

# **DECENTRALIZATION AND GENDER**

A STUDY ON COORDINATION AND COOPERATION IN LGA FOR MATERNAL  
HEALTH

PMO-RALG

Royal Norwegian Embassy

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Thanks are also due to Bodil Maal, Royal Norwegian Embassy, and Lesley Saunderson, PMO-RALG, who facilitated the study and took great interest in the findings.

List of acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ALAT	Association of Local Authorities in Tanzania
AMREF	African Medical Research Foundation
CBO	Community Based Organization
CCM	Chama Cha Mapinduzi (Political party)
CSPD	Child Survival Protection and Development
D by D	Decentralisation by devolution
DADS	District Agriculture Development Support
DFID	UK Department for International Development
DMO	District Medical Officer
DOC	Drivers of Change
GEWEF	Gender Equality and women Empowerment Framework
GMWG	Gender Macro Working Group
GRB	Gender Responsive Budgeting
HIV	Human Immune-deficiency Virus
IRDO	Ileje Rural Development Organization
LG	Local Government
LGA	Local Government Authorities
LGRP	Local Government Reform Programme
MDG	Millennium Development Goal
MKUKUTA	Mkakati wa Kupunguza Umaskini Tanzania (PRSP)
MMR	Maternal Mortality Rate
NGO	Non-Governmental Organization
NGOs	Non Governmental Organizations
NORAD	Norwegian Agency for Development Cooperation
PLWHA	People Living with HIV/Aids
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
REPOA	Research on Poverty Alleviation
SADC	Southern African Development Community
SIDA	Swedish International Development Agency
SOSPA	Sexual Offences Special Provisions Act
TASAF	Tanzania Social Action Fund
TGNP	Tanzania Gender Networking Programme

## **Executive summary**

### **Introduction**

#### **Decentralisation by Devolution**

Tanzania initiated the Local Government Reform Programme in 1996. The objective was to strengthen Local Government Administrations' ability to deliver quality and accessible services as well as to empower local communities. It was considered necessary to review the planning and implementation process to broaden the participation of local communities, NGOs, CBOs, the private sector and other development actors, to achieve the key aspects of “D by D”, decentralisation by devolution.

#### **Gender equality and equity**

Tanzania has committed herself to address gender equality and equity as well as women's empowerment by ratifying a number of global and regional instruments which advocate for gender equality. Improved service delivery at local government level as well decision making are key gender issues.

#### **Maternal mortality**

In May 2006 the Royal Norwegian Embassy supported the Prime Minister's Office for Regional Administration and Local Government (PMO-RALG) to review how gender issues were integrated in the local government planning and implementation processes. It was agreed that while gender mainstreaming and specific women empowerment initiatives are being undertaken within local governments, there is a need to use an additional issue based approach, based on the priorities of the National Strategy for Growth and Reduction of Poverty and the Millennium Development Goals. In line with the Local Government Reform, it was decided to focus on cooperation and coordination between different actors at the local level – using maternal health as the entry point and example.

The Norwegian Government has signed a bilateral agreement with the government of Tanzania supporting initiatives regarding maternal and infant mortality with 30 million USD during the five year period 2007-2011.

### **Goal, objective and organisation of study**

The focus of the present study is on coordination and cooperation. Maternal mortality, one of the Millennium Development Goals, is used as the entry point and example, bearing in mind that there is a close link between MDG 4 and 5, i.e. between infant and maternal mortality.

The objective of the present study is to identify the reasons why some districts are performing better than others when it comes to cooperation on maternal health, identify best practices, and disseminate the practices to other districts.

The final goal of the present study is to

- contribute to the strengthening of D-by-D and strengthening of governance at district level
- contribute to sharing and learning among districts on gender issues
- contribute to create greater demand for resources for “women's issues” at district level and to contribute to highlight the maternal health situation as a public problem

The study is organized in three different phases:

- Phase 1: January – March 2007: Visit to four selected “good practice” districts
- Phase 2: May 2007 – March 2008: Dissemination of good practices to ten other districts
- Phase 3: March – May 2008: Summing up of results.

During phase 1, districts were selected that could represent good practices. The criteria for selection for phase 1 were:

- The situation with regard to maternal mortality.
- The situation with regard to % of population below poverty line
- The situation with regard to % score of LGA performance

The following districts were selected:

District	Region	MMR (out of 100,000)	People living under basic poverty line (in percent)	Score on LGA Performance (in percent)
Moshi (R)	Kilimanjaro	39	28	85
Ileje	Mbeya	97	31	65
Serengeti	Mara	115	61	69
Misungwi	Mwanza	116	40	66
Mtwara ( R )	Mtwara	119	37	69

Mtwara district was later abandoned for practical reasons.

The phase 1 team, included two international consultants, Liss Schanke and Siri Lange, four national consultants: Christine M. Warioba, Rehema Mwateba, Betty Muze, Julian Myeya as well as two representatives from the Royal Norwegian Embassy; Bodil Maal and Amina Joyce Lwasye.

In addition, the field visits involved PMO-RALG and contact persons in the four districts who participated in many of the meetings and also contributed with the organisation of meetings. The key contact in PMO-RALG has been Governance adviser Ms. Lesley Saunderson. The team also met with the Director of the PMO-RALG Governance department, Mr. S. Kahitwa. The ownership of the study lies with PMO-RALG.

The district visits were done by teams of 2-4 persons; meetings were conducted either in English or in Kiswahili. The teams met with representatives of the Regional Secretariat, the Local Governments administration and elected councillors, NGOs, CBOS, health institutions and communities.

## Main findings from phase 1

### Fruitful approach

The team found that it was fruitful to use maternal mortality as a concrete entry point to cooperation and coordination. The approach made it possible to get specific and concrete information from the districts visited.

The team believes that it is correct that the maternal mortality rates are low in all the four districts visited – but that the reasons for the low rates differ in the different districts.



The team believes that a focus on improving cooperation and coordination on maternal health has positive side effects:

- for the health situation for women and children in general as well as for the entire population
- on cooperation and coordination regarding other areas and services

### **Different reasons for low maternal mortality**

In the case of Moshi, the low MMR is first of all due to the general high level of education, the positive economic situation, women's income, and a large number of health facilities (partly established by missions, partly by self-help activities and wealthy individuals). These are all factors that are hard to replicate in districts that have less favourable socio-economic backgrounds.

Ileje, Misungwi and Serengeti, on the other hand, are more interesting in terms of replication and learning. The three districts are all relatively poor, and the low maternal mortality rates are the result of specific area based donor funded projects and local initiatives targeting maternal health (as well, in the case of Ileje and Serengeti, mission hospitals).

### **Area based projects with similar focus**

All the projects focusing on maternal health have similar characteristics:

- Vertical cooperation between health facilities and staff: regional, district and village
- Horizontal cooperation between health facilities, government and private
- Focus on the initiatives at community level: the voluntary village health workers, the village health committees and the traditional birth attendants
- Focus on increasing delivery at health facilities and improvement of health facilities
- Mobile clinics and outreach units to isolated areas as well as improved means of transport and communication
- Committed and serious key staff and improvement of health workers' attitude and language
- Women's economic empowerment was a key factor in all the projects; one of the projects included savings groups for delivery and transport expenses. Two of the district projects included a male involvement, i.e in the savings groups and in the transport on stretchers when pregnant women needed to go to health facilities for delivery.

### **Cooperation between district departments**

The cooperation between district staff and departments varies between districts, departments and staff members. In all districts the Health Department played a key role, and the coordination with Department for Planning seemed to be good, as well as with the Department for Works.

The Department for Community Development plays a minor role re. community improvements for maternal health improvements in all the four district – due to the financial position. In all the four districts the department lacks transport and fuel and depend upon transport from Departments of Education and Health to visit communities. This implies that the key function of this department and their staff is not adequately fulfilled. However, in one of the district, this department was coordinating the data collection regarding maternal deaths.

### **Cooperation between district staff and councillors**

District councils are complicated bureaucratic organisation with large budgets and plans. The councillors' key role in decision making is complex – and probably difficult to grasp for most councillors with relatively limited education and experience. This does not mean that only people with a high level of education should become councillors, but does constitute an enormous challenge for councillors' training. In some cases, the difference in educational level between councillors and staff seems to have created conflicts: lack of respect for councillors among staff and lack of understanding of the staff members' situation among councillors. In two of the districts, the relationship was good. The cooperation between councillors from different political parties seems to be relatively good in all four districts.

### **Cooperation between district and NGOs**

There still seems to be a potential for improvement in this area. Two of the districts mention that the NGOs were reluctant to share information on funding. With regard to HIV and education the situation was very good as the funding goes from the national level to the district – and is allocated to the NGOs by the district. In one of the districts, the district facilitated the work of the NGOS, e.g. through introduction letters to the communities.

According to the LGR, the district administration has a key role in the local coordination of service delivery. Only one of the four districts, Moshi, seems to have an adequate number of staff – and qualified staff. The three other districts all have shortage of staff with regard to positions filled and qualifications, one of them a very serious shortage. This has a negative impact on the district coordination with NGOs and with the private sector in general. The number of female staff varies very much between councils, from 50 percent of Heads of Departments to none.

### **Cooperation between district and private sector**

One of the districts had had several cases of staff misuse of funds. Some of the cases were related to cooperation with private sector, e.g. procurement of goods and services. The team did not go into issues regarding tendering procedures, contracts and follow up of contracts, but this may often be a complicated area for district staff as well as for councillors.

### **Different access to external funds**

The number of donor projects in the four districts varies greatly. Moshi has a very large number of donor funded projects, the other three relatively few. The existence of projects does not seem to be proportional to the actual needs. In Moshi for example, 64% of the population have access to clean water – and this will be even better in the future since the district has been granted a large German funded project. In Misungwi, on the other hand, only 32% of the population have access to clean water (and no large scale water projects are planned).

### **Important basket funding mechanism**

Several of the districts have profited from the LGCDF – apart from one that was not eligible due to unclean audit reports. All districts get Health Basket Funds.

### **Examples of conflict resolution**

The Terms of Reference for the study included the role of women in conflict prevention and resolution – in line with the UN Security Council Resolution 1325 on "Women, War and Security". The team did not have any specific findings regarding this issue related to cooperation between local governments, communities, NGOs and private sector, but the team

did learn about initiatives from traditional leaders in the Serengeti district related to thefts and fights – using social isolation as a method – which has led to a decrease of all forms of criminality.

## **Good practices**

### **Good practises from Moshi**

In the case of Moshi, the low maternal mortality rate is due to socio-economic factors that are not easily replicable:

- general high level of education
- positive economic situation, women have income from milk and bananas
- large number of health facilities, partly established by missions, partly by self-help activities and wealthy individuals.

### **Good practices from Ileje, Misungwi and Serengeti**

In the case of Ileje, Misungwi and Serengeti, the low maternal mortality rates are first of all the result of specific area based donor funded projects targeting maternal health, as well as other local initiatives.

