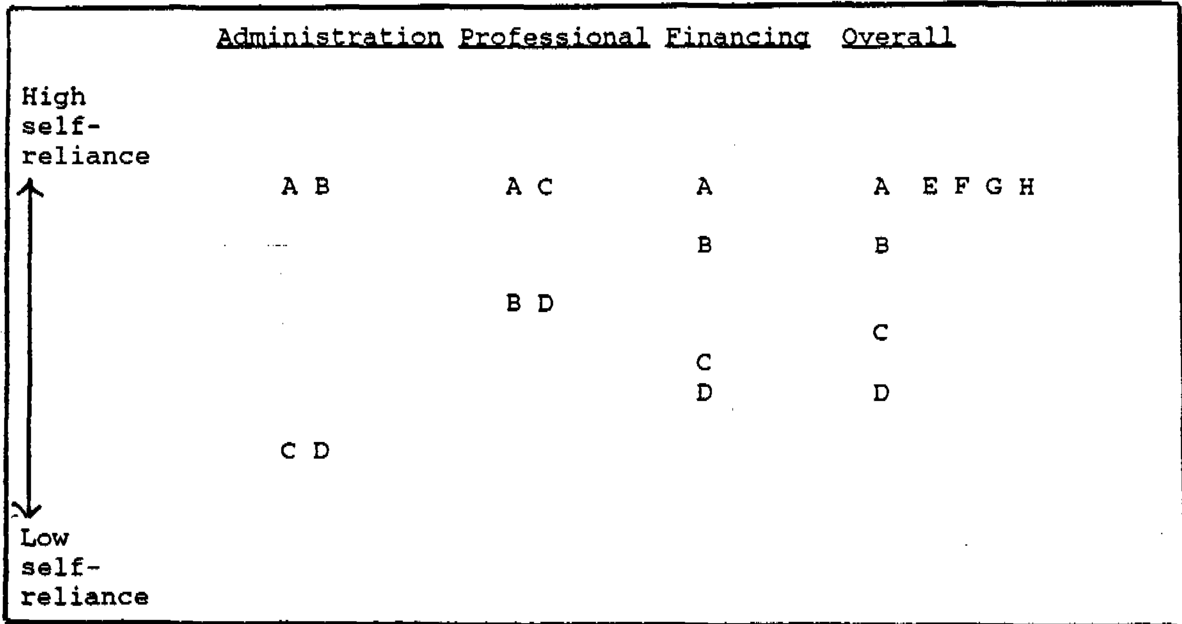
As to the administration, two of the four VA dispensaries have Swedish administrators as persons in charge. In the other two, the person in charge of the medical service, a medical assistant (MA), is also in charge of the administration.(The Swedish-administered dispensaries have no MAs employed at the moment)

As to the health care service, two of the dispensaries have only Tanzanian staff. In the others there is a Swedish nurse.

The financial situation varies. One of the dispensaries is self-sufficient, one is self-sufficient to a high degree, while the other two are still dependent on financial support from abroad. The financial situation is elaborated further in chapter 12.

The four VA dispensaries were given scores in accordance with the relation between Tanzanian/foreign influence as to the aspects mentioned above and an overall index of self-reliance was formed. This rating resulted in the following *rough picture* in which the four dispensaries have been given the codes A, B, C and D, and the governmental health centres E, F, G and H.

Figure 7.1 Degree of self-reliance



As can be seen from the chart one of the VA dispensaries is self-reliant as to all the three indicators used and we can certainly consider this as *a mature health facility,* provided that the health care is of high quality. A second VA dispensary can also be considered as self-reliant to a high degree, a third is self-reliant as to the professional work , while there is still foreign influence in all aspects in the fourth VA dispensary.

According to our definition of sustainability a project or a program should be self-reliant *and* of high quality in order to be named sustainable. We shall therefore continue our analysis taking up the quality aspect.

8. The quality of service

8.1 The starting-points

As mentioned earlier we have chosen to limit the concept of sustainability to HFs that are both self-reliant and give an adequate health care. It is therefore important to look a little closer at the quality of service given at the health facilities studied.

The ultimate goal of health care is better health for the target groups. Consequently, to assess the quality of a HF it would have been desirable to have measures of change of the health situation within the catchment areas. However, neither reliable information, nor comparable statistics on such data is available. Instead, the service rendered at the HFs has been used.

Firstly, the service has been assessed from the target group's viewpoint. Does the institution offer the health service the community finds most important? *Secondly*, the service has been evaluated from a professional viewpoint. Is the service adequate in order to improve the health situation and in relation to local circumstances? (See further appendix 6)

Voluntary agency health facilities and corresponding government facilities are expected to provide the same quality of the service, the only difference being that government facilities should give free service whereas church facilities are expected to charge fees.

8.2 Patients' expectations

In interviews with patients, women, and village leaders the following views were expressed on the government health centres:

Sometimes they operate sufficiently, depending on avaliability of drugs. In most of the health facilities the drug kit that they receive monthly is finished after a couple of weeks. Moreover, the delivery of the kits is irregular due to transport problems. Therefore traditional health care is one alternative, whereas church facilities are another for those who have money.

As to the church health facilities, these were described as mini-hospitals. People expected them to carry out all the functions that a district hospital does, even though they are dispensaries. The patients expressed wishes that the church facilities should carry out surgery and blood transfusions apart from diagnosis and treatment of common diseases.

Many patients and members of the local communities were satisfied with the quality of the service offered by the HFs. They felt that the quality was due to dedicated staff and patient fees. In the dispensaries where missionaries work, the quality was partly seen as a result of external support of drugs and equipment, and the presence of missionaries was seen as something necessary to maintain the quality of the service.

A general conclusion about the patients' views is that they appreciate the high quality and that the curative care is much more emphasized than the preventive side.

8.3 The quality at the VA dispensaries from a professional viewpoint

8.3.1 Preventive care

Mother and child (MCH) and immunization (EPI) programmes are run according to the national plan. MCH clinics are given 3-5 days per week. Daily health education with monthly or longer planning is not always present. Teaching aids are scarce. Outreach activities are mostly directed to child health, with health education, road-to-health-card monitoring, and vaccinations. The extent to which outreach clinics exist outside formal catchment areas depends on transport facilities.

Community health activities are scarce. Where special programmes are run by, say, UNICEF or health, sanitation and water programmes like HESAWA - village health workers (VHWs) are supervised by the district, without coordination with the dispensaries, which is proposed.

8.3.2 Curative care

The curative care is of high quality concerning both out- and inpatients. There is seldom or never lack of medicine. The church facilities visited get (i. e. pay 38.000 T Sh which is to be put into a revolving fund) the dispensary essential drug-kits (yellow-labelled), some of them can get two kits monthly. In addition, drugs are purchased abroad or locally.

Most of the additional drugs are according to the essential drug (ED) list - in fact the major part are the same items as included in the ED-kit. There is a tendency to polypharmacological treatment and some overuse of antibiotics and antimalaria drugs.

Treatment is focussed on major diseases in the area, and appropriate referrals are made to government or denominational VA hospitals.

Three of the VA dispensaries had no regular tuberculosis (TB) and leprosy programme. In the fourth dispensary, situated in an area where TB is still common, both treatment and follow-up is given. The AIDS control programme provides the dispensaries with information material, and one institution also had some equipment.

8.3.3 Equipment and transport

Diagnostic equipment (stethoscope, blood pressure machine) as well as laboratory utensils for malaria, sputum, stool and urine examination are available at all church dispensaries, even though some have old microscopes and lack stains and slides. (Evaluation of the laboratory service is seldom done by the supervising unit.)

The dispensaries have minor surgery instruments (for stitching of wounds, incision) as well as dressing utensils, even though the amount is small. They are well-stocked as to gloves, syringes and needles.

Delivery equipment for normal deliveries and for a few defined emergencies is available such as scales, knickers and road-to-health-cards. The pressure cookers for sterilizing are in order. Beds, mattresses and sheets are available, but for some of the dispensaries replacements are needed. The facilites have very little teaching material for health education.

All but one of the church dispensaries have functioning cars which are used as ambulances and to a limited degree for outreach activities. Patients pay a mileage fee to cover fuel and maintenance. Bicycles are available at some institutions but they are seldom used.

All the church facilities visited had sufficient water supply. The latrines are most often of pit latrine type.

The most common problems defined by the staff were

* that the staff have to fetch vaccines and kerosine from the office of the district medical officer (DMO)
* that no feedback is given to the monthly statistics sent to the district.

8.4 The quality of government health centres from a professional view

8.4.1 Preventive care

All the health centres studied have daily MCH clinics. It is not uncommon that there are transport problems at the district level, leading to shortage of vaccines and kerosine at the health centres, so dedicated staff have to search for different kinds of temporary solutions. As in the church dispensaries, the health centres visited have few organized community health activities.

8.4.2 Curative care

Curative care is insufficient. The drug-kit (blue labelled, twice the size of the dispensary kit) generally lasts 2-3 weeks, and no additional drugs are supplied. This means that the rural health centres are without drugs 1-2 weeks every month. The same situation is valid for the urban health centre visited, even though the procedure for obtaining drugs is different from that of the rural health centres.

When drugs are out of stock, patients are advised to buy medicine wherever it is available.

8.4.3 Equipment

Diagnostic, laboratory and surgery equipment is as a rule missing, scarce or worn out. Delivery equipment is insufficient, and pressure cookers were found out of order. Road to health-cards and scales are avaliable but knickers worn out.

None of the rural health centres, but the urban health centre, had a well functioning car. Referred patients in the countryside have to find private means of transport. Bicycles belonging to the rural health centres were out of order as well, but private bikes were occationally used.

One institution has reliable water supply. There, water closets were used and functioning. In the other health facilities the water supply was insufficient. Pit latrines with concrete slabs were used.

8.5 An overall comparison

In order to be able to make an overall comparison of the institutions studied a *rough*, comprehensive measure of the quality in each of the facilities was needed. Curative and preventive services were to be given the same weight. For this purpose ten factors were used :

Health Education, Mother and child/immunization activities (MCH/EPI), Outreach activities, Contacts with traditional health workers, Number of trained staff, The essential drugs program and additional drugs, Availability of car, Clinic equipment, OPD equipment and Ward Equipment.

Every health facility was given a score for each factor according to a three-grade-scale. The government health centres and the VA dispensaries were assessed acording to the same gauge.(see further table in appendix 6) Again, we would like to emphasize that our observations of the government facilities were limited. (see also 2.2)

First of all we can state that there is a certain difference between the VA-dispensaries and the government health centres. The average score for the first category is 18.2 while it is 14 for the others. If the urban health centre is excluded the difference becomes still more striking. It is however interesting that three of the four twin pairs together have about the same score, which raises the question if there is certain balance between "neigbouring facilities".

Continuous essential drugs supply and extra drugs as well as good service due to appropriate equipment puts the bedded VA dispensaries on a level between dispensaries and hospitals. Roughly one could say that these VA dispensaries have the function that government rural health centres were planned to have, while these latter *actually* play the role that the government dispensaries were supposed to play.

If preventive and curative care is separated the difference between the dispensaries and the health centres becomes more evident.

Table 8.1 Average quality scores

	Preventive care	Curative care
Government Health centres	8	5
Church dispensaries	5	12

The table (8.1) confirms that the curative care at the church dispensaries is of a considerably higher quality.

8.6 Conclusions

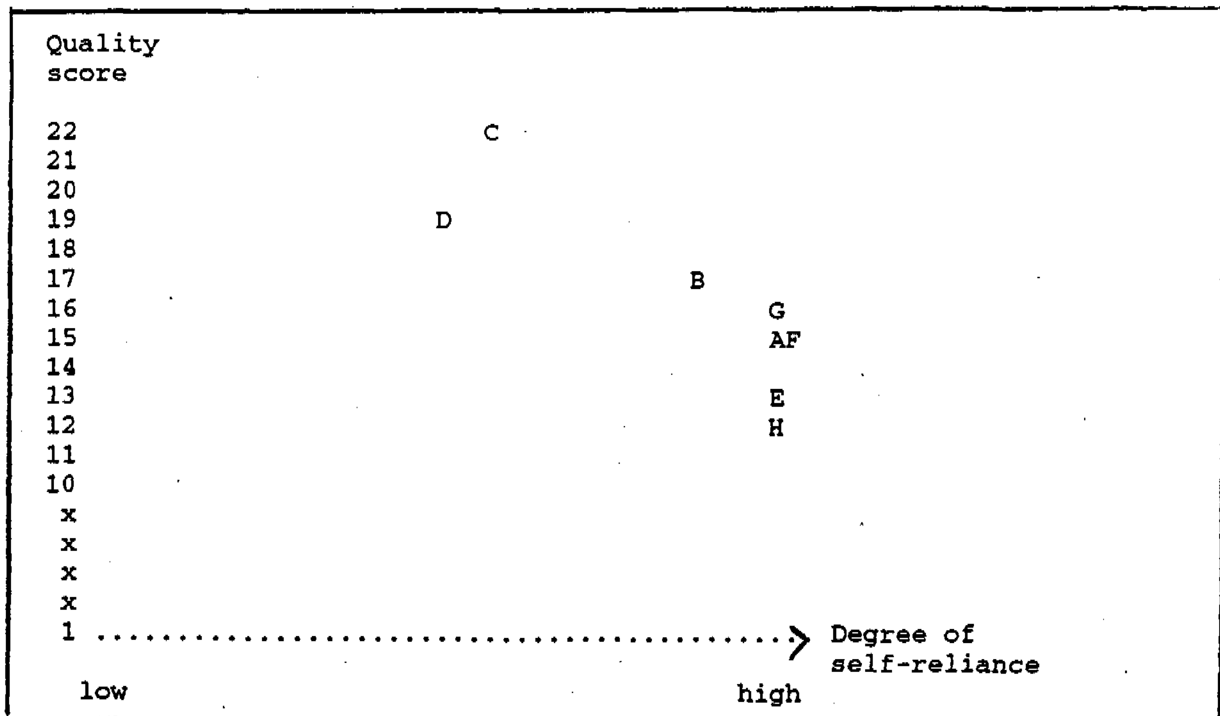
The main difference between the VA dispensaries and the government health centres is the curative care. This attracts a lot of patients to the dispensaries who in fact should have gone to a government facility. When representatives of the community and patients are asked for the reason why they prefer a VA facility to a government one, most answer *"because of the continuous availability of drugs"*. However, this is just one side of the truth. The high quality is also strongly related to appropriate and well-maintained equipment, the availability of a vehicle, and as we shall see later on, to well-motivated staff members.

9. Quality and self-reliance

9.1 The relationship between quality and self-reliance

In the figure below the overall score on self-reliance presented in chapter 7 has been related to the quality scores mentioned in section 8.5.

Figure 9.1 Self-reliance and quality



First of all we should again point out that the church dispensaries and the government health centres have been assessed after the same gauge. This implies that even though some of the government facilities have reached a rather high quality score they do not play the role they are supposed to play, but that the quality corresponds to that of a good dispensary. (see 8.5) Anyhow, it means that there are health facilities that can be characterized as both self-reliant and of a rather high quality. These are worth special attention in the forthcoming analysis, as they are sustainable according to our definition. Aldready now we can conclude that one of the two government centers with a high score is urban. The other one receives assistance from a catholic mission now and then, which helps to maintain the quality and the motivation of the staff.

We can further conclude that there is a certain relationship between quality and degree of self-reliance. The higher the degree, the lower quality, and if the government health facilities had been assessed according to another scale than the VA dispensaries, this tendency would have become still more striking.

The VA health facilities that are most self-reliant in administrative, as well as in professional and financial senses have a lower quality than the VA dispensaries that are more dependent on foreign support. *To lower the quality somewhat seems to be the price of self-reliance.* This does not however imply that self-reliance is the cause of low quality, but the correlation raises questions such as; What is the minimum quality? How high a quality is it possible to sustain with Tanzanian resources? Which are the preconditions for sustaining a certain quality?

We observed for example that much of the equipment at the dispensaries is not available in Tanzania. Consequently, the more self-reliant a health faciility is, the more difficult it is to maintain such equipment. The same problem is valid for a vehicle. On the other hand, if self-reliance can be attained without going below the acceptable or minimum level the move would be positive.

9.2 Conclusions

In order to avoid a deterioration of VA dispensaries when they become self-reliant it is essential to have *proper plans for running and maintaining the technical equipment.* In remote areas transport facilities are very much needed particularly when patients need to be referred to a hospital. *It seems, however, very difficult for a self-reliant dispensary to keep a vehicle* if *no* assistance is at hand from abroad.

Considering the findings in this and in earlier chapters we can further conclude that *the VA dispensaries cannot be analysed isolated from the rest of the health care structure.* The present sustainability of a VA health facility is very much dependent on the fact that there are none or few government facilities of high quality in the vicinity. At the moment the VA dispensaries have taken over a considerable part of the responsibility of the government health facilities. If the state of these facilities improve, the situation for the VA dispensaries will also change. Therefore, an adequate health plan for each district is badly needed. In this plan *all* the health facilities should be given a position and well-defined responsibilities within the health care structure. The bedded dispensaries act for examle as rural health centres, a problem that has to be straightened out. Furthermore, catchment areas have to be defined in order to be able to follow-up and evaluate the service, and to plan for a balance between prevention and cure.

10. The macro-economic context

The economic crisis and the structural adjustment programme do affect the health sector in Tanzania in many ways both directly and indirectly. Before entering into an analysis on the health facility level in order to examine factors related to sustainability we therefore would like to point to the importance of the macro-economic context.

The chapter is based on a report by David W. Dunlop et al. The Sustainability of US Supported Health, Population and Nutrition Programs in Tanzania 1971-1988 (1990).

10.1 Three indicators

Three indicators are important in defining the relationship between the economy as a whole and the financing of the GOT's part of the health sector:

*The growth of the gross domestic product (GDP)
*The trade balance
*The imbalance between government spending and revenue, i e the deficit

10.1.1 The growth of GDP

With respect to the growth of the Tanzanian economy as a whole, the economy experienced negative real rate of economic growth, as measured by the growth in GDP, in only three years over the 1961-1987 period. Two of them were in the early 1980's. However, over the last decade, 1978-1987, the rate of economic growth was less than the rate of population growth such that the rate of growth in GDP *per capita* has been declining for nine of the ten years at an average of nearly 1.9% per year, or about 19% total decline in *per capita* income.

Thus the period from Independence to the late 1970's was a period of economic growth and relative economic prosperity. Then the situation reveresed.

10.1.2 The trade balance

Information about the trade sector shows an increasingly adverse situation regarding the supply of foreign exchange earned by direct economic activity within Tanzania. After 1970, the country has run an increasing trade deficit. This deficit has grown to over 100 % of merchandise exports in half of the last ten years. When there is such an imbalance in the trade sector, a foreign exchange shortage occurs throughout the economy and affects every sector, including the health sector.

Given the shortage of foreign exchange available to the GOT, the financing problem manifests itself for example in the availability of pharmaceutical items, repairs and maintenance of equipment and buildings, logistics and information systems. So have for example pharmaceutical imports for all health sector providers in the country declined, and are now at a level below that experienced in the early 1970s. This decline and the reduction in total *per capita* health expenditures occurred at the same time (See further table 10.1).