All the area based initiatives seem to be based on the same core components:

- Empowerment and training of village health workers – in some cases supported by networking between the village health workers and minor financial compensations such as bicycles or exemption from community project contribution.
- Systematic tracking of all village pregnancies by the village health workers or the village health committees, with visits to each pregnant woman several times during the pregnancy and planning of the delivery.
- Discussion and analysis re. each maternal mortality at village and district level to discuss what could have been done to prevent the death.
- Improvement of health facilities and attitudes of health workers – combined with mobile clinics and outreach units to isolated areas.
- Campaign to motivate pregnant women to deliver at health facilities
- Training of traditional birth attendants to motivate them to ensure delivery at health facility – and to recognize the danger signals that makes facility delivery crucial.
- Improved radio communication, transport of women to health facilities for delivery and ensuring the means and funds for transport.
- Life skills education and programs for young girls, including young pregnant girls.
- Last but not least: Committed and serious key staff

### **Good practices from other areas: Morogoro and Rufiji**

In addition to our case study areas, there are a number of other geographic areas that represent interesting good practices, for example Morogoro and Rufiji. The Tanzania Essential Health Intervention Project (TEHIP) which is being implemented in Morogoro rural and Rufiji districts, demonstrates a best practice in regard to integrating research and development interventions at community level.<sup>1</sup> As a research activity, the project has been able to collect information and data on all deliveries happening at home, including deliveries resulting in maternal deaths. In addition, data on infant mortality (IMR), under-five mortality (U5MR), and other forms of ‘out of health facilities’ morbidity have been recorded. Within four years of the project child mortality has been reduced by 40 percent. A further investigation can be undertaken to ascertain these facts, the approach and methodology applied in this project, to

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<sup>1</sup> Savigny, Don de, et al In Focus: Fixing Health Systems, IDRC, 2004

enable other districts to learn from them. It will be useful to document and use the TEHIP project as one of the best practices that other districts can learn from.

## 5. Recommendations for phase 2.

The objective of phase 2 is to disseminate and replicate the good practices from phase 1 regarding cooperation and coordination – with maternal health as entry point and example – to districts where the maternal mortality rate is high.

The team proposes to select districts that are relatively close to the four districts with low maternal mortality rate from Phase One. The reason for this proposal is to facilitate and encourage follow-up and exchange of experience between “good practice” districts and districts with a potential for improvement during the 12 months period covered by phase 2.

The team acknowledges that ideally, the twinning districts should be in the same region, to facilitate institutionalization at the regional level. However, only two of the phase one districts are located in regions where there are *also* districts with high MMR. The principle of choosing districts within the same region can therefore not be carried through in all the cases.

Based on the above, the following districts are recommended for phase 2:

### Partners for phase 2

Good practice districts		Districts with potential for improvement	
Moshi Rural	Kilimanjaro region	Ngorongoro Monduli Pangani	Arusha region Arusha region Tanga region
Ileje	Mbeya region	Chunya Sumbawanga	Mbeya region Rukwa region
Serengeti	Mara region	Bunda Kiteto	Mara region Manyara region
Misungwi	Mwanza region	Kahama Urambo	Shinyanga region Tabora region

The team is of the opinion that it is important to include districts from the south-eastern part of the country in the project. There are two options: Mtwara rural and Rufiji. Mtwara rural was originally among the selected ‘good practice’ districts but the team was unable to visit this district as planned. Rufiji has been part of the Tanzania Essential Health Intervention Project (TEHIP), and probably has many good practices to share. We therefore propose that one of the two districts is chosen and twinned with Liwale (MMR 484/100,000) or Mkuranga (MMR 320/100,000).

**Optional additional partners**

Good practice districts		Districts with potential for improvement	
Mtwara rural	Mtwara region	Liwale Mkuranga	Lindi region Coast region
Rufiji	Coast region	Liwale Mkuranga	Lindi region Coast region

**Commitment as precondition**

The action plan is based on a written response and a commitment from the districts in question, implying that the actual number of districts accepting the invitation is likely to be less than the number of those invited.

**PMO-RALG will be responsible for the following activities at central level:**

- Ensure PMO-RALG ownership and capacity
- Clarify institutional arrangements
- Coordination with other ministries and other national institutions
- Clarification of statistical data
- Elaboration of new D by D policy

**PMO-RALG will be responsible for the following activities at district level:**

- Information/public awareness campaigns
- Assessment and application for funds (assistance offered to districts that need it)
- Elaboration of a district plan for the activities selected by the district
- Elaborate budgets

**PMO-RALG and the Royal Norwegian Embassy will be responsible for the following:**

- Clarification of budget
- Overview and development of information material

**Activities to be implemented at the local level:**

- Public awareness raising on maternal health needs
- Targeted exchange of experience with Best Practice districts
- Implementation through the political system (councillors, women special seats, village chairpersons, sub-village chairpersons)
- Awareness raising at village level
- Awareness raising in district administration
- Improvement and strengthening of village health workers
- Use of local NGOs projects or programs – if already in place
- Monitoring of results (base line study – showing the present situation – and new study in May 2008)

### **Financial arrangements**

In order for the project to be sustainable and to inspire councils to use the same method for other issues than maternal health at a later stage, the team proposes that existing funds should be used as far as possible, ie. the Local Government Capital Development Grant and the Capacity Building Grant. In addition, there are specific funds allocated to health interventions, e.g. the Community Health Fund or the Health Basket Fund.

There are, however, certain challenges:

- The sums allocated to the districts show great variations – as they are based on the number of inhabitants as well as performance indicators
- Some of the districts may have specific plans for the funds

Some of the districts may not have the necessary administrative capacity for assessing the funding possibilities and may therefore need assistance. It is vital that the plans and initiatives are integrated in the planning and budget cycle – at district, ward and village level.

### **Other funding possibilities**

The Norwegian Agency for Development Cooperation, Norad, is developing a Norway-Tanzania Partnership Initiative (NTPI) focusing on maternal health and child health. Within this framework, it might be possible for PMO-RALG to ensure some funding for the following:

- the implementation of activities in districts where no other funding is available
- the PMO-RALG follow up and coordination
- the initial base line study and the final assessment

### **Importance of local culture and traditions**

During the visit to Pangani the team observed that issues related to maternal health seem to be strongly related to traditional cultural attitudes and values where local civil society informal organisations and leaders can play a key role. The district administration cannot change traditional cultural attitudes to child birth, but it can influence the choice women make by providing safe quality facilities and services at a reasonable price.

### **Focus on civil society and religious organisations**

The importance of traditional cultures in matters related to maternal health implies that phase two must have a strong focus on civil society, informal as well as formal. This implies that civil society organisations and religious organisations must play a leading role. This is particularly important in a district like Pangani where few members of the district administration staff are from the district.

At a practical level, the above will imply that at least 50 percent of the persons involved in phase two exchange visits and seminars should represent elected representatives (councillors, including women special seats), as well as NGOs, CBOs and FBOs.

### **Focus on women**

Maternal health is very much seen as a women's issue. This implies that approximately 50% of the persons involved in phase two exchange visits and seminars should be women.

### **Methods for transfer of knowledge**

Study visits between districts do not in itself necessary lead to transfer of knowledge, or the implementation of new knowledge. It will be important to integrate a focus on this through a process of planned steps, based on mutual commitment, clear plans, realistic actions and systematic assessment of how the information and activities are being brought down to the local level.

At village level, the project should be anchored in the village government and its health committee. At the sub-village level, sub-village chairpersons (who are also members of the village government) should arrange separate meetings for men and women, led by a male and female village health worker respectively.

### **Planning and documentation of learning**

Before any exchange visit, the visiting district will be asked to discuss and describe— in specific not general terms:

- what they see as problematic regarding the present
- what kind of things they would be interested in seeing and learning
- how they are planning to use this knowledge.

After the visit, the visiting district will be asked to describe:

- what they saw and learnt
- how this will be implemented

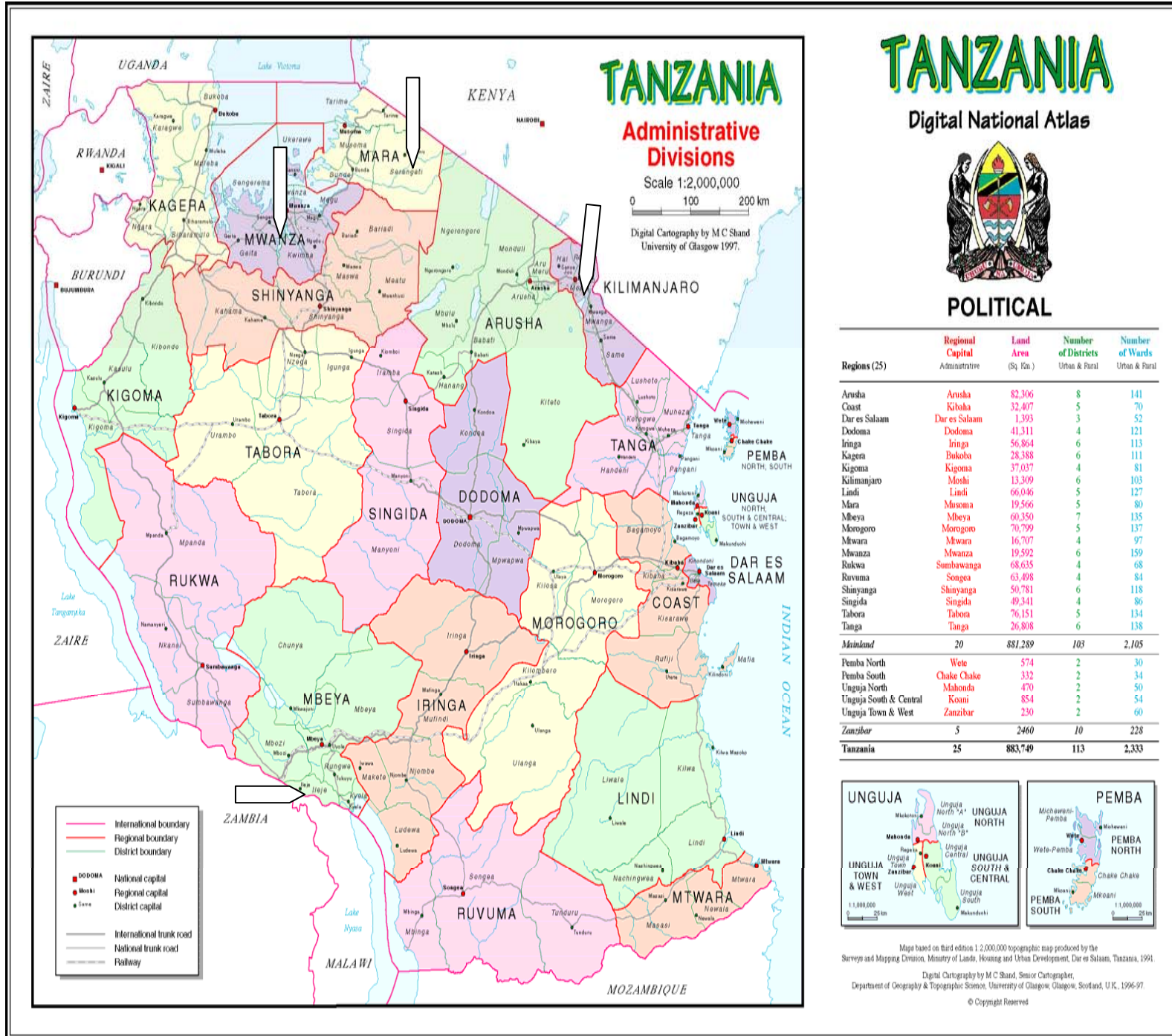
After a number of months the district will be asked:

- whether they were able to implement any of the new ideas
- if yes – how?
- if no, why not?