10.1.3 Imbalance between spending and revenue

Data on the trend in expenditures, and the extent to which the GOT is financing these expenditures from tax and other revenue shows that there has been a *significant deficit* over the two-decade period, 1964-1985. (Only four out of 22 years was the deficit less than 20%, and in the early 1980s it reached its peak at about 30% per year)

Due to the large annual deficit there is a continuous and increasing pressure to cut expenditures, something that aggravates the financing problems within the health sector and the government health institutions.

The government has been financing the additional expenditures primarily by borrowing from the central bank, thereby increasing the money supply and creating additional inflationary pressures. This financing strategy has pervaded the health sector as well as all other sectors of the economy.

10.2 The trend in government expenditures

The table presented below shows the trend in GOT expenditures on health from the fiscal year 1971 to 1987.

Table 10.1 The Tanzanian Government Expenditures on Health 1971-1987.

Fiscal year	Health Expen-ditures (Mill of TSh)	Popu-lation (Mill)	GDP Deflator 1980=100	Real Health Expen-ditures per capita (T Sh)	Index of Real Health Expenditures per capita 1980=100
1971	152	13.63	36.2	30.8	74.4
1972	159	14.00	38.6	29.4	71.1
1973	203	14.37	43.9	32.2	77.7
1974	362	14.76	52.3	46.9	113.3
1975	416	15.31	58.9	46.1	111.4
1976	430	16.41	63.5	41.3	99.7
1977	522	16.92	71.0	43.5	105.0
1978	649	17.44	76.9	48.4	116.9
1979	723	17.98	85.0	47.3	114.3
1980	769	18.58	100.0	41.4	100.0
1981	864	19.17	119.0	37.9	91.5
1982	926	19.78	139.9	33.5	80.0
1983	1.014	20.41	153.2	32.4	78.3
1984	946	21.06	171.4	26.2	63.3
1985	977	21.73	182.5	24.6	59.5
1986	1.273	22.46	237.2	23.9	57.7
1987	1.693	23.21	284.6	25.6	61.9

What is of particular interest to us is the real *per capita* health expenditures, i e column five in the table. These rose from about 31 T Sh in 1971-1973 to an average of about 45 T Sh during the next six year period (1974-1979), which is a nearly 50% increase in expenditure. However, by 1982, government support to the health sector declined to 33 T Sh, i e the level recorded a decade earlier. Finally, in the subsequent four years through 1987, expenditures declined to an average of 25 T Sh. This is a reduction of an additional 22% from that recorded in 1983.

The corresponding figures for Tanzanian shillings in value of 1987 were also calculated, and the outcome is presented in the table and the figure below. As can be seen the figures are higher. In 1971 the real expenditures were 88 shillings, arose gradually to reach 138 shillings in1978. Since then the expenditures have decreased. In 1987 they were 73 shillings per capita.

Table 10.2 Real health expenditures per capita GDP deflator 1987=100

Year	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
Real expenditure per capita	88	84	92	133	131	118	124	138	134	118	108	95	92	75	70	71	73

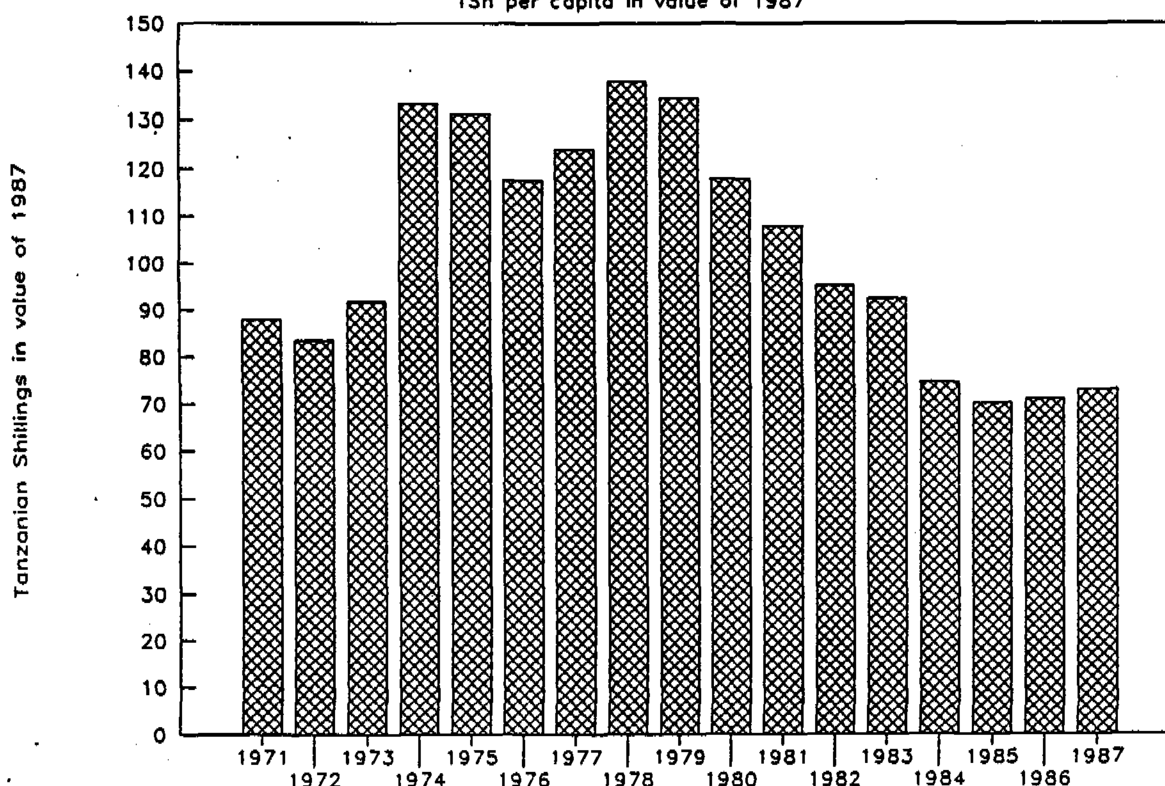


Figure: Bengt Oberger

11. Human resources at the health facilities

11.1 Staff - an important resource

Staff is an important resource for the sustainability of a health facility. It is the staff that gives the patients the service, and it very much depends on the behaviour of the staff if the health facility attracts patients. During the preparation of the study an assumption was even formulated that the dedicated staff at VA health facilites was the main reason for the large number of patients coming to the dispensaries.

We therefore tried to find out if conditions as well as attitudes and behaviour of the staff is different in the government health centres from the situation in the church facilities. Interviews were made with different staff categories, persons in charge, patients and the community where the health station is situated.

An overall conclusion is that *the staff is a very important resource* as to the continuity and functioning of the health facilities. It was also concluded that the staff employed by the churches are generally better taken care of than staff at government centres.

The material conditions of the government staff are very meagre. Even though the basic salaries are the same within the two types of health facilities staff at government institutions sometimes have to wait for months for their salaries. Moreover, staff at the VA dispensaries get an allowance on top of their salaries. This might amount to 25-35%. The professional conditions also differ. While the staff at government institutions often complain of not being able to perform their tasks in an adequate way because of lack of supplies or instruments, such situations are rare at the well-epuipped VA facilities.

In some of the government centres the staff is however very dedicated and does a good job under difficult conditions. Assistance with supply and drugs from voluntary organisations has improved the situation to some extent.

Most of the staff working with the VA dispensaries studied have been trained at church institutions and feel that they are now working in their own health facilities, which makes them stay for quite some time. The same feeling is not present in the government health facilities.

There was an assumption that the staff at church HFs would feel that they had a "calling" to the profession of health worker. This assumption received no support. Instead the health workers gave very professional reasons for having chosen the job.

Almost all staff members interviewed felt a need for and were eager to continue their studies or to attend refresher courses. Many expressed the opinion that they were not qualified enough for their tasks. As a rule, a staff member has to work for a couple of years before getting further training, which makes it difficult to catch up with the rapid technological development within the medical field. All information collected reinforced our ideas about the importance of the staff if a health facility is to maintain a high quality.

As to the relationship between the staff's situation and sustainability we could state that the staff at the most sustainable VA dispensary have longer working experience than the staff at the less sustainable VAHFs. They are very dedicated, but this property they share with staff at the other institutions. As to patients' perception of the quality of service much points to the fact that equipment, instruments, supply of drugs etc are more important factors than the staff *per se*. On the question to patients why they choose a church dispensary instead of a government health facility they all spontanously gave answers related to medicine and drugs rather than the behavior of the staff. This does however not mean that the staff's behaviour is unimportant.

11.2 Skilful managers

Management skills and good leadership is supposed to influence the capabilities of an institution and thereby also the sustainability. Such skills are said to be among the scarcest of human resources required for development, and during the life of a project management is often handled by expatriate advisers. When the advisers leave, the capability to administer the programme goes with them (OECD, 1989, p 23).

The observations made in the study confirm the statements above. The sustainable dispensaries are administered and organized by very skilful Tanzanians. As these dispensaries are to be economically self-sufficient the demands on the persons in charge are many. They have to know their patients, where to get hold of drugs and supplies at lowest prices, how to organize the staff well, as there is no economic space for a large staff etc. And they have to see to it that the dispensary gets a good reputation so as not to lose clients.

At the institutions that do not have Tanzanian administrators the argument is that there is no such person available. That is not only the opinion of the expatriates but also of most of the staff and the patients. Many fear that there would be a deterioration if the expatriates left. This reaction is much more common within PCAT than within ELCT.

Some of the persons interviewed suggested that the difference between PCAT and ELCT can be explained by historical circumstances. Many ELCT congregations that are now supported by Swedish denominations were earlier mission areas for German mission societies. During the First World War the German missionaries had to leave Tanzania, and the congregations were left on their own. (The term "orphan churches" was often used to describe the situation.) A positive consequence of this was that the congregations started to organize the work themselves. In this way a certain institutional capacity was built up. Representatives of PCAT also give another explanation for the difference. Their congregations lie in remote areas and their members generally come from the poorest groups. As PCAT has not emphasized the importance of education and training there have been few persons within the denomination who could take over responsibility for the health facilities.

A general conclusion is that it is necessary to introduce a counterpart-system within the health facilities which are still administered by expatriates.

12. The economic resources of the health facilities

12.1 Difficult to compare VA institutions and government institutions

One of the aspects of self-reliance and sustainability is the financing. To what extent is a HF self-sufficient and from which sources does the income come? Which are the expenses?

In order to try to answer these questions as much data as possible was collected at the church dispensaries by examining reports and books. At some of the VA dispensaries the data-collection was sometimes hampered due to lack of adequate book-keeping and the fact that some of the information had been forwarded to church head quarters. The government institutions are deliberately dependent on central resources, and information was neither available at the centres themselves nor at the district level. Consequently, it is only to a limited extent that it is possible to compare VA dispensaries and government health centres from an economic point of view.

We know for example that both categories receive kits within the essential drugs programme, the salaries are known in both types of institutions, and we also know that gifts, donations and patient fees are something characteristic of VA health facilities. And while each of the dispensaries has its own budget, income and expenditure, the government rural health centres have no cash whatsoever at their disposal. As a consequence of this a government health centre cannot even pay for minor repair of the instruments, equipment or the ambulance belonging to the centre.

12.2 The main categories of income at VA dispensaries

The total annual income for three of the four dispensaries was in 1989 approximately 2.000.000 T.Sh, and for the fourth dispensary about 2.800.000 T.Sh.

One dispensary had a surplus of 394.000 T. Sh, one a surplus of 44.000 T.Sh and a third one a deficit of approximately 153.000 T Sh. (No information is available for the fourth HF)

For the VA institutions there are different types of sources of income. This income can be divided into *local and external income.*

12.2.1 Local income

Local income is income available within the country and can be divided into *patient fees* (a), *government grants* (b) and *other types* of income (c).

(a) *Patient fees*. These fees consist mainly of sale of drugs which is the cost of acquisition of the drug plus a certain percentage for overheads. There is also an amount charged as part of patient fees, called service charge. In institutions with beds, in-patients pay a bed fee.

(b) *Government grants*. These are grants paid by the government to the VA institutions for salaries, training and maintenance depending on the status of the respective facility.

(c) *Other income*, for example of food to patients, transportation, rents from staff houses, water charges, and electricity charges.

12.2.2 External income

External income is an income which the VA dispensaries receive from the missions abroad either as a grant or subsidy to meet running costs or purchase of drugs.

12.3 The relative distribution of income categories

The relative distribution of the categories of income is presented in the following table.

Table 12.1 Income categories. Relative distribution.(in%)

	VA Health Facility			
	A	B	C	D
Income category:				
Patient fees	93	87	51	53
Governm grants	6	-	-	-
Other local income	1	13	14	11
External income	-	-	35	36
Total	100	100	100	100

It is obvious that the patient fees is the most important source of income for all of the four studied dispensaries.

In one of the institutions (A) as much as 93%, and in another one (B) 87% of the income consists of patient fees. As these two dispensaries do not get any financial support from abroad they have been defined as financially self-sufficient.

As to the other two VA dispensaries more than one third of their total income comes from abroad.

It is also interesting to observe that the income from "other sources" constitutes a little more than 10% of the total income in three of the dispensaries. This is mainly income from staff houses, or transport fees paid when the car has been used for other purposes than referrals of patients. Income-generating activities like selling agricultural products, manufacturing mosquito-nets and overnight service for patients' relatives have been discussed by the staff at the dispensaries but have not yet been realized.

12.4 Running costs

The main expenditures of a VA dispensary consist of purchase of drugs, salaries, maintenance of the car, if such exists, supplies, maintenance of housing, cleaning and firewood.

The purchase of drugs accounts for a large amount in all four VA dispensaries studied. The division of the running costs are described below for three of the four dispensaries. Data for the fourth dispensary was not obtained.

Table 12.2 Running costs. Relative distribution (%)

	VA Health Facility		
	A	C	D
Running costs:			
Drugs	62	33	54
Salaries	21	17	27
Other expenses	17	50	19
Total	100	100	100

As can be seen the drugs account for between one third to two thirds of all expenses at the dispensaries. The relatively low percentage used for drugs at one of the dispensaries is related to the fact that the institution has a vehicle, and that the running and maintenance of this is expensive.

The amount of expenditures going to salaries is related to certain categories of staff at a dispensary. We met four different categories in the dispensaries:

* The missionaries. These are paid by their missions abroad and their salaries are not normally reflected in the institution's books.

* Seconded staff. This category works in the health facilities on a secondment basis, i. e. they are employed by the government but have been "lent to" the institution for 2 - 4 years. After this period seconded staff have to decide if they want to return to a government HF or if they want to remain at the VA facility. The salaries of this category are paid by the government.

* Graded staff. This category of staff is employed by the VAHF which is refunded for the salaries. If a dispensary is registered as bedded dispensary, the GOT normally

pays the salaries of a certain number of professional staff such as medical assistants and aides for mother and child health services.

* Employees who are being paid from the VA health facility's own funds without assistance from anywhere.

12.5 The relationship between income and running costs

In the following table the expenses and the patient fees from the four dispensaries are compared.

Table 12.3 Patient fees (PF) and running costs (RC) in 1.000 T.Sh.(1989)

Dispensary	PF	RC	PF/RC (%)
A	1.869	1.611	116
B	1.744	1.798	97
C	1.446	2.770	52
D	1.034	2.112	49

As can be seen from the table the income from patient fees covers all the running costs in two of the dispensaries, and about half of the costs in the other two health institutions. It has not been possible to separate different parts of the patient fees but it is obvious that *the main part consists of sale of drugs*. We shall therefore also relate the purchase of drugs to patient fees.

Table 12.4 Purchase of drugs and patient fees in 1.000 T Sh (1989)

	Purchase (a)	Patient fees (b)	Difference (c)	Difference/ Purchase (c/a)
A	990	1.869	879	89%
C	1.038	1.446	408	39%
D	1.135	1.034	-101	-9%

Information from the fourth dispensary has not been obtained.

12.6 Conclusions

If all the figures presented above are put together, it emerges that the financial self-reliance of a dispensary is very much related to buying adequate drugs at reasonable prices, to prescribing them, and to letting the patients buy them at higher prices. It is however also connected to having some staff members whose salaries are paid by the government, letting staff houses, and not having a vehicle which needs maintenance.

12.7 Discussion

An important question to be discussed is how the quality of the service at a dispensary is affected by such a situation. There is a risk that the curative part of the health care will be emphasized, that there will be an over-prescription of drugs, and that the staff will not be able to leave the actual building for preventive care and for health education, not only because there is a lack of transport, but also because the institution cannot afford to employ staff involved in activities which do not result in income.

These drawbacks could be mitigated by having more seconded and granted staff for out-reach activities. Such a solution would not necessarily mean that the VA institution looses the special character that the unity of the staff now gives it, provided that the facility itself has a certain influence on the selection of staff. It implies however that the status of the respective health facility has to be changed.

Furthermore, there are a lot of ideas about income-generating activities for the VA dispensaries. Such ideas should be discussed and encouraged. Among the projects suggested are: tea-shops and small quarters for relatives of in-patients, growing vegetables for sale, producing mosquito-nets, grinding maize, and cleaning. The situation for each dispensary is unique, and the projects should therefore be carefully analysed before they are initiated.

13. Planning procedure and programme design

13.1 Formal planning procedures

One hypothesis formulated during the preparation of the study was that sustainability of a programme can to some extent be planned for. This made the team look into the formal planning procedures within the churches as well as within SIDA and the Government of Tanzania.

13.1.1 Evangelical Lutheran Church of Tanzania (ELCT)

In each of the 17 ELCT dioceses/synods the planning of health projects is taken care of by the medical secretary of the diocese, who reports to the medical board of the diocese. During the planning phase the district medical officer (DMO) is always contacted for approval of the health project. However, this does not imply that the district actively directs the diocese as long as the general guidelines from Ministry of Health (MOH) are followed.

After approval from the diocese the project is scrutinized by ELCT before it it is sent to Lutheran Coordination Service (LCS) in Helsinki (LCS coordinates the activities of Church of Sweden Mission (CSM) and Swedish Evangelical Mission (SEM), among others) or to the Lutheran World Federation in Geneva. Projects are also sent directly from the diocese or synod to the Swedish sister churches CSM and SEM.

13.1.2 The Pentecostal Association of Tanzania (PCAT)

Health facilities supported by the Pentecostal Mission and the Holiness Mission are registered under PCAT, an umbrella association with limited capacity and resources. Planning of projects is coordinated by the PCAT medical committee at the Nkinga hospital, where also the PCAT medical secretary is based. There are also many direct links between the health facilities supported and the supporting churches and congregations in Sweden.

13.1.3 The churches in Sweden

The Swedish Mission Council (SMC) as well as the Pentecostal Mission, PMU-InterLife, have a coordinating role in channeling government funds to the Swedish churches for development cooperation. SMC has elaborated a manual for project planning and evaluation. The manual gives advice on planning for taking-over of projects. Among other things, training of staff and ability to take over running costs is emphasized.