# DECENTRALISATION AND GENDER

Map 1. Tanzania districts

Case study districts are marked with arrows





## 1. INTRODUCTION

Tanzania initiated the Local Government Reform Programme in 1999 (based on the LGR Agenda of 1996-2000). The main goal of the reform is to implement the policy of decentralisation by devolution, to have autonomous LGAs to deliver quality and accessible services, contributing to poverty reduction, as well as to empower local communities. The good governance within D by D stresses participation, democratisation, transparency, accountability, rule of law and equity. It was considered necessary to review the planning and implementation process to broaden the participation of local communities, NGOs, CBOs, the private sector, and other development actors. This study looks at cooperation and coordination between those groups and LGAs as contributing factors to performance.

The study is part of the effort by the Prime Minister's Office - Regional Administration and Local Government (PMO-RALG) to address good governance in local government authorities (LGAs) in Tanzania. This is part of the PMO-RALG Strategic Plan and part of the Local Government Reform Programme (LGRP). The LGRP is implementing the Government's policy on decentralisation by devolution (D by D). This is set out in the Policy Paper on Local Government Reform (1998) and is being implemented under the current Medium Term Plan and Budget (2005-2008). A core element of good governance is equity. That is equity in service delivery, in staff management and in council planning and budgeting decisions.

In May 2006, PMO-RALG, with significant support of the Norwegian Embassy, undertook a study on the status of gender in LGAs and in the policies and tools developed to support the D by D drive.<sup>2</sup> The report and its recommendations were discussed at a stakeholder workshop in August 2006. It was agreed that the most effective way to make improvements was to select specific, practical and targeted interventions, in the first instance.

In November 2006 it was agreed that, using support from the Norwegian Government, a specific gender-related case study would be undertaken. A consultant was engaged to do some scoping and identify a way forward, i.e. the study area. Those consultations led to the report that identified two issues that PMO-RALG could focus on (see the report for the rationale for these choices):

- cooperation and coordination at LGA level, and
- maternal health.

It was agreed that the approach for the way forward would be:

- to use a mix of international and local experts
- to focus on positive experiences for lesson learning and attempts at replication
- a phased approach:
  - Phase 1 - study lessons
  - Phase 2 – dissemination and replication
- finding ways to build capacity at central, regional and local levels within the work to be done.

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<sup>2</sup> Liss Schanke (2006). A study of Norway's support to women and gender issues in rural Tanzania. Royal Norwegian Embassy Dar es Salaam. December 2006, unpublished.

This report covers Phase 1. The report is deliberately being circulated in draft form to a wide stakeholder group (see annex for list). It is hoped that these stakeholders will read the report and participate at a workshop in May 2007, about the findings and way forward.

## 1.1 Goal and objectives

### Objectives

Based on the PMO-RALG Review and scoping study, the objectives of the present study (Phase 1) is to:

- identify the reasons why some districts are performing better than others when it comes to cooperation on maternal health
- identify best practices that are to be disseminated to other districts

### Goal

The final goal of the present study is to contribute to:

- the strengthening of D-by-D and strengthening of governance at district level
- sharing and learning among districts on gender issues
- create greater demand for resources for “women’s issues” at district level and to
- highlight the maternal health situation as a public problem.

### The total study will be conducted through three phases:

#### *Phase 1: January – March 2007*

Selection of “Best practises” districts using existing data and reports. Visits to the four selected districts took place in February. The findings will be shared with stakeholders during a workshop in June 2007.

#### *Phase 2: May 2007 – March 2008*

Dissemination of good practices to 10 districts with a potential for improvement.

#### *Phase 3: March – May 2008*

Summing up of results.

## 1.2 Focus on coordination and cooperation

The main focus of the study is on coordination and cooperation – not on maternal health as such. Maternal health is seen as a case or an entry point, illustrating the need for cooperation and coordination. This is underlined by the fact that the institutional focus is on PMO-RALG and the local authorities. The focus on coordination, cooperation and synergy effects between different actors and stakeholders is a general trend and in line with Tanzanian policy as well as international development policies (i.e. the Paris Declaration on Aid Effectiveness, and the Norwegian Development policy). The report “Enhancing Aid Relationships in Tanzania” (2005) states the following:

*“Integration of national processes with sectors and local governments has made progress but areas of concern remain. There is still a disconnection between sector policies, strategic plans and the budget. SWAPs have not been developed into fully integrated sector programmes guided by clear strategic plans consistent with*

*MKUKUTA. Sector MTEFs, client consultation mechanisms, defines coordination and harmonisation processes also lag behind.*<sup>3</sup>

### **Levels of cooperation**

Cooperation can be defined as a continuum of five different elements: Contact, Exchange of Information, Division of Services, Collaboration on Services and Coordination of Services.<sup>4</sup>

The concept of co-operation distinguishes between horizontal and vertical cooperation:

- *Horizontal* co-operation describes the link between actors at the same level, e.g. local government and NGOS/CBOs
- *Vertical* co-operation describes the link between actors at different levels, e.g. central government, local government/NGOS and local communities.

### **1.3 Maternal Health as the entry point**

Maternal Mortality - one of the Millennium Development Goals (MDGs) - is used as the entry point and example in this study. Linking the issue based approach to MKUKUTA (PRSP) and MDGs has several advantages:

- It increases the focus on the situation of poor rural women in Tanzania – as the MKUKUTA and MDGs are based on poverty alleviation
- It ensures a focus on measurable results based on agreed targets and indicators that are already being monitored. This is a huge advantage compared to identifying new targets, indicators, base line studies and monitoring mechanisms.
- It facilitates cooperation with national stakeholders, central ministries, local authorities and NGOs - as their work is also based on the Mkukuta and the MDGs.
- It facilitates cooperation with international NGOs and development partners – because of their focus on the MKUKUTA and the MDGs.

A focus on maternal health will, in this specific case, entail a clear focus on women, not on gender issues in general. The team believes that a focus on improving cooperation and coordination on maternal health has positive side effects:

- for the health situation for women and children in general as well as for the entire population
- on cooperation and coordination regarding other areas and services

### **Definition and importance of maternal death**

Maternal death is defined as any death that occurs during pregnancy, childbirth and within two months after birth or termination of pregnancy. The data regarding maternal mortality tend to be mainly based on deaths in health facilities and do not always include home deliverance. The Infant Mortality Rate and the Under Five Mortality Rate on the other hand, are calculated on the basis of a sample size of 1000 live births. As a result, the statistics of deaths of infants and under five years old are more accurate than the statistics of mothers dying from maternal deaths.<sup>5</sup>

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<sup>3</sup> Report of the Independent Monitoring Group to the Government of Tanzania and Develop Partners Group, (2005).

<sup>4</sup> This definition is taken from a study conducted by The Norwegian Association of Local and Regional Authorities and Agder Research (2002-2005).

<sup>5</sup> URT Socio-Economic Profiles of all regions of Tanzania Mainland, National Bureau of Statistics and Regional Commissioners Offices of all regions, coordinated by PO-Planning and Privatisation, DSM 2003-2005.

## DECENTRALISATION AND GENDER

In 2006, there were 5 registered maternal deaths in rural Moshi – all occurring at health facilities. According to the statistics at the DMO's office, two died from Post Partum Haemorrhage, and three from "HIV infection". Such cases are challenging when it comes to definitions and statistics. At the one hand, women who have developed AIDS and die during or soon after delivery, would perhaps not have died so soon if they were not pregnant. At the other hand, many districts probably don't register HIV/AIDS as a factor behind maternal deaths.

An analysis of the Regional Socio-Economic Profiles of all the 21 regions of Tanzania Mainland reveals that maternal mortality does not feature among the top ten causes of death in any of the regions. The most common registered causes for death are malaria, Upper Respiratory Tract Infection (U.R.T.I.), diarrhoea, intestinal worms, etc. Although the figures of deaths through maternal mortality is quite small compared to other causes of morbidity and mortality, it is a key gender issues and a key development issue as maternal mortality is closely linked to infant mortality and the general well being for the children and families involved.

## 2. METHODOLOGY

As set out in the introduction, this study is based on an earlier and broader study,<sup>6</sup> further discussions between PMO-RALG and the Government of Norway, and the scoping study<sup>7</sup> in December 2006 that identified the theme for the current work: outcomes of cooperation and coordination, using maternal health as an entry point. The assignment benefited enormously at the outset with the support of the Permanent Secretary and the Director of Local Government of PMO-RALG. The implementation was jointly between GoT and Norwegian Embassy, with the consultants leading the technical research and field work. This was facilitated by the offices of the Zonal Reform Teams (ZRTs) and the Regional Secretariats.

It was agreed that this work would take place in phases. The methodology described here is for Phase 1. The aim was to have a collaborative study between GoT, NGOs and DPs. This was achieved to a limited degree, perhaps due to the timing of the study and invitations to participate. This is a lesson for Phase 2.

This is the first thematic study that PMO-RALG has commissioned for gender and governance. For the first phase PMO-RALG relied on sector staff in Regions and LGAs, and the mixed skills in the consultancy team. For Phase 2 there will be more formal engagement with the Ministry of Health and the Ministry of Community Development, Gender and Children.

### 2.1 Organisation of phase 1.

Phase one included the following activities:

- Elaboration of pre study work regarding the maternal health situation and selection of districts (section 2.2 below)
- Contacting DPs and NGOs about the study, with the background information
- Drafting and transmission of information to the districts and Regional Secretariats
- Visit to Moshi district, as a phase 1 test visit (sections 2.3 and 2.4 below)
- Revision of information to be sent to 3 remaining districts after visit to Moshi
- Visits to Ileje, Misungwi and Serengeti (section 2.4)
- Elaboration and discussion of report
- Debriefing on assignment and findings to PMO-RALG and the Norwegian Embassy
- Submission of draft report.

#### Phase 1 was conducted by:

Ms. Liss Schanke	Norwegian Association of Local and Regional Authorities Senior adviser, team leader
Ms. Dr. Siri Lange	Chr. Michelsen Institute, Senior Research Fellow
Ms. Christine M. Warioba,	Consultant
Ms. Rehema Mwateba	Consultant
Ms. Dr. Betty Muze	Consultant
Ms. Juliana Mbeya	Program officer, CARE
Ms. Bodil Maal	First Secretary, Norwegian Embassy
Ms. Amina Joyce Lwasye	Programme Officer, Norwegian Embassy

<sup>6</sup> PMO-RALG, May 2006.

<sup>7</sup> Liss Schanke (2006). A study of Norway's support to women and gender issues in rural Tanzania. Royal Norwegian Embassy Dar es Salaam. Unpublished report. December 2006.

The field visits involved PMO-RALG contact persons in the 4 districts who participated in many of the meetings and also contributed with the organisation of meetings. The key contact person in PMO-RALG has been Governance Adviser Ms. Lesley Saunderson. The team also met with the (Acting) Assistant Director of Local Government (Governance), Mr. Kahitwa.

## 2.2 Selection of “good practices” districts

The criteria for selection of districts that could represent good practices for phase 1 were:

- The situation with regard to maternal mortality
- The situation with regard to percent of population below poverty line

The MMR information was extracted from the Comprehensive Health Plans for 2006/2007 of all the 122 districts with the exception of 17 whose reports were not available at the time of the study.<sup>8</sup> Most of the districts indicated that the MMR presented in the reports was of December 2005. Some of the districts reported two figures, which indicates a typographical error (see appendix 17.13 for the consultant’s list).

The consultant’s report<sup>9</sup> says that it was hard to call the districts to counter check the statistical data. Some of the district reports indicated that the MMR was estimated on the basis of data collected from health facilities. Other districts did not include information regarding how the data had been collected. A few district’s MMR is similar to the national MMR of 2004, that is 529/100,000. Such cases casts doubt on the accuracy of the data, and these districts were excluded from selection. The *Tanzania Demographic and Health Survey* (2004-2005) cautions that less than half (47 percent) of births in Tanzania are delivered at health facilities, while 53 percent are delivered at home.<sup>10</sup> This being the case, we can expect that the actual MMR is higher than the statistical data given in the reports. Data on poverty was taken from the *Poverty and Human Development Report 2005*.<sup>11</sup>

The five districts that have the lowest MMR are: Moshi rural, Mwanza, Rombo, Bukoba rural, and Ileje (see appendix 8.6 for a table which includes MMR and poverty statistics). The five districts are within the regions/locations which benefited from an early establishment of education facilities (through missions): Kilimanjaro (three of the five districts), Kagera and Mbeya regions. On average all the five districts have also done well on the local government assessment. Education plays a critical role in the reduction of MMR, as well as reduction of poverty. The 5 best practice districts in MMR also have a relatively lower proportion of people living under the basic needs poverty line.

Realizing the limited geographical location of the best practice districts, and after consultations, it was decided to include at least one district that is in danger of conflict. The reason for this choice was to enable the implementation of the UN Resolution 1325, on the involvement of women in conflict management and peace building. Another factor that had an impact on the selection of districts was the need to minimize transport problems in light of the rain season. As a result of the above factors, two districts from Kilimanjaro and Kagera were

<sup>8</sup> Magu, Kilombero, Mtwara Urban, Handeni, Lushoto, Kasulu, Same, Songea, Arumeru, Hanang, Simanjiro, Mbozi, Kyela, Mbarali, Kongwa, Nkasi and Mpanda.

<sup>9</sup> Christine M. Warioba (2007). Second draft report on the study on the cooperation and coordination on reproductive health with particular focus on maternal mortality at district level.

<sup>10</sup> *ibid*

<sup>11</sup> URT (2005). *Poverty and Human Development Report 2005*. Dar es Salaam: Mkuki na Nyota Publishers.

dropped, and the next three on the list were selected: Serengeti district, which also has conflict related issues (land issues/FGM); Misungwi district, and Mtwara. Mtwara rural unfortunately had to be omitted at the final stage of preparations due to insufficient personnel to make up a full team to undertake the study at the same time as the others.

The final four districts selected are listed in Table 1 below.

**Table 1. Districts selected for study of “good practices”**

District	Region	MMR (per 100.000)	Under five Mortality rate <sup>12</sup>	Poverty <sup>13</sup> headcount (in percent)	Score on LGA Performance (in percent)	Audit report rank <sup>14</sup>
Ileje	Mbeya	97	146	31	65	2
Misungwi	Mwanza	116	133	40	66	103
Moshi rural	Kiliman-jaro	39	57	28	85	30
Serengeti	Mara	115	181	61	69	66

## 2.3 Use of a pilot district

One of the districts, Moshi rural district, was used as a pilot district to test out the collection of information (February 13-16, 2007). The visit was fruitful and demonstrated that it worked well to use maternal health as an entry point to study cooperation and coordination.

After the test visit to Moshi, the following improvements were made:

- the information to the districts was redesigned; a new letter was elaborated for the three districts, in Kiswahili as well as in English
- a detailed plan for meetings in the districts was elaborated, providing more specifications as to how the days in the districts should be spent.

## 2.4 Collection of information in the districts

It is the goal of this report to map cooperation and coordination among different stake holders at the local level, with emphasis on local authorities, health facilities, and civil society organizations.

### 2.4.1 Local authorities and local communities

Government regulations say that each village and ward should have a health committee. At the village level, the village chairman organizes a village assembly where the villagers are

<sup>12</sup> Numbers taken from the Poverty and Human Development Report 2005.

<sup>13</sup> From 2000/1.

<sup>14</sup> Ranking from 1 (best) to 115 (worst) based on audit data for 2004/05 (questioned expenditure). HakiElimu leaflet: “Are local governments managing money well? Findings from recent audit reports”.

invited to voice their development priorities. The ward councillor attends the meeting. The councillor is the chairman of the Ward Development Committee. Village leaders present the priorities of their respective villages. The WDC makes development priorities which are brought to the various committees of the District Council. The committees present their plans and budgets to the full council meeting. Within the local district administration, The Council Health Management Team has main responsibility for implementing the plans that are health related.

**Table 2. Administration of health at district level**

<b>Administrative level</b>	<b>Committees</b>	<b>Civil servants</b>	<b>Elected representatives</b>	<b>Voluntary workers</b>
<i>District Administration</i>	The Council Health Management Team	District Medical Officer heads the Health Department	Full Council	-
<i>Ward</i>	Ward Development Committee	Ward Executive Officer	Councillor	-
<i>Village</i>	Village Health Committee	Village Executive Officer	Village Chair	Village Health Workers
<i>Hamlets/streets</i>	-	-	Hamlet chair	In self-help projects, each hamlet is responsible for certain days

### 2.4.2 Civil society organisations

Lobbying and advocacy around maternal health has not yet gained momentum, especially not at the local government level. However, there is presently more advocacy work than in the past on obstetric fistula (coordinated by the Women Dignity Project). Most NGOs and CBOs work on other issues, such as economic empowerment, HIV & AIDS, and environment. Some of the interventions are donor funded projects which are implemented at the district and community levels.

NGOs working on maternal health issues include:

- Faith-based organizations, which run health facilities
- Family Planning Association
- Maria Stopes
- AMREF
- Women Dignity Project (obstetric fistula)
- UNICEF, World Vision, CARE, and other international NGOs

### 2.4.3 The health sector and corruption

In the Top Ten Corruption Problem Areas identified by 109 LGAs in their Anti-corruption Action Plans, inadequacies in the delivery of health services are ranked as nr. 2 and



misadministration of drugs and medicines as no.7. According to the NGOs in the Health Equity Network,<sup>15</sup> there are many factors contributing to this:

- Provider relations, i.e. discrimination/connections
- Health care charges, unofficial payments and bribes
- Poor implementation of the exemption and waiver scheme
- Lack of mechanisms for grievances and appeals
- Community participation in planning and management
- Weak knowledge of reforms and entitlements
- Lack of accountability for politicians and staff

The team includes these aspects in the district studies, both with regard to the Best Practice districts as well as districts with potential for improvement.

#### **2.4.4 Collection of information in the districts**

The visits were done by teams of 2-4 persons, consisting of international and national consultants. All teams included native speakers of Swahili, and meetings were conducted either in English or in Kiswahili.

- a) PMO-RALG sent a letter of introduction to the District Council and the respective Regional Secretariat, providing background information on the purpose of the study, the process, and reasons why that particular district had been chosen. The letter also presented the team, the duration of the visit in the district, and listed the kind of people/organizations that the team intended to meet.
- b) Upon arrival, the team paid a courtesy visit to the RAS and the DED to introduce themselves and to ensure adequate information for the rest of the stay. The team emphasised that the Local Government Reform in Tanzania underlines the need for cooperation on service delivery:
  - between local governments, NGOs, CBOs, and the private sector
  - between line ministries, regions, districts – and communities; wards, villages and hamlets

The team underlined that the mission wanted to study this cooperation – using maternal health as concrete example and entry point. The team also underlined that the district is among the districts in Tanzania that fare comparatively well in terms of maternal mortality and that the PMO-RALG is therefore interested in learning from them, in regard to cooperation relevant to maternal health.

- c) The team then held a briefing meeting with district authorities to plan meetings and interviews. Meetings were requested with the following:
  - DMO and all the DHMT members on intervention and services at health facilities; prioritization/non prioritization of maternal health; planning processes, budgeting processes, achievements and challenges in reduction of MMR in the districts;

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<sup>15</sup> The Health Equity Group consists of a group of NGOs: Youth Action Volunteers, Care, Women's Dignity Project, Save the Children and TGNP.

- NGOs, CBOs, FBO involved in health and other related issues, their roles in addressing and reduction of MMR in the district; cooperation and collaboration amongst stakeholders in the district;
- Female and male councillors (including Chairperson of the council); on processes on priority setting, planning and budgeting allocations on interventions meant to reduce MMR
- Planners and budget officers on planning and budgeting processes and allocation of resources on interventions meant to reduce MMR;
- Health facilities (preferably one hospital, one health centre and one or more dispensaries
- Community members (community meetings or individuals), including village leadership, workers of health facilities, Village Health Committees, women groups/key informants; CBOs/NGOs

## **2.5 Methodological challenges**

Interviews with groups and individuals were conducted on the basis of a check-list, not structured interview forms or questionnaires. The advantage of this methodology is that the interview situation becomes very flexible – the team members could follow up on interesting issues as the situation required. The draw-back of this methodology is lack of coherence in the kind of data that was collected in each district. Another challenge was limited time in the districts – particularly in Ileje where the team had to spend two of the five research days travelling to and from Dar es Salaam. Long distances within the districts also meant that transportation reduced the time available for interviews. However, several of the teams offered lifts to people along the road who would be interviewed informally on the topic of coordination and maternal health in their district.

## **2.6 Drafting of reports**

The team took written notes from all meetings and interviews. Based on the notes, the teams drafted a brief description of the socio economic and health situation for each of the four districts – as well as findings regarding cooperation and coordination. These reports are the basis for chapter three to six of this report. Despite editing, the chapters therefore vary in terms of style and content. For example, some chapters have sections on the role of traditional authorities, while others do not. The district reports are given in alphabetical order. The exchange rate between US dollars and Tanzanian shillings was 1 US\$ = 1248 Tshs. at the time of the study.

### 3. FINDINGS FROM ILEJE DISTRICT

#### 3.1 Socio-economic situation



##### Geographic conditions and climate

Ileje district is situated in the Southern Highlands, in the South East of Mbeya region.<sup>16</sup> The district borders to both Malawi and Zambia, and there are frequent interactions across the borders. Ileje was earlier part of Rungwe district. The district covers almost 2000 sq.km. of which half is arable land. The topography of the district is characterised by a wide plateau surface with hills. The southern part of the district is very mountainous and the roads in those areas are impassable during the rainy season. The

altitudes range from 1360 to 2500 meters above sea level.

##### Economic activities

The variation in altitude, soil quality and rainfall entails that agricultural activities varies between the various zones. The majority of the population are subsistence farmers relying on maize, finger millet, cassava, and beans. Traditionally, the work load for women is not as high as in some of the other rural districts in Mbeya.