The general policy of the Swedish Denominations is to assist a Sister Church during a limited time, something that is reflected in the document *Mission and better mission* (1979) from the Holiness Mission :

"Projects should be limited in time and if continued as soon as possible be transferred to national resources. Such planning should be done from the beginning..."

13.1.4 The Tanzanian Government

Primary health care (PHC) in Tanzania is *in principle* planned at national, regional, district, ward and village level. The formal chain goes from village and ward, via district health committees and planning committees, district management team and district council to the regional health committees and regional planning committees.

Regional plans are coordinated by the Prime Minister's Office before they finally go to the planning commission. All planning is made according to the guidelines drawn up by Ministry of Health and the overall national health policy.

13.1.5 SIDA

SIDA has formal guidelines for project support preparation and implementation, but the project cycle is adapated to and intimately connected with the recipient country's project preparation cycle. In an ideal situation the initial project assessment should have the results of a pre-feasibility study as its starting-point. This should result in the joint formulation of the terms of reference for project design and a more thorough feasibility analysis. SIDA's project support preparation is in an ideal case based on a comprehensive analysis of the Swedish input, its volume, orientation and terms.

13.2 The VA dispensaries - results of needs rather than plans

Following manuals and formal procedures described above has been the exception rather than the rule when the health institutions under study were planned. Proper base-line studies have generally not been made until a project has been decided upon. Elaborated plans for maintenance seldom exist. The same thing is valid for training of counterparts who can take over the administration. Discussions on community participation are absent in the planning documents.

The dispensaries have gradually taken shape over a long period of time and as responses to obvious needs. No facility was planned to be what it is today from the very beginning. Funds have been raised from SIDA and/or from the Swedish denominations for one piece at a a time: the building, water, staff houses, electricity, a maternity ward etc.

It is difficult to conclude what consequences the absence of concrete long-term plans has on sustainability. Maybe more dispensaries had been sustainable if such plans had existed. On the other hand flexibility is a strength of the VA institutions. As to the government health centres it is doubtful that sustainability could have been planned for, given the difficult macro-economic situation. In this case, a long-term involvement of the donors would probably have been more reasonable.

13.3 Duration of involvement

Often too optimistic calculations are made as to the time required for a project or programme to function and to become self-sustained. Experience shows that the process of handing over the responsibility to the recipient country is long. Trying to

achieve it within a five-year project time-frame usually guarantees failure. (OECD, 1989, p.44)

Swedish denominations have been working with health care projects in Tanzania for more than fifty years and have supported some of the dispensaries studied for just as long.

As mentioned earlier the cooperation between SIDA and the Government of Tanzania as to the rural health centres was limited to a short period while the health centres were constructed.

It has been stated that sustainability is something rare, also among the "old" health institutions. Therefore, no general conclusions as to the time factor *per se* can be made from this study. In view of earlier experiences, it could be suggested that *a long-term external involvement is a necessary but not a sufficient condition for a health facility to become sustainable.* However, bearing in mind that a long relationship can also create a continous dependence, thus preventing sustainability, it is obvious that there is no simple answer to the question.

13.4 The scale of supported projects

One question formulated in the terms of reference for the study is the relationship between the scale of a project and its sustainability. The hypothesis was formulated, as it was thought that VA institutions get considerable attention as they are small projects. This was supposed to facilite their sustainability.

The design of this study does not allow any analysis of the importance of scale. However, an interesting observation made is that *the sustainability of a facility is related to a certain service level,* for instance that of a dispensary or that of a health centre. If that level is increased by expansion there is a great risk that the HF will no longer be financially sustainable but will have to ask for external assistance.

As mentioned before, the government rural health centres form part of the national health structure and exist under quite different conditions than to VA institutions. *These different conditions affect sustainability, irrespective of scale of programme.*

14. Community involvement

At the beginning of the study it was hypothesized that the church health institutions involved people and understood their needs and that this contributed to sustainability. In order to test the hypothesis we interviewed the staff at the dispensaries, women's groups and village leaders.

14.1 The VA dispensaries

The interviews showed that - with the exception of immunization campaigns - the villages had seldom or never been involved in the activities of the dispensary. Patient fees, service hours, expansion plans for the institutions - everything was decided upon without consulting village leaders.

Asked why they did not take the initiative to become involved in the affairs of the dispensaries, village leaders and women's groups pointed out that this was not possible because the facilities were not under their control. The institutions are not considered "theirs" but a property of "the mission", "the church", "the foreigners" or "the Europeans". The connection was defined as a relation between providers (HFs) and receivers (patients), in which the response of local communities was taken for granted. The community is seldom or never asked for assistance when it comes to solving problems within the health institution.

The staff in most of the facilities indicated that they did not involve people either because they were too busy or because they had never thought it necessary. The fact that patients continued to flood the dispensaries was seen as an indication of people's satisfaction. This is, however, not always a correct conclusion.

14.2 Government health centres

In the government health centres the staff indicated that the extent to which they can involve people in solving problems is specified by policies and regulations. Patients can be asked to contribute with minor things like kerosene for the sterilization of equipment. The staff meant that the involvement of the people would never be particularly efficient as long as the institutions are in such bad condition as they are now, and as long as the economic situation is beyond the control of both the villagers and the staff.

The staff at one of the government centres often inform village leaders about problems. But the leaders themselves cannot do anything to solve them. What they do is to inform the government.

Village leaders had however been involved in mobilizing the local community during immunization and sanitation programmes, something that was very much appreciated by the staff.

People stated as a rule that the health centres were operating poorly mainly due to shortage of drugs and poor equipment. When we asked them how they could help solve the problems most of them answered that they did not know as the institutions belong to the government. Moreover, they had never been asked for help.

14.3 Conclusions

An overall conclusion is that the level of people's participation is low, and that the relationship can be described as that between *provider and receiver.* The health institutions provide service wheras local communities are mere receivers without control over the type and quality offered. And receivers do not take responsibilities.

The local potential that the community in fact is, will consequently not be used unless the type of relationship changes. One precondition for such a change is that the staff goes out of their institutions and becomes more involved in the affairs of the local communities.

Another conclusion is that *it is very important to involve both sexes when planning and involving the communities.* Women often have different views from men. This became obvious when patient fees were discussed. While men found the fees reasonable, many women complained about having to use their meagre income for the benefit of family health.

15. The role of the local church

15.1 The assumption

During the preparation of the study it was assumed that the role of the local congregation was essential for the sustainability of a church dispensary. It was believed that the local church assisted the health institution when needed, as health care has always been considered an important part of the mission work; already from the beginning some health care was provided by the missionaries - sometimes simply by dressing wounds, other times in more sophisticated and well-planned forms, carried out by a nurse.

Historically, Lutheran congregations were established in the 1890s. German Mission Societies were involved early, but after the first World War missionaries were deported, thus strengthening local leadership and responsibility.

Swedish Evangelical Mission came to southern Tanzania in the 1920s and Church of Sweden Mission was called by the local church in the 1940s. The Pentecostal Congregations started in the 1930s and The Holy Mission in the 1950s, thus being younger than the Lutheran Churches. When the health institutions were handed over in the 1960s, they became property of the dioceses/synods in ELCT or of the PCAT. Thus the health facilities have never been the property of the local congregations.

In order to get an idea of the actual relationship between the dispensaries and their local congregations we interviewed pastors, other congregation members and the dispensary staff in the places visited. Within ELCT we also made interviews with members of medical boards and medical secretaries on the diocese level, and within PCAT we made complementary interviews with members of the medical committee and the coordinators in Dar.

15.2 Dispensary committees - the main link

All the four dispensaries have dispensary committees. The chairperson of a committee for a PCAT institution is always the person in charge of the dispensary in question, and the dispensary staff is in majority.

In the committees within ELCT the pastor is chairman and the staff is in a minority. The village is sometimes also represented.

In PCAT the dispensary committees report to the medical committee, which is headed by the doctor in charge at Nkinga Hospital. ELCT committees report to the diocesan/synodal medical board and the medical secretary. The reporting is of informative character, even though the dispensary committees sometimes come up with suggestions.

15.3 Weak involvement of the local congregation

All staff interviewed regard the input from the congregations to the dispensaries as limited. The leaders of the congregation are supposed to read services and give individual counselling at the institutions, but other congregation members have no special contact with the dispensary. Regular contributions, financially or in form of labour do not exist, but it is rather the dispensary staff that assists the congregation in form of education and information.

The staff is not obliged to belong to the congregation where they work, but they are expected to be loyal to Christian ethics. In fact, most of the staff belong to the church for which they are working.

15.4 Ownership

Within ELCT the dioceses are considered to be owners of the health facilities, but the institutions are regarded as self-governed. External support is on an interchurch level and not dependent on missionaries or the mission.

As to the PCAT dispensaries it was not possible for the team to clarify ownership. In some cases the Pentecostal Association, in other cases the mission or the missionaries were understood as owners.

15.5 Conclusions

The hypothesis that the local congregation takes an active part in the activities of their health institution is not confirmed, and the potential of the local congregation is not used. The integrity of the dioceses and PCAT towards the sister churches seems to be more important than the local congregation as to the sustainability of a health institution.

The relationship between a dispensary and the church is more on another level, (diocese or PCAT). It is of administrative character, even though the relationship also offers the dispensary some kind of safety net.

The network of the local congregation could likely be used for outreach activities and community feedback, thereby increasing the sustainability of the health institution. In this connection it is worthwhile discussing local ownership and mutual relationship between the local congregation and the health service given.

16. Integration into the health care structure

As mentioned before there are clearly stated national objectives regarding PHC to which all health institutions should be geared. These objectives first formulated in the 1970s were to be achieved gradually depending on the government's ability to develop and run health institutions. One question is consequently in what ways the VA institutions fit into or hamper this structure. Another question is to what extent the SIDA-built rural health centres were timely in achieving the national objectives.

16.1 The VA dispensaries

Most church facilities are small well-functioning islands loosely linked to the health care structure. In terms of management these facilities operate independently. As service institutions they are linked to the health care structure through the professional supervision of district medical officers (DMOs) in addition to the fact that they provide service to people with poor or no alternatives. The role of church health institutions is thus important for the plans of the health care sector and vice versa.

16.2 The SIDA-built rural health centres

Most of the SIDA-built rural health centres are now in urgent need of repair and general maintenance. This is due to the shortage of funds experienced by the government arising from the general decline of the national economy.

However, at the time of their construction, the health centres were seen as a punctual support within the health care structure. Given the healthy state of the economy at that time, the ability of the government to run the health centres was taken for granted and no serious efforts were made to assess the long-term capacity to maintain the quality of the facilities.

16.3 Conclusions

Church health institutions are dependent on patient fees and subsidies whereas government facilities are dependent on government funding. Both categories are also dependent on each other and complement each other, and at least the sustainability of the church facilities is very much related to the government policy as well as the service offered at government facilities in the vicinity.

Throughout the report, we have also shown that given the actual macro-economic situation, being an integral part of the government health care structure is a serious obstacle for the sustainability of a health institution such as a rural health centre or a dispensary.

17. Overall conclusions

17.1 A variety of mechanisms influence sustainability

The macro-economic situation in Tanzania, like in many other African countries, makes it difficult to achieve sustainability. This is especially relevant for the health sector, always one of the most vulnerable and affected sectors.

Earlier studies have shown that the government health facilities do not have the functions they were planned to have, thereby distorting the whole national health care structure. The same conclusions are still valid.

The prerequisites for health care projects carried out by voluntary agencies (VAs) are different. The projects are limited to a certain number of health institutions. To some extent these institutions have other goals than the government health facilities. The national health care structure is to be financed by the government and is supposed to give free service to all Tanzanians. The government support to the VA health facilities is limited. An important goal for them is therefore to see to it that the institutions survive economically.

These differences make it difficult, sometimes also irrelevant, to compare sustainability conditions of single institutions run by voluntary agencies and an overall health care structure.

17.2 Factors without a clear relationship to sustainability

Some suggested factors that were investigated did not show any clear and direct relationship with sustainability. This does not mean that such a relationship does not exist, only that *the factor is not a necessary precondition* for sustainability. To find out if the actual factors further sustainability *under certain conditions*, another, more sophisticated study design would have been needed.

It was for example supposed that involvement of the local community increases sustainability. In the study, neither the sustainable nor the non-sustainable HFs have a continous contact with the local community. None has consistently involved the community in the activities, even though this is a potential resource. The same is valid for the local congregation, that does not play the role it was thought to do.

Representatives of the communities, both women's groups and village leaders, have throughout expressed a will and interest to assist the health facility if necessary. However, VA health institutions are considered as *"belonging to the church"* or *"mission dispensaries"*, and the villagers do not want to interfere, if not asked.

As to the design of projects we have found no obvious relationship between *planning procedures, scale of the projects* or *length of time of donors' involvement* on one hand, and degree of sustainability on the other. A long-term involvement may further sustainability but it may also prevent such a development and make a certain

dependence permanent. The scale of a project is not directly related to sustainability, even though it seems as if a small project can more easily adapt to necessary changes than a large project. Furthermore, involvement of the recipient country in the planning process does not guarantee sustainability.

17.3 Necessary preconditions for sustainability of VA dispensaries

While the government health centres are very much dependent on the macro-economic situation and decisions taken on the national level, the VA health facilities are highly autonomous units. The VA dispensaries can be described as small health care enterprises with a committed staff and with a tie to its church, which functions as a safety net, in case of difficulties.

Given the actual context, there are several factors at the local level and inside a VA health institution that are important for its survival. In the study we have found that the following *necessary preconditions* have to be at hand in order for a VAHF to be sustainable.

A good reputation. When the patients were asked what they thought they could do to the health institution, many answered: *Tell others about the good service!* And actually, the most important precondition for a VA health facility to be sustainable is a continous stream of satisfied patients.

Creating local income. All church dispensaries studied have chosen to charge patient fees, which mainly consist of sale of drugs. A precondition for having an income from the sale of drugs is that the dispensary obtains the drugs at a subsidized price from different donors as well as from the essential drugs programme. It is also necessary that the health facility buys and keeps the adequate stock of drugs. Hence, the management capability of the HF is very important. Relying heavily on drugs for sustainability financially is however a risky matter and furthers development towards curative are.

It is also very much dependent on the macro-economic development. The situation in one of the VA dispensaries could be used as an example. In 1979 90% of the running costs was covered by patient fees in that HF. In 1989 the corresponding figure was 45%. This change can be explained by increased expenses like staff salaries and purchase of drugs.

Furthermore, the sale of drugs is very much related to both insufficient preventive health care in the surrounding community and to lack of drugs in governmental health facilities, a situation that will hopefully change in the future.

Minimizing the staff. Another precondition for a VAHF to be financially sustainable is to have as few staff members as possible. The HF identified as most self-sufficient is in fact understaffed by as much as 40% in comparison to Government RHCs.
In the long run, the staff question has to be solved by assistance from the Government through staff grants or/and seconded staff.

Promoting the staff. The trained staff at the (most) sustainable HF has remained longer than at any other of the VA facilities studied. This is explained by the fact that the staff is encouraged by up-grading, by scholarships and other incentives during studies. Stressing common values and a *"we-feeling"* are also of importance.

Adapting transport means to the economy. The VA dispensary that is financially self-reliant cannot afford to buy a car for referrals, out-reach activities or mobile clinics.
It implies that it is only possible to keep a high service quality outside the HF if other transport means are available. This is the case with the sustainable dispensary, that is situated close to a highway. However, it seems as if missionaries have often chosen remote places, where no public transport exists. In these cases, sustainability may be reached at the expense of a deteriorated service quality.

Caution as to expansion. Financial self-sufficiency is related to a certain defined service level. When, in the case of expansion, the health facilities obtain support from abroad in form of capital investments, like buildings, the expenses increase. Experiences show that problems easily arise, and that support from outside is often needed for maintenance and salaries.

Skilful management. In order to fulfil the preconditions above a skilful management of the health institution is needed. If the administration does not function very well, if the person in charge does not plan and follow-up activities, the number of patients coming for curative service might decrease.

A solid and/or equal community. It is evident that there is a variation between communities as to the ability to pay patient fees, and in some of the VA health facilities the number of unpaid bills was high. This is particularly valid for transport costs for referrals to hospital.

Sometimes, there is also a variation within a community. Women complained about the patient fees more often than men. This was particularly the case when the women had to use their scanty resources for health care for the whole family.

A tie to the local church. A good relationship between the person in charge and the local church is another necessary precondition for a church health facility to remain self-reliant and to be able to maintain an adequate quality. For a sustainable health facility the church plays the role of safety-net in case of problems. For facilities that are not (yet) self-reliant the church has the permanent role of life-line. However, in most of the cases studied the local congregation is little involved, in spite of the fact that it is a potential resource for all the VA health facilities.

The positive policy of the government. Without the positive attitude that the authorities show towards the voluntary agencies and their facilities, these health facilities would not be able to exist. For the future it is necessary that VAs invite representatives of the local governments, both on local and district level, for advice and exchange of ideas about the activities at the health institutions.

In order for more VA health facilities to develop towards self-reliance a mutual relationship between the facility and the community is also suggested.

S I D A
Planning Secretariat
Evaluation Section

APPENDIX 1

1 October, 1990

STUDY ON SUSTAINABILITY IN HEALTH CARE SECTOR PROJECTS IN DEVELOPING COUNTRIES

TERMS OF REFERENCE

BACKGROUND

During the last few years, donors have become increasingly aware of the lack of sustainability observable in development assistance projects. Activities which have received financial, material and technical assistance for many years often experience serious difficulties when this support is withdrawn. This phenomenum may depend on several factors ia the financial pre-conditions for the project's continued activities, the design of the assistance received, how long the support has been supplied and how this external support was phased out.

In this context the question arises as to whether any distinctions can be observed between the projects which have been supported by SIDA and those run by NGOs, and in that case what the cause of these distinctions is. Both SIDA and the NGOs would benefit from increased knowledge as to how the design of the assistance and its sustainability are interconnected.

Sustainability is no given concept but must be defined. The concept consists partly of an aspect concerning time - that the activity continues after withdrawal of external support - and partly of an aspect concerning quality - the activity must offer a service level of acceptable quality. Another issue concerns whether all external support must have been withdrawn if a project is to be assessed as sustainable or if a certain level of limited assistance in some form can be accepted.

Development assistance within the Health Care sector in the form of support to primary health care in rural areas has been carried out by both SIDA and NGOs - primarily the Missions - for many years in, among other countries, Tanzania. This is therefore a suitable country in which to implement a study on sustainability. Lessons learned from such a study could be expected to be specific to the Health Care Sector but also be of a more general application. This latter information could

therefore also be useful in other development assistance sectors operated by both SIDA and NGOs.

Bilateral health care development assistance has been evaluated in several different studies. The Missions also implement regular studies of an evaluation nature. There is much information, therefore, already gathered within both these organisations.