The level of income generating activities is low, but there is some cash crop cultivating, particularly of coffee, cardamom, bananas, and sun flowers. Civil servants from other parts of the country have started farming activities in Ileje. Local farmers have been inspired by their way of farming, and have started cultivating larger fields than they used to, renting tractors.

##### Infrastructure

Parts of Ileje got electricity in 2002. The grid comes from Zambia, and the Tanzanian government pays for the power. The Mission hospital at Isoko has power from its own hydropower system. The great majority of the roads within the district the district are dirt roads, and the mountainous landscape means that there is need for a large number of bridges.

##### Population, religious and ethnic composition, education

The population of Ileje is estimated to have been around 113 thousand in 2004, of which around 60,000 were female and 53,000 were male. The main ethnic groups of the district are Ndali and Lambya, but there are also Malila, Nyiha, Nyamwanga and Nyakyusa. The district has a high proportion of Morovians. There are also a number of other Christian denominations as well as some Muslims (mainly teachers). The income per capita is low, around Tsh. 115,000 per year. The team was informed that poverty is rampant but that awareness of the usefulness of social development is high, since they have involved many NGOs for sensitization on various issues. The educational level in the district is not very high, but at present primary school net enrolment is 80.2%.

<sup>16</sup> This section is based on interviews in February 2007 as well as the Annual Plan of the Tanzania Government and UNICEF new country programme (Tanzania Government and UNICEF new country programme. Ileje District Council. CSPD Annual Plan 2004 and 2005. Ileje District Council 2004).

**Gender relations**

The district is dominated by patriarchal ideology/male chauvinism (*mfumo dume*). Very few men involve women in decision making, and “men stand to be main decisions makers and holders of household economic wealth”.<sup>17</sup> Traditionally, women are not allowed to keep their own income, but the practice varies. Some are allowed to keep income from “small” products like beans (*maharage*), while a few couples share economic responsibilities. Women’s lack of economic freedom means that in cases where the husband is away and the wife or a child fall ill, the wife can not sell a chicken because the household property belongs to the man. Customary laws are adhered to, and wife inheritance (brother marrying his deceased brother’s wife/wives) is not uncommon.<sup>18</sup> Most women in Ileje do not have a say regarding how many children she should have. Acceptance of family planning was only 21% in 2005.<sup>19</sup> Some women use contraceptives in secret, but men are said to be in the process of understanding the importance of family planning. Despite the above, council staff argued that there are comparatively few traditions that “hinder” development.

**Table 3. Basic facts of Ileje district**

Population (estimated 2004)	(60,087 female, 53,105 male) 113,192
Size (sq. km)	2000
Wards	16
Villages	68
Income per capita per year (in Tsh)	115,000

**Table 4. Gender Composition of Ileje District Council 2007**

	Male	Female	Total	Vacancies
Council Management Team				
Council Health Management Team				
Key department staff				
Councillors	16	6 <sup>20</sup>	22	

**Table 5. Sources of Health Budget, Ileje District Council 2006**

	Ministry of Health	Own resources	Donors	Total
Health budget				

**Table 6. Own resources, Ileje District Council 2006**

	Revenue from fees etc	Tax/donations from industry, tourism and individuals	Other	Total
2005				
2006				

<sup>17</sup> UNICEF/Ileje District Council 2004.

<sup>18</sup> The team interviewed one woman who had escaped being inherited by her brother in-law, but who lost any rights to her late husband’s property in the process.

<sup>19</sup> CSPD Annual Plan 2004 and 2005. Ileje District Council 2004). Tanzania Government and UNICEF new country programme.

<sup>20</sup> All female councilors are “special seats”.

### 3.2 Decentralisation by devolution

The district headquarters are located in Itumba township. Ileje entered the Local Government Reform, LGR, in 2003. LGRT arranged a stakeholders' workshop in the council where political parties, business people etc participated. Together they made a vision and mission for the council, and a strategic plan. The regional secretariat talks warmly about the district and praise the district council's attitudes and activities. With the reform, the organization structure now varies from council to council. Some can choose *not* to have a civil servant/adviser in a certain area that is not relevant to them (i.e fish, honey). This releases the burden of the council staff of paying salaries of experts who have no contribution to the development of the district. The mortality rate of civil servants in Ileje is low (few who die from AIDS).<sup>21</sup>

According to the LGR staff and their performance assessment (benchmarking) reports, the level of transparency is much better than it used to be. Some say it is much better than at the central government level. There is no spending without the agreement of the full council, and the EPICOR accounting system ensures that one can not spend more money than what has been budgeted for. There are notice boards which show the spending etc. According to one informant, the tendency of "one man rule" is gone (*Hakuna tena one man rule*).

At the moment, all heads of departments are men, and there are relatively few female staff members at the district head quarters. The DED explained that the district would like to have more female staff, but that central government sent them men. Female civil servants prefer to work in urban areas, and often follow their husbands when they are transferred.

### 3.3 Cooperation and coordination

#### 3.3.1 Cooperation among district staff

The council is conducting review meetings for all development projects. As one staff member put it: "Good roads are important also for women's health".<sup>22</sup> Several staff members emphasise that there is good collaboration among the staff. One area where this comes through is the organisation of TASAF (Tanzania Social Action Fund) projects. During the first phase of TASAF (TASAF I), TASAF was a parallel institution, isolated from the district with a staff that was privileged with higher salaries and far better technical equipment. In TASAF II, TASAF is fully incorporated into the district organisation. The district delegated two of its regular staff members to coordinate TASAF projects. Ileje has had a very high acceptance rate of TASAF projects, with a total of Tsh. 750 billions in support. According to the TASAF coordinator this is a much higher sum than most other districts, and he says the success is due to "high team spirit". He emphasises the support from the DED and the District Commissioner (DC) in particular. The DC has been given copies of all correspondence. Neither the DED nor the DC is from Ileje, but they are committed in their work. The TASAF coordinator also says that people in Ileje are very cooperative, and that the leaders therefore are happy to work with them. TASAF works in Ileje, he says, "because they involve experts from different levels".

<sup>21</sup> This is a big contrast to Makete district (also in Mbeya region). In 2002, all the civil servants of the community development department died, and 80 teachers were sick, lying in bed, unable to work.

<sup>22</sup> The road from the junction (main road Mbeya-DSM) to Isongole is national, and a dirt road. From Isongole to Itumbi is regional, and also a dirt road. The district has put tarmac at parts of the road which is their responsibility. The councillor we talked to sees it as the MP's task to lobby for tarmac at the national and regional roads.

Another example of cooperation among district staff is the willingness to use cars that belong to a specific department also for other tasks. For example, police who visited a village to do investigations in relation to crime during our visit used their car to bring a young woman with obstructed labour to the nearest health centre during. Initially, the district had only three cars (one for the DED, one for the Department of Education, and one for Department of Agriculture). Ministry of Health recently provided the health sector with two cars.

The District Reproductive and Child Health Coordinator says that the turning point for improved maternal health was in 2003 with the introduction of health basket funding which enabled them to conduct segmented sensitisation all over the district. Also in 2006, the district used health basket funds to provide training in safe motherhood for dispensary and clinic staff, as well as TBAs, for 6 days. The focus was on HIV/AIDS and pregnancy and how to give ARVs to babies born from HIV+ mothers. Unfortunately, many of the participants work at health facilities where there is no testing equipment.

The DRCHC emphasizes that they chose a segmented approach because the various segments play different roles. In her view the targeting of TBAs was the most significant factor because they used to administer local herbs (*dawa ya kienyeji*) believed to “untie ropes”. These herbs have potent birth hastening chemicals. Consequently the health facilities received many cases of ruptured uterus and this was a major factor contributing to maternal deaths. The sessions with TBAs centered on changing their role from birth assistance to referring and escorting pregnant women to the nearest health facility for delivery. They were asked to conduct delivery only as an emergency. Besides counselling TBAs on the possible dangers of traditional herbs, the TBAs were taught the importance of cleanliness. This was particularly important in connection to the cleanliness of the cord, since traditionally, cow dung was smeared on the cord to stop bleeding, something that could entail tetanus. They were also taught on referring and escorting pregnant women. The Itumba Health Centre has had several cases where women with retained placentas have delayed to come to them and have died after arrival.

District wide public campaigns targeted influential men and women in the wards. The messages included mobilising community members of the importance of early clinic attendance. In the past the majority of expecting mothers attended antenatal services late in the pregnancy because they believed early clinic attendance would expose them to evil people who would harm them by “tying” their pregnancy. The decision to exempt pregnant women from participating in communal development activities such as road construction, school building etc made pregnant women announce their pregnancy earlier than before. After the exemption was passed, pregnant women were required to inform the VHW about their situation. The VHWs have in turn utilised this opportunity to collaborate with pregnant women on a one to one basis to ensure safe delivery. In some cases, men who do not take good care of their wife are given a fine. The VHWs are said to be highly respected because they were selected by community members themselves in the village assembly. Members of the VHW have no salary, but whenever there are training opportunities, they are considered first. They are also provided with calendars that the district receives free of charge from the Repro GTZ and Women Dignity project (based in DSM).

The doctors at Isoko District Designated Hospital, originally a mission hospital, say that they have a good relationship with the District Commissioner and the DMO but that they are worried that they will lose economic support from the government when the Health Centre in Itumba is being upgraded to District Hospital. They will not be able to operate the hospital

without government support, since their European donors have announced that they will phase out their support between 2008 and 2010. If the hospital loses its government support, the hospital will either have to close down, or they will have to charge fees that the majority of the population can not afford. This issue appears not to have been discussed enough in the district council.

### 3.3.2 Cooperation between councillors and council staff

There are 22 councillors, of whom 6 are women (special seats). After the last election, all councillors are from CCM. During the preceding period, there were five councillors from opposition parties. One of the council staff says that at that time, problems in the council were sometimes blamed on CCM, while the councillor says that the cooperation between the councillors was not affected by party background.

The majority of the councillors have primary school only. About 5 of them have form 4. Both council staff and the councillor interviewed say that the relationship between the two groups is good. The councillor had been a councillor since 1988. In that year they had removed a staff member who misused alcohol, but since then they have never had conflicts with the staff. When asked, however, he confirms that the LGR has brought changes:

*“They (the staff) used to hide the financial records (Ukaguzi wa vitabu). They didn’t explain too us. But after the seminar for the Finance Committee in Mbeya in 2006, we learned that we have the right to have full insight.”*

Council staff was generally very positive about the councillors and their efforts:

*“In the past many women delivered at home. Councillors have been helpful in mobilising delivery at health facilities.”*

*“The councillors help us. They explain the issue of cost sharing. Since they have accepted it in the full council, they have to explain it to the people.”*

*“The councillors are politically inclined (wako kisiasa). Because of ‘voting power’ councillors do not like to pass on information to people if they feel it can cause displeasure with the result that they lose votes. In one ward, the councillor was reluctant to mobilise people to contribute towards secondary school construction. A head of department teamed with him to mobilise people”.*

The informants say that full council meetings are being held four times a year, as the law requires. At one point, the councillors were told that there couldn’t be a meeting because there was no money for allowances. The councillors had answered that they wanted to conduct the meeting even without allowances, and the meeting was held (and the councillors were paid their allowances).<sup>23</sup>

### 3.3.3 Cooperation and participation at community level

Compared to other districts, it is, reportedly, comparatively easy to make people participate in development projects in Ileje. The cooperative spirit is demonstrated by, among others things,

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<sup>23</sup> At the moment, the allowance per full council meeting is Tsh. 4,800, but the councillors have requested an increase to Tsh. 10,000 per meeting.

collective cattle shelters. The physical conditions of the district are also central. There are a large number of bridges. The communities must cooperate to keep them passable. During the study it was noted that people were repairing bridges and roads after the last heavy rainfall.