During the course of time, the goals, scope and character of development assistance within the Health Care Sector have altered considerably - a fact which should be noted when health care inputs are assessed. Priorities within the area of primary health care have shifted e.g. from curative to preventative health care, the individuals own responsibility for their health has been emphasised more and more, decentralisation of organisational structure has been carried out and the implementation responsibility for development assistance projects has been successively transferred to recipient country institutions. The strategy for primary health care adopted by the WHO conference at Alma Ata in 1978 has been decisive for the direction taken in such projects in developing countries. Many developing countries including Tanzania have adopted health care sector strategies of their own which reflect the ideas behind the Alma Ata Declaration.

SIDA's assistance to the Health Care sector has a time perspective of 25 years, while the Missions' activities stretch over a considerably longer period. It is essential that the planned evaluation take this historical perspective into consideration when assessing projects. They must be appraised from the point of view of the development assistance philosophy relevant to the period of design and commission, and the development assistance philosophies which held way in the different periods which followed.

AIM OF THE EVALUATION

The aim of the evaluation is to increase both SIDA's and NGOs' knowledge of factors which contribute to successful sustainable development assistance. The study is limited to the Health Care Sector, but some conclusions will hopefully be applicable to other sectors as well. It is hoped that this knowledge will lead to project planning and implementation structures which will include these essential factors which lead to sustainable development after withdrawal of support.

The study shall concentrate on identifying the factors which contribute to, or hinder, the sustainability of the project. The study shall not attempt to assess individual projects.

THE TASK

The study is to be carried out in Tanzania where both SIDA and the NGOs have several development projects of a long term nature.

The study shall concentrate on development assistance inputs in the Health Care Sector in the rural areas of Tanzania where support has been given to health centres and dispensaries/clinics in the form of buildings, equipment, technical assistance personnel, training and drugs. Attention shall be paid to the intersectoral co-operation within the Health Care Sector with e.g. the Water, Education, Agriculture and Nuitrition Sectors.

The following should be examined:

- the methods of planning and implementation of Health Care sector projects; the normal route from idea to implementation for SIDA respectively Mission projects.

- the length of time of the respective donors' involvement; how long do they continue to contribute technical assistance personnel and other resources? How is phasing out and withdrawal implemented?

- the degree of adaptation to and integration into the recipients' health care structure. To which extent do the donors build their own structures and which long-term effects does this have?

- the scale of the projects, small or large? Can certain inputs only succeed if carried out on a small-scale basis? Do the Missions' projects function specially well because they are on a small scale? Do larger scale projects have the same chances of success?

- The churches' projects often take the form of "pilot projects". It is well known that pilot projects tend to be specially successful as they are paid maximum attention and problems are solved as they arise even to the extent of taking out-of-the ordinary measures. Often results are less good when these projects are replicated or implemented on a larger scale. Are there any examples of projects which have been replicated on a larger scale eg establishment of a series of clinics/dispensaries? Have successful results been maintained?

- Special characteristics of NGOs versus governmental development assistance. To what extent does the everyday community life of the two church groups affect the result? How much does motivation affect development assistance?

- Does the Mission have a greater ability to organise popular participation in health care sector projects and what effects does this have on sustainability? How is help to self help stimulated in such projects?

The evaluation team shall attempt to establish connections between the above mentioned factors and sustainability. The evaluation team shall also attempt to identify other connections.

Common experiences among donors have shown that the following factors are generally critical for the sustainability of development assistance projects:

1. The developing countries' commitment during the planning and implementation of projects.

2. Management, organisation and local participation.

3. Continued regular flow of funds to cover operational costs.

4. The correct and appropriate level of technology in comparison to the competence of local personnel and institutions and the financing of the project. Also the establishment of mechanisms for the maintenance and renewal of technology.

5. Integration of projects into the socio-cultural context in which they are expected to work. The adaptation of the project to the situation of the different target groups eg men, women and children. The projects' ability to reach the poorest.

6. Adaptation and consideration for environmental and ecological factors.

7. External factors lying outside the control of the project eg political and economic instability, cultural difficulties. Natural disasters obviously affect the sustainability of the project. (In Tanzania for example, the economic crisis and the structural adjustment programme have probably affected health care sector assistance).

The evaluation team shall test and attempt to verify to what extent these 7 factors have affected sustainability in the Health Care Sector projects included in the study.

METHODOLOGY AND TIME SCHEDULE

The study shall be implemented in close co-operation with SIDA, the organisations whose projects are included in the study and the recipient country (Tanzania).

The work is to be initiated by two pre-studies;

1. A survey of health care sector organisation in present day Tanzania plus an historical perspective. This should preferably be carried out by a Tanzanian. Estimated time allotment - approx 4-5 weeks.

2. A survey and collation of Swedish development assistance to Tanzania within the Health Care Sector. A description of how assistance has developed and altered over time. This should preferably be carried out by a Swede. Estimated time allotment - approx 3 weeks.

The study is to commence in Sweden with studying, the reports from the two pre-studies plus any other relevant material and with complementary interviews. The different concepts to be utilised will be defined, a framework and a definition of constraints will be established, evaluation methodology will be decided upon, criteria for sample selection will be agreed and the actual selection made. Before the field trip(s) to Tanzania, the team shall present a proposal concerning definitions, constraints, selection and methodology to the Executive Group for comment and approval.

The next phase of the survey will be in the field in Tanzania. This shall comprise visits to selected projects plus in-depth interviews with target groups, personnel, project management and government representatives at local, regional and national level. Depth is preferable to breadth in this survey. The emphasis is to be put on the people who form the target group and the health care offered to them.

The Tanzanian involvement in this study is important. This will be acheived in two different ways. The pre-study on health care sector structure and situation will be carried out by a Tanzanian. It is also adviseable if half the evaluation team (two people) is composed of Tanzanians. An active dialogue with the target group, personnel and project management shall form an important part of the study. When the study has been completed it will be translated into Kiswahili in order for a wide circle of interested parties in Tanzania to be able to share in the conclusions drawn. It is planned that seminars and

discussions will be held in Tanzania once the study has been completed and presented.

It is proposed that the evaluation team consist of two Swedes and two Tanzanians and that the following areas of knowledge be properly covered by the members of the team:

- development assistance in the Health Care Sector

- health care in Tanzania

- development assistance methodology including organisational matters, transfer of knowledge and institution building

- the roles of women, children and men

- evaluation methodology

The main study, including the report writing phase is estimated at 14 weeks, (five weeks preparation and documentation study, 4-6 weeks in Tanzania, 3 weeks analysis and report writing) for the team leader who is also responsible for the production of the report. The rest of the team will be engaged for approx 6-8 weeks.

REPORTING

A verbal report concerning preliminary conclusions will be provided to the Development Cooperation Office (SIDA), to the organisations and to other relevant bodies in Tanzania before the team leaves the country.

A draft report shall be submitted to SIDA and the organisations within two weeks of the end of the commission. The draft report will be studied by the Executive Group and returned to the evaluation team with comments in order for a final report to be established. The final report shall be submitted by 7 January, 1991.

The report shall be written in the English language and be translated into Swedish and Kiswahili.

The evaluation shall be presented at seminars in Sweden and Tanzania. Participation in these seminars forms an integral part of the evaluation teams commission.

The report shall be typed on an IBM or IBM compatible word processor using the word processing programme WORD.

THE EXECUTIVE GROUP

This group shall be responsible for the study being carried out in such a way that its aims are acheived. This group shall meet and jointly make any necessary decisions at strategic points in the evaluation process. The most important of these points are:

Approval of Terms of Reference

Selection and procurement of consultants

Approval of plan of operation established by evaluating team

Commenting on draft report

Approval of final report

Planning of seminars, possible publishing of report and other points in the transfer of knowledge process.

The Executive Group consists of:

From SIDA

Elisabeth Michanek - Evaluation Section, Planning Secretariat (Chairperson)

Gunilla Essner, Health Division (Substitute Lise Munck)

Bo Stenson, NGO Division

From the Churches

Märtha von Holst, SMR, Swedish Mission Council, Office for International Development Co-operation (substitute Ruth Abrahamsson EFS, Swedish Evangelical Mission)

Ingvor Agnarsson, PMU, InterLife (substitute Evy Norrman)

Rune Backlund, SKM, Church of Swedish Mission (substitute Martin Ljungman)

Appendix 2
List of Abbreviations

CCM	Chama Cha Mapinduzi
CSM	Church of Sweden Mission
DED	district executive director
DMO	district medical officer
EDP	essential drugs programme
ELCT	Evangelical Lutheran Church of Tanzania
EPI	expanded programme of immunization
GDP	gross domestic product
GOT	Government of Tanzania
GOTHF	government health facility
HC	health centre
HESAWA	health, sanitation and water programme
HF	health facility
HM	The Holiness Mission
IMR	infant mortality rate
MA	medical assistant
MCH	maternal and child health
MCHA	maternal and child health aide
MOH	Ministry of Health
NGO	non-governmental organization
OPD	out-patient department
PCAT	Pentecostal Church Association of Tanzania
PHC	primary health care
PM	The Pentecostal Mission
RHC	rural health centre
RMA	rural medical aide
SEK	Swedish kronor
SEM	Swedish Evangelical Mission
SIDA	Swedish International Development Authority
TB	tuberculosis
TBA	traditional birth assistant
TM	traditional midwife
T Shs	Tanzanian shillings
VA	voluntary agency
VAHF	Voluntary agency health facility
VHW	village health worker

Appendix 3

Acknowledgements

The study has been planned and carried through in close collaboration with the reference group in Stockholm, consisting of representatives from the Planning Secretariat, Health Division and NGO Division, SIDA, representatives of The Church of Sweden Mission, The Holiness Mission, The Pentecostal Mission, and The Swedish Evangelical Mission.

There has also been a continous exchange of ideas and experiences with members of the staff in the health institutions visited in Tanzania. Without their interest and commitment, it would not have been possible to carry out his study.