Civil servants emphasise that people in Ileje always attend information meetings, and that they are “very cooperative”. One councillor interviewed, however, argued that it was very hard work to make people contribute to the building of secondary schools. In his ward, they were able to raise Tshs10.5 million, but only one third contributed. The sum asked for was Tshs10, 000 per adult person. In his view, the lack of contributions is lack of will (*moyo mgumu*), and reluctance to look ahead (*hawatazami mbele*), not lack of money.<sup>24</sup> Individuals who did not contribute are followed up (*bado tunawasaka*) with help from the Ward level.

During the last Full Council meeting, the Council decided that the local authorities should help sanctioning individuals who do not contribute towards secondary school construction and other communal development activities. The district council encouraged councillors to link up with the legal system so that the legal system could deliver fair judgements to wrongdoers.

The UNICEF project - which provided training for village health committees and village health workers - appears to have been a success (see section on health below). The question is whether village health workers will continue to work when there are no material incentives. According to the councillor, part of their motivation up to now has been that they were given bicycles by UNICEF, as well as allowances during National Immunization Days (NID).

Like the WEO's, the Village Executive Officers are meant to implement plans and enforce contributions. However, since they are from the same place, it is often hard for them to enforce – it means enforcing their own relatives. Some VEOs ask to be transferred to another place, where they can fulfil their role more easily.<sup>25</sup>

The relationship between village leadership and district staff can be illustrated by the case below where the village leadership of Izuba village contacted the DMO after a maternal death had occurred:

*In 2006 a woman at Izuba gave birth assisted by a TBA. Unfortunately, the placenta did not come out, and the TBA did not tell her to go to a health facility. The woman gave birth at 11 am, and died at 3 pm the following day, after continuous bleeding. The village leaders, the VEO in particular, reported the tragic incidence to the acting DMO, and held a special village meeting to avoid that such tragedies should happen again.*

### 3.3.4 Cooperation between district and donors/NGOs

DANIDA funds the agricultural sector through District Agriculture Development Support (DADS). A local NGO, Ileje Rural Development Organization (IRDO), has also supported

<sup>24</sup> The team members can not evaluate the validity of the councillor's statement. However, the ward in question is in the low-land and people here are more wealthy than in other parts of the district.

<sup>25</sup> VEO's have Form Four or Form Six education. The VEO's salary is Tshs76,000 per month (used to be Tshs55,000). WEOs salary scale ranges between Tshs114,000 to Tshs166,000. They must have completed form 6 or have a two years course (Agriculture or Community Development).



this sector. The organisation was established at the initiative of a donor (from Belgium), but it is now supported by various donors, among them GTZ. Due to time limits, the team was unfortunately unable to visit DADS or IRDO.

### 3.3.5 The role of traditional authorities

Clan elders (*Wazee wa koo*) are some times invited to ward level meetings, but they do not have a prominent role and do not take part in council planning. In land disputes the case is brought before the ward level leadership and the local court (*baraza*).

### 3.3.6 Relationship with the private sector

There are no industry or tourist facilities in the district, and the council's tax income is very low. The councillors are making an effort to increase the district's income by getting a share of the tax income from the coal mine in Kyela. The processing plant is in Kyela district, but the coal is under the land of Ileje district. The councillors have gone to the coal mine administration to discuss the issue and the initial response is positive.

### 3.3.7 Relationship with religious institutions

The Morovian church runs a number of service facilities (hospital, health centre, dispensaries and vocational school), and support orphans, but they are not involved in the district planning and they did not participate in the writing of the Comprehensive Council Health Plan.

## 3.4 Health situation

According to district staff, people in Ileje have a relatively good health situation because there is no food insecurity. However, the UNICEF Child Survival Protection and Development (CSPD) plan states that "the health status of the majority of the population is poor", mainly due to poor hygienic and sanitation practices in some areas, but also because of food insecurity in some areas. In 2003, 14% of the children had moderate malnutrition (highest in Itumba ward with 26%), while 0.5% had severe malnutrition. These numbers are better than the national figures, which show that 22% of under-fives have moderate and severe underweight, while 4% have severe underweight.<sup>26</sup>

The "top ten" diseases are: Malaria, respiratory diseases, pneumonia, diarrhoeas, eye/ear diseases, skin diseases, worms, STD's, minor surgical conditions, and ill defined conditions. Malaria accounts for 68 percent of all deaths in the district. The HIV prevalence is between 7 and 12 percent. Around one third of the households have access to clean water. The district has great problems in getting qualified health extension staff. This problem goes for the Southern Zone in general.

### 3.4.1 Maternal health

Home delivery is still common, but women increasingly prefer to give birth at Isoko hospital, which has around 700 deliveries per year. Some women go to deliver at Chitipa hospital in Malawi, and it is also common to go there for testing/treatment (*tiba*). Patients only need a border pass. Services in Malawi are free even for Tanzanians; there is no cost sharing or community health fund. If someone dies, they bring the body to Ileje. The management team of the Malawian hospital has come to discuss HIV, TB and Malaria with the DMOs office in Ileje, and has suggested that they meet regularly.

<sup>26</sup> Data from UNICEF ([http://www.unicef.org/infobycountry/tanzania\\_statistics.html#23](http://www.unicef.org/infobycountry/tanzania_statistics.html#23)).

On the basis of information collected during the field visit, the team believes that it is correct that Ileje has a relatively low rate of maternal deaths. First, a large UNICEF project has focused on maternal health. The number of maternal deaths has been halved in the project period, from 164/100,000 in 2001 to 97/100,000 in 2005 (see table below). Secondly, this and other projects have emphasised the importance of registering both births and deaths. Decentralisation of registration (through WEOs rather than directly to the District Council has helped to improve the number of registrations.

**Table 7. Maternal mortality rates for Ileje 2001-2005**

Year	MMR (per 100,000)
2001	164
2002	284
2003	175
2004	100
2005	97

Maternal deaths are recorded weekly at the council's Community Development Department. Severe malnutrition and maternal deaths are recorded at village level, compiled at ward level, and then brought to the department. The staff confirm that the reporting is actually being done (we were shown some examples), and that they have visited every village/ward to ask for such reports. The reporting is part of the UNICEF project that was funded for 2005 and 2006. In the period 1997-2003, 24 girls in primary schools became pregnant. Many of the caesareans at Isoko hospitals are being done on girls who are 14-18 years old.

Recently, the councillors accepted that cost sharing in dispensaries should be Tsh. 1000, - (used to be Tshs 500,-), and at health centres Tsh. 1500, - (used to be Tshs1000,-). Pregnant women and under-fives are not supposed to pay, but in some cases the obligation to bring bed sheets and new clothes/khanga for delivery forces poor women in labour to go to a TBA instead.<sup>27</sup>

### 3.4.2 Health facilities

#### *Health facilities in Ileje*

Hospitals: 1 (originally mission, now Designated District Hospital)

Health centres: 2 (government)

Dispensaries: 16 (4 belong to the Morovian church, 2 belong to government institutions,<sup>28</sup> the rest are regular governmental dispensaries)

Mobile clinics: 13 (government)

#### **Isoko hospital**

There is only one hospital in the district, Isoko Hospital, which is situated in the mountains 67 km from the district headquarters in Itumba. Due to the bad conditions of the road, the drive takes around 2 hours. In order to ease the access for people in Itumba and surrounding areas, the district is in the process of upgrading the Health Centre in Itumba to become a District Hospital. The mission at Isoko was established in 1899 by the German Morovian church, and

<sup>27</sup> We were told about a case where a woman went to a dispensary for delivery but did not bring with her extra khanga/bed sheets. She was retained at the dispensary until her husband brought new clothes, and the husband was very angry with his wife.

<sup>28</sup> Ileje Secondary School, and Itumba prison.

the health services have been continually expanded. The hospital became a District designated hospital in 1976.

The maternity waiting home was built 3-4 years ago and has 15 beds. The doctors argue that even if the women don't have particular problems, they should come two weeks before expected delivery. If they wait until first signs of labour, it can be problematic due to the distances and transport problems. The number of uterus fracture used to be high, but the hospital has not had any incidences for the last three years. The staff members think that the reason is that services are free - this encourages women to come to the hospital. To illustrate the quality of services and staff commitment, the doctors told the team about a nursing officer who used to work with them, but who married and went to another district to work. She has told them she wants all her relatives to deliver at Isoko. They quoted her as saying:

*“At Isoko you are always very active. When a patient comes, you take action. Where I am now, they are not in a hurry. They delay. At Isoko the nurses will call a doctor as soon as a woman in labour comes in.”*

### **Itumba Health Centre**

Itumba Health Centre is situated close to Itumba township and the district has started the process of upgrading the health centre to become a district hospital (Isoko hospital now serves as district designated hospital, see above). The health centre gets money directly from the Ministry of Health into their account. Some disbursements come every third month, others come every month. They regularly run out of money for petrol. They then ask the DED if there is an emergency. The cost sharing at health centres is Tsh. 1500 for each consultancy (pregnant women and under-fives get services for free).

### **3.4.3 Donor supported health projects/programmes**

DFID supported the health sector in Ileje by renovating and upgrading the two health centres as well as some of the dispensaries in 1998.<sup>29</sup> GTZ and NACP (National AIDS Control Programme) have a sensitization program covering all the 16 wards. The program targets youth in particular, and provides counselling to both affected and non-affected individuals.

#### **UNICEF - CSPD**

This program appears to be the intervention that has had the greatest positive impact on maternal health. The program was started in Ileje in 1995. In the period January 2004 – June 2005 the estimated budget for the program was around Tsh. 75 millions, of which the District Council contributed around Tshs10 millions. UNICEF has not had any representative in the district, but has come for regular visits. One of the main themes of the CSPD is Decentralization and Community Development (DCD). As part of the project, training on issues like antenatal care, and the distribution of Vitamin A and iodated salt has been provided for district officials, ward leaders, extension staff, village leaders, and village health workers (one male and one female in each village after UNICEF standards). Voluntary village health workers are supposed to be in place in all villagers. They have special responsibility for children's health.

During the first phase of the program, village registers were set up in all the 68 villages. According to the UNICEF plan (2004) the rate of registration of births and deaths was very

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<sup>29</sup> This was under the Family Health Project, under the then ODA.

low when the program started, partly due to lack of understanding of its importance, partly because it was inconvenient for villagers to report to the District level. The district staff informed the team that reports now go through the WEO, and that the registration system functions well.

The district has 136 Village Health Workers (VHW). Initially, all the VHW's received training. However, due to high turnover, only 50% of the VHW active in 2003 had received proper training. The program therefore provided new training in 2004 to VHWs (12 days) as well as Ward CSPD coordinators (6 days). The training was done at Isongole centre, not at village/ward level. In the team's view, it would be better if such such trainings could take place locally. Then more people could attend, and the villagers would get a sense of what was going on. However, practical issues may make this arrangement difficult. In addition to training, TBAs were given delivery kits with soap, plastic sheets, gloves, a lamp etc.

According to the UNICEF plan document, factors contributing to maternal deaths in Ileje were the following (when they initiated the project):

- Lack of awareness of the importance of early booking for pregnant women
- Late referral to health facilities
- Low coverage of Health facilities
- Lack of knowledge among health staff on focused antenatal care, including prevention and treatment of syphilis and malaria in pregnant mothers

The project provided community sensitisation as well as training of service providers with the goal of having all pregnant women tested for syphilis. Council health staff confirms that the project has contributed to people being more conscious about the importance of antenatal follow-up. UNICEF used to fund regional level review meetings, with a little allowance, as well as regular training. One informant said that now that this was no longer taking place; "the strength of the project is gone". Other informants claimed that the programme is still very important and functioning well. They said that even though 2007 is the last year of the UNICEF programme, the activities would be continued in the years to come:

*"Their support was first of all training and designing of the forms.<sup>30</sup> The forms are a sustainable element of the UNICEF programme. UNICEF trained us and we subsequently gave training at ward and village level."*

This informant said that village health workers know all the pregnant women in their village, and follow them up. The forms means that one will know exactly how many women gave birth at health facilities and how many gave birth at home. The forms are brought by the WEO when he has other things to do in the village anyway. The District Community Development officers can therefore easily detect which wards which have problems. Ideally, men who do not follow up their wives are reprimanded. If a pregnant woman's card is marked with red (colour indicating danger signs), the WHC call the wife and husband and talk with them.

### 3.5 Conclusion

On the basis of information collected during the field visit, the team believes that it is correct that Ileje has a relatively low rate of maternal deaths. The maternal mortality rates were close

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<sup>30</sup> Village Health Workers fill in forms to register births and deaths in the village.

to halved between 2003 and 2004. Based on our interviews and a UNICEF CSPD project report, the main reasons for decreasing levels of maternal deaths appear to be the following:

**Issues that are specific for Ileje, not easily transferred**

- Relatively easy to mobilize communities for development projects/new initiatives due to political, religious, and ethnic homogeneity (development projects not politicised)
- Cooperative spirit – exemplified by high participation in TASAF projects
- Good cooperation among District staff - exemplified by success in securing TASAF sponsorship and in implementing/organising TASAF projects
- The number of district staff is low, easier to know what the others are doing
- Relatively good food stability
- Workload of women is low compared to other districts
- The MOH provided the district with two cars after the district had had transport problems for many years
- Well functioning UNICEF project where village health workers and TBAs were given training and the latter were given delivery kits with soap, plastic sheets, gloves, a lamp etc.
- Mission hospital which is relatively well equipped and has well trained, dedicated staff

**Good practices from Ileje**

- Council Management Team (approximately 16 members) has a daily meeting (should be reduced to once a week if replicated)
- Village level institutions, like Village Health Committees and voluntary Village Health Workers, are active
- Village health workers have been strengthened through health basket funds and UNICEF CSPD project
- Village health workers are exempted from voluntary/self-help activities
- Pregnant women are exempted from voluntary/self-help activities (this is an incentive to register their pregnancy with village health workers)
- Basket funds have been used to widespread sensitisation, among other things on “Birth preparedness”
- Regular village Health Days where health experts in the village interacts with the community members and vaccination etc takes place (started with the UNICEF project)
- District health extension workers have separate meetings with TBAs
- Each health facility has a catchments area to which they provide out-reach following a set time table. As a result of this and other interventions, more women than before give birth at health facilities. Most of them give birth at clinics/hospitals, only a few at dispensaries.
- Maternity waiting home at the hospital to serve people from remote areas

## 4. FINDINGS FROM MISUNGWI DISTRICT



### 4.1 Socio-economic situation

#### Geographic conditions and climate

Misungwi is one of the eight districts in Mwanza region. The district is a relatively new district, established in July 1995. By car, the district head quarters can be reached from Mwanza city in about 45 minutes.

#### Economic activities

74 percent of the Misungwi labour force are engaged in agriculture, mainly cotton, maize, rice, and beans. 26 percent are employed in other areas, e.g. fishing. The district has relatively fertile soil and potentiality for irrigation agriculture in some areas, but this is not developed due to poor technology, resulting in low productivity. The district is also relatively rich in natural resources (sand, stones, mineral deposits etc.). There is evidence of depletion of the renewable and non-renewable resources for example unattended over fishing and deforestation.

#### Population, religious and ethnic composition, education

Misungwi is one of the most populated areas in the region with a population of almost 260,000 (around 126,000 men and 131,000 women). The main ethnic group is the Sukuma who accounts for almost 95 percent, while other ethnic groups include Kerewe, Jita and Ha.

#### Infrastructure

The water situation is critical – only 32% of the entire district population has access to safe water.

#### Gender relations and community Issues

Misungwi is the second poorest of the 4 districts in this study (second only to Serengeti), in regard to poverty headcount. According to statistics of 2000-2001, 40 percent of the population live below the poverty line. There is high illiteracy rate in the communities, and little understanding about the danger of harmful traditional practises.

**Table 8. Basic facts of Misungwi district**

Population	(125,970 men and 131,185 women) 257,155
Size (sq. km)	2553
Wards	20
Villages	78
Income per capita per year (in Tsh)	90,000

**Table 9. Gender Composition of Misungwi District Council 2007**

	Male	Female	Total	Vacancies
Council Management Team	8	3	11	-
Council Health Management Team	6	1	7	-
Key Department staff situation	8	2	10	-
District Council staff			228	222
Councillors	18	9	27	-

**Table 10. Health budget of Misungwi (in million Tshs.)**

Central government	Own resources	Communities	Donors	Total
925	49	21	658	1,653

**Table 11. Own resources, Misungwi District Council 2006 (in million Tshs.)**

	Revenue from fees etc	Tax/donations from industry, tourism and individuals	Other	Total
2005	96,261,900	4,333,577	7,151,550	107,747,027
2006	112,441,000	2,400,000	5,800,000	120,641,000

## 4.2 Decentralisation by devolution

The team was informed that cooperation with the RMO is good, and that the RMO arranges meetings with the staff every 3 months. In the staff's view, "the RMO contributes a lot."

The district has 20 wards and 78 villages. The Misungwi District Council Strategic plan of 2006 states that the decentralization policy has enhanced people's participation in decision making. The plan points out the shortage of skilled staff as the main weakness. The shortage of staff is indeed serious. The personnel required according to the strategic plan are 450, while the available is 228. This means that there is a shortage of 222 staff. Since the finalization of the strategic plan the situation has worsened; according to the DED, only 39% of the district positions are presently filled, and there are unskilled staffs in many positions. The problem to get skilled staff is due to many factors, including the following:

- the general shortage of qualified staff in Tanzania
- the general poverty of the area, e.g. lack of water.
- the lack of staff housing

It is also possible that the staff shortage will in itself make it more difficult to recruit new staff, that candidates who are aware of this will prefer other districts and that this therefore constitutes a vicious circle.

The strategic plan also points to lack of opportunities for training and upgrading of skills. Shortage of skilled staff is likely to have a profound negative impact on the general district capacity for cooperation on coordination:

- within the district departments
- between the district departments

- between the district and the councillors
- between the districts and NGOs, CBOs, private sector and communities.

The shortage of skilled staff may also be part of the reason for the recent cases of misuse of funds in the district:

- The Finance Department: involving the cashier and the treasurer
- The District Engineer
- The Health department: Transport and procurement officer
- The District Planning Officer

All five are presently being charged. This has of course been a cumbersome process for the staff as a whole – and has probably created a difficult situation between staff members, a combination of lack of trust, suspicion and disappointment – combined with the added workload when persons have been suspended from their jobs. As a result of the unclean audits, Misungwi is not eligible for the Local Government Capital Development Fund. However, the team was impressed by the commitment by many of the staff members we met in Misungwi, particularly the staff in the health sector.

### **4.3 Cooperation and coordination**

The district administration has a key role in the coordination and cooperation at local level. The situation of the district administration – acute shortage of staff - will therefore affect cooperation and coordination as well.

#### **4.3.1 Cooperation among district staff**

It was stated by several that the cooperation between district departments was “average” or that could be improved:

*“The scarcity of resources is presently discouraging cooperation between the departments. The scarceness makes the departments jealous of each other.”*

The district seems to have profited by the Basket Health Fund. This may be the result of good plans, and good cooperation between the health department and the planning department. The Department for Community Development was seriously under-funded. Staff members said that this forced them to sit in their offices and do nothing – as they had no funding for activities – apart from four million Tsh. per year for women groups and a similar amount for youth groups. This implies that the key function of this department and their staff is not adequately fulfilled.

#### **4.3.2 Cooperation between councillors and council staff**

The severe shortage of staff is likely to create delays in implementation of plans – aggravated by the lack of funding. This is a difficult situation for managers, staff and councillors. The staff shortage combined with reduced funding is a difficult situation for the council. The council is a 100 percent CCM council with a chairman who is eager to implement the CCM program. Informants said that it is difficult for the council to see that neighbouring districts are able to provide better services to the communities than Misungwi.

Since the educational level of the councillors is relatively low, few of them are likely to understand the impact of reduced funding or staff shortage on technical work. In more manual



jobs, like farming, tailoring or carpentering, shortage of manpower implies that the number of products is reduced, but that the ones that are produced can still be made at the same speed as before. In a bureaucracy, the different jobs are interlinked and shortage of staff or weaknesses in one department or function will have an impact on the actual time and quality for other staff members to deliver – or even whether it is possible to deliver at all.

The shortage of staff is of course extremely difficult for the Heads of Departments who receive criticism for delayed implementation. In the words of one of the managers:

*“The cooperation with councillors is not very good. The staffs suffer from poor resources and the councillors do not show any appreciation, but only gives criticism. Their aspirations are high. The staffs are demoralized by the criticism.”*

It is not possible for the managers to hire temporary staff for lack of funding; salary for temporary staff has to be funded by the District itself.

The Misungwi DED is a woman. Generally speaking, women managers tend to be more exposed to criticism than men as most people are still not used to women in management positions and generally tend to demand more of a female than a male manager.

Some of the staff members stated that they found the councillor criticism “cumbersome” and difficult. The councillors have participated in the penalizing, transferring or suspending staff. Such actions are of course justified when it comes to misuse of funds, but may not always be the right method for improving performance in an organisation with staff shortage.

#### **4.3.3 Cooperation and participation at community level**

The communities have been receptive and they have been able to adjust according to the various health initiatives and to profit by them. The communities visited were very positive to the improvements that have come as a result of the CARE project.

#### **4.3.4 Cooperation between district and donors/NGOs**

There are relatively few NGOs in the area. The main ones in the health sector are CARE, MEDA, and AMREF. According to the district plan, there is limited “funding for projects because of bureaucracy, strings attached to donor funding, mistrust between donors and the district”. This study has not gone into that, including whether it is localised support to Misungwi or through national mechanisms. One general explanation may be the unclean audits which have led to the district not being eligible for the Local Government Capital Development Grant. In addition, unclean audits may generally speaking, lead to donor mistrust.