We would like to express our gratitude to all those whose names appear in the list in appendix 4, and we are particularly grateful for the hospitality and the friendliness the staff members at the visited dispensaries showed us. We would also like to thank many others for their valuable contributions; all the women and men, patients and villagers who shared their views and impressions with us during the field phases of the study . We hope that their voices will be heard and that the future health care will not only be planned *for* but will be elaborated *together with* the community.

The team members

Appendix 4
Persons interviewed

Mwanza
Per Brandström, HESAWA
Mr Mtui, Deputy Director, HESAWA

Bukoba
Mr P.M. Faiko, Regional Health Officer, Kagera
Mr J. Lutabingwa, Adminstrative Secretary, ELCT/NWD
Rev. Dr Samson Mushemba, Bishop, ELCT/NWD
Dr S.M. Tibangayuka, Ag. Regional Medical Officer, Kagera
Mr E. Ngemera, Medical Secretary, ELCT/NWD
Rev W. Niwagila, Head of Ruhija EA, ELCT/NWD

Izimbya Dispensary
Mr E. Rwabukamba, Medical Assistant
Mr Mats Leijman, Nurse

Kyaitoke village leadership
Protas Benedict, Chairman, Kyaitoke village

Kyaitoke parish
Rev. G. Lwegayura, Parish pastor

Katoro Rural Health Centre
Mr B. R. Kishobera, Medical Assistant in charge, Katoro RHC
Mr A. Rwegoshora, Medical Assistant, Katoro RHC

Nkinga Hospital
Dr Anders Brunegård
Mrs Gudrun Brunegård
Ms Astrid Boork, Matron
Dr Martin Wahl, Medical Officer in charge

Kahama District
Mr M.M. Mwinyijuma, District Party Secretary
Mr J.M. Gasembe, District Executive Director
Mr E. T. Temba, District Officer
Mrs Laurencia Gasembe, District Health Secretary
Mr J.K.N. Mulazi, District Planning Officer

Ukune RHC
Mr L.J.N. Mbogo, Medical Assistant
Mrs Mary G. Mampala, Public Health Nurse, Ukune RHC

Mpera Dispensary
Annette Gren-Johansson, Sister in charge

Mpera Village Leadership
Mr William Silutongwe
Mr Dalali Kazwala, chairman
Mr Adam Kulaba, Secretary
Mr Kodoge Ntemi

Mpera Women's Group:
Mrs Pascalia Silutongwe

Mpera pentecostal congregation
Mr S. Kalyango, parish pastor
Mr P. Masonda, parish elder, Head of Vocational Training School

Lowa Dispensary
Inger Strandvik, Sister in Charge
Mary Johansson, Nurse

Isanzu Dispensary
Mr Deusdedithy Peter, Rural Medical Aid in charge

Iringa Diocese
Mr Mats Lundgren, Auditor
Mr E. Munyawami, Medical Secretary

Iringa Regional/District Hospital
Dr Omari Lushino, Ag Regional Medical Officer

Iringa Municipal Council
Mr S. A. Tarimo, Municipal Director, Iringa

Ilula Dispensary, Iringa
Mr M. Saga, Medical Assistant, Ilula/Itunda Dispensary
Mrs Saga, MCH Aid

Ilula Parish
Rev. Peter Kinyaga, Pastor

Women's group, Ilula
Mr Faines Nyinge, coordinator

Village leadership, Ilula/Itunda
Mr Petro Mnenegwa, Chairman
Mr William Kimbavala, Secretary

Ipogoro Urban Health Centre
Mr M.P. Salila, Medical Officer in charge
Mrs H. Masito, Nursing Officer in charge

Kibondo District

Mr Michael Bashingwa, Chairman District Council
Dr Clement Masanja, District Medical Officer
Mr Katole R. Kibegwa, District Health Officer

Muhange/Kabare Dispensary
Ms Marie-Louise Bergendahl, Sister in charge
Ms Anne-Marie Hylander, Nurse
Ms Christina Emilsson,Nurse Assistant
Mr Gunnar Axelsson, Building Engineer
Mr Samson, Rural Medcial Aid
Mr Nashon Bakobwa, Rural Medical Aid

Kabare/Muhange Village Leadership
Mr Pius Barumuhati, Chairman
Mr Boniface Chiza, Ward Secretary
Mr Joseph Nderego, Counciller
Mr Renatus Nyakamoi, Branch Secretary, CCM
Mr Raphael Manangara, Ward Assistant
Mr Zacharia Wamie, Village Secretary

Kaziramihunda Village
Mr Mosses Mapha, Village Chairman

Muhange Village
Ms Koleta Nura, Coordinator Women's Group
Mr Laurian K. Ntumva, Community Development Assistant
Mr Ramadhami Bakari, Rural Medical Aid, Muhange Government Dispensary

Keza Dispensary
Ingmarie Klasén, Sister in Charge
Ulla Gustavsson, Missionary in charge

Keza Pentecostal Congregation
Mr I. Makoko, Pastor

Nyanzige RHC
Mr M. Mattama, Medical Assistant in charge

Dar es Salaam
Dr Mahimbo, Executive Secretary, Christian Medical Board, CMBT
Mr Royne Westberg, Coordinator, PCAT
Mr Reine Log, PCAT
Mrs Safe, N/O PHC, MCH/EPI Program, Ministry of Health (MOH)
Dr A. Mzige, Medical Officer, MCH Program, MOH
Dr Kimambo, Medical Officer, EDP, MOH
Mr J. Kelya, Health Secretary EDP, MOH
Mrs Emma Sundberg, SIDA Coordinator, MOH
Mrs Margaretha Sundgren, Health and Water Program Officer, SIDA
Mr Arne Ström, Head of SIDAs Development Cooperation Office

Members of the reference group in Stockholm

SIDA:
Elisabeth Michanek
Gunilla Essner
Karl-Anders Larsson
Lise Munck
Bo Stenson

The Churches:
Ingvor Agnarsson
Rune Backlund
Märtha von Holst
Bernt-Olof Karlsson
Evy Norrman

Appendix 5

Fig. Actors involved in the SIDA supported rural health centres - a model

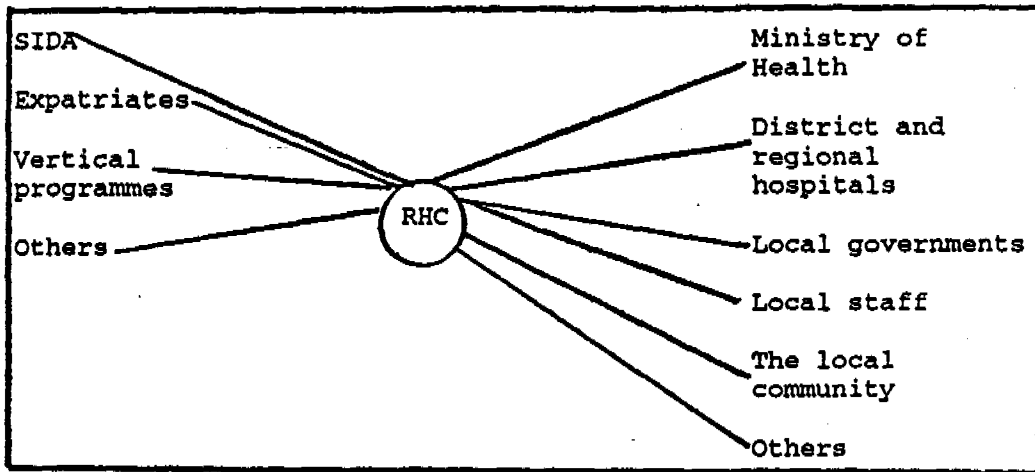


Table. Patients' homes in % of all patients within each visitor category
a=inside the catchment area
b=outside the catchment area

Dispensary:	A		B		C		D	
	a	b	a	b	a	b	a	b
Type of visitors								
Out-patients	55	45	62	38	96	4	27	73
Ante-natals	50	50	58	42	93	7	40	60
Children	60	40	54	46	93	7	30	70
Deliveries	70	30	(96)	(4)	?		62	38
In-patients	66	36	52	48	92	8	-	

Appendix 6
Quality Assessment

Different types of data have been collected. Interviews and observations have been combined with monthly and annual statistics from the institutions. So for example the availability of equipment for medical service as well as facilities for running an institution were observed, and the transport issue given particular attention.

The basis for the professional assessment are the objectives formulated for the primary health care programme (PHC) adopted by the Government of Tanzania in 1978. The program is concretized by activities, often referred to as *the eight elements:*

> health education, local disease control, essential drugs availability, MCH service and immunization, nutrition, water and sanitation. Lately, mental and dental care have also been added.

Quality assessment of the eight HFs studied

	Institution							
	A	B	C	D*	E	F	G	H
Health education	3	2	1	1	2	2	2	2
MCH/EPI	2	2	2	2	2	3	2	3
Outreach	1	1	2	1	2	2	2	1
Contacts with traditional health workers	0	1	0	0	1	2	1	1
Trained staff	1	1	2	1	2	2	2	1
EDP	2	2	3	3	0	0	3	0
Car	0	2	3	3	0	0	3	0
Clinic equipment	2	2	3	3	1	1	2	1
OPD equipment	2	2	3	3	1	1	1	1
Ward equipment	2	2	3	2	1	1	0	1
Total	15	17	22	19	13	15	16	12

*) This dispensary is categorized as an unbedded dispensary but has proper overnight beds

We would like to stress that the table should be looked upon as a very rough measure and as a basis for discussion. It should not be considered as an evaluation of the individual HFs. It is the general patterns that are of interest.

Appendix 7

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