NGOs involved in the health sector in Misungwi are CARE, MEDA and AMREF. According to the district administration, the cooperation varies from NGO to NGO. Some are willing to cooperate with the district; they even have joint planning meetings. Others seem to be less willing to share information.

#### **4.3.5 Relationship with religious institutions**

The cooperation between the district and the private hospital owned by the Roman Catholic Church seemed to be good; there are regular meetings between the district and the private hospital to discuss the cause of maternal deaths. At a joint budget meeting, it was decided to

increase the private hospital share of the Basket Health Funding from 10 to 12% as all parties agreed that this was a “strategic priority”.

#### 4.4 Health situation

There are a number of diseases and recurring epidemics in the district, for example cholera and dysentery.

##### 4.4.1 Maternal health

Initial checks to cross reference data and data collection concluded that the published data seen before the study visit were reliable and that the maternal mortality in Misungwi has decreased.

The data collection is likely to be reliable for several reasons:

- There is increasing deliverance in health facilities – where mortality registration is accurate
- There is monitoring of pregnancies and deaths in the communities by the village health workers.

It is even possible that the actual decrease is bigger than the official one, as there seems to be a tendency for women in some of the neighbour districts to deliver in Misungwi if they live closer to the Misungwi district hospital than to their own.

The decrease seems to be the result of systematic project initiatives at several levels, mainly by the CARE project that started in 1997 (see section 4.5 below).

**Table 12. Maternal mortality rates for Misungwi 2001-2005**

Year	MMR (per 100,000)
2001	329
2002	258
2003	153
2004	144
2005	116

##### 4.4.2 Health facilities

According to the District Strategic Plan 2006, the district has a total of 37 health facilities:

- 2 hospitals, Misungwi District Hospital (government) and Bukumi Hospital (owned by voluntary agency)
- 4 health centres (governmental)
- 31 dispensaries (29 governmental and 2 owned by voluntary agencies)

#### 4.5 Donor supported health projects/programmes

CARE initiated a health project in Misungwi in 1997. The project contains a number of components:

##### Emphasis on Voluntary Village Health Workers

- Training of voluntary village health workers
- Village health workers track pregnancies and visits 3-4 times to each pregnant women
- Establishment of health committees in all villages encouraging facility delivery and planning for emergencies

**Community mobilisation**

- Establishment of savings clubs –saving of money for delivery transport and other issues
- Involvement of men, the CARE saving clubs have 30% men
- Establishing of community by-laws fining delivery outside the health facility

**Improved accessibility and transport**

- 9 mobile health clinics to communities far from health facilities
- 1 ambulance
- Transport of pregnant women by tricycles, ox charts, boats

**Improved delivery facilities and equipment**

- District hospital surgery theatre for caesareans

**Learning systems**

Discussion of each maternal death at village and district level and tracking of the causes.

## **4.6 Conclusion**

**Issues that are specific for Misungwi, not easily transferred**

- Well functioning CARE project which ahs focused on maternal health
- Relatively close to Mwanza city with regional hospital and private health facilities

**Good practices from Misungwi**

- Village level institutions like Village Health Committees are active
- Village health workers have been strengthening through the CARE project, and track all pregnancies
- Saving clubs secure money for transport and other delivery expenses (CARE initiative)
- Pregnant women are exempted from voluntary/self-help activities

## 5. FINDINGS FROM MOSHI DISTRICT



### 5.1 Socio economic situation

#### **Geographic conditions and climate**

Moshi rural is situated in Kilimanjaro region and borders to Moshi Urban. The district covers two very different ecological zones; dry land savannah in the south-west and lush mountain slopes in the north.

#### **Economic activities**

Moshi rural has traditionally been a wealthy district due to early involvement in cash crop production of coffee (and bananas) on the mountain slopes. The main economic activities today are agricultural production (cash crops as well as food crops) – and informal sector activities.

#### **Infrastructure**

Moshi Rural is very well equipped with roads (see map above). The main road between Dar es Salaam and Moshi/Arusha runs through the district, and people in the mountain areas are active in building/repairing their roads.

#### **Population, religious and ethnic composition, education**

Moshi rural has a total population of 402,431 (192,998 men and 209,433 women). The majority ethnic groups are the Chagga; the Chagga Council was established around 1935, and the district council is presently housed in the old Chagga Council premises.

#### **Gender relations and community issues**

The area has been exposed to foreign influence for many years, Western as well as Muslim and Indian. The missionaries focused on education, health and craftsmanship, and health services and schools were established in the 1930s. The present level of education is very high. Moshi is one of the oldest districts in Tanzania.

Despite the fact that income from coffee has been drastically reduced in recent years due to falling prices, Moshi rural is one of the richest districts in Tanzania. Only 28% of the population presently lives below poverty line. This is considerably lower than in the poorest districts, where the percentage is around 50 percent (Meatu in Shinyanga, Ukerewe in Mwanza, and Biharamulo in Kagera).

The team was informed by several informants that the Chagga has a system in which there is a clear division of income. Men own cash accrued from coffee, while women own money accrued from selling milk and bananas and are free to spend this money on any expenses that might be needed in the home. Typical comments from informants on women's situation in Moshi/Kilimanjaro were the following:

## DECENTRALISATION AND GENDER

*“The women of Kilimanjaro are very hard working. Women know their rights, and they would not allow the men to take their money. Women pay school fees, and they have small projects. ”*

*“There is very little violence against women. Women know their rights. You see that clearly. Moshi women do small businesses. They have income. Therefore they have greater place and room. Also clan leaders and other influential people would come in and oppose to violence. Even the church has played a role in the empowerment of women”.*

**Table 13. Basic facts of Moshi district**

Population (estimated 2004)	(192,998 male and 209,433 female) 402,431
Size (sq. km)	1,713
Wards	31
Villages	145
Percentage below poverty line	18

**Table 14. Gender Composition of Moshi District Council 2007**

	Male	Female	Total	Vacancies
Council Management Team				
Council Health Management Team				
Key Department staff situation				
Councillors	31	11	42	-

**Table 15. Health budget of Moshi (in million Tshs.)**

	Ministry of Health	Own resources	Donors	Total
Health budget				

**Table 16. Own resources, Moshi District Council 2006**

	Revenue from fees etc	Tax/donations from industry, tourism and individuals	Other	Total
2005				
2006				

## 5.2 Decentralisation by devolution

Moshi has a high level of education for all groups; district managers and staff, councillors, as well as inhabitants. This is not only important for the way the different groups are functioning, but also for the interaction between them:

- between managers departments and staff members
- between staff and councillors

- between staff, councillors and inhabitants.

The population in Moshi seems to demand more, because of their educational level. One district staff member said:

*"They can demand more, they know their rights and they know what is important. If a civil servant performs badly, people will complain. People here in Kilimanjaro are different from others in this way."*

A specific example was given:

*"A woman went to give birth (at a private health facility). The health provider left the woman in labour to talk with someone outside, and the woman delivered on her own. Because the woman was educated she complained. The health worker was not fired, but she was retrenched for 6 months. It was in 2001. It was a lesson for others."*

Several managers emphasised that there is a positive change taking place in regard to commitment:

*"People are changing and the working environment is changing. People like their jobs, and many people want to do a good job; there is a self-actualization even if there are not necessarily more incentives".*

The administration of medicines has also been improved:

*"Earlier, we used to get general kits, without looking at what we actually needed. Now, each facility orders what it needs. Selling of the medicine is not done there. The Health committee of the village looks after it. The committee is under the village government. When the boxes are opened, the health committee is there, and controls the content. However, there are sometimes delays and we sometimes get something we didn't order."*

All villages have 2 village health workers, one male and one female. They have created their own network, and this is seen as an important strength for the district.

### **5.2.1 Cooperation between the Regional level and the district**

There seems to be positive communication between the district staff and the counterparts at the regional level: planning, agriculture, education, water etc. The district staffs seek formal and informal advice at the regional level.

### **5.2.2 Cooperation among district staff**

Many people from Moshi who have received their education and/or worked elsewhere want to come back to Moshi to work, and Moshi therefore easily attracts qualified staff. Moreover, Moshi district council has a large number of female staff at all levels, a female DED and 50% female Head of Departments. In addition, the Regional Administrative Secretary is a woman.

The cooperation between managers and staff members seem to be good. One of the heads of department stated that:

*"There is a big workload in Moshi, there are many staff members, and many with university degrees. There is a big difference between Moshi and where I have been before. The educated staffs help me as a Head of Department. If the staff members are given tasks, they understand them very fast and implement them effectively and efficiently. In the district where I used to work before many of the staff had only form 4 and needed more explanation and follow up. However, more education also means that the staff members know their rights. They can go to the DED or the District Commissioner if they have complaints."*

### **Cooperation between district departments**

There seems to be a positive cooperation between the district departments. It was said that there is less "less compartmentalization" than there used to be.

The health department and the water engineer are both satisfied with their mutual cooperation. A specific example was given when it comes to ensuring that health facilities have water. The team was informed by the Health Department that the water engineer contributes with the necessary water installation and that he ensures that there are water tanks to catch rain water at every health facility. World Vision has supported the district to dig wells, but unfortunately some of them are destroyed. With the D by D, the local communities and the health facilities have more responsibility and independence:

*"Each health facility has its own account. The money from the council is distributed to all health facilities' account. If they have problems that require support from the engineer (i.e repair of a building or a new construction) – they ask him to assess what should be done. The Council helps the village to look for a contractor. They go through the tender board, the council role is just to control. When the contractor is identified, the Council transfers the funding into the village account. The village must contribute 15%. They do this without problem. The village is in charge of the building, the district engineer will only oversee the work. The role of the council will later be to equip the health facility and hire and pay staff".*

The water engineer underlines that he is given a car and fuel if necessary for supervising repairing or maintenance of wells or pipes for health facilities.

### **5.2.3 Cooperation between councillors and council staff**

The team got conflicting information with regard to the relationship between staff and councillors. The Chairman of the Council informed the team that he gave a speech to the staff just after election, underlining the partnership between the councillors and the staff. He emphasized that staff and councillors should compliment each other, and that it is the role of the councillors to make decisions and the role of the staff to implement these decisions.

It was stated by councillors that there was some problems in the beginning of the period because many of the Council decisions were not implemented – not even after some of the Heads of Departments had been given a warning. Finally, after complaints from the Council, the HoD in question has now been transferred to other districts. According to the Council chairman, "the staffs now are very good, the others have been transferred."

It was stated by the Council Chairman that before 1992 - with the single party policy - the same persons were often party and government representatives:

*"This made it difficult to raise charges in case of misuse of funds. After 1992 when we got the multiparty system, misuse of funds is at a minimum. And systems are more transparent. We want revenue and expenditure reports. We urge the villagers to prepare reports on revenues. Today the government is very strict when it comes to divisions of positions between the party and the governments. The village party chairman should not be village chairman."*

It was said by councillors that the initial problems might have been "because the staff were used to working under the oppositions party and had become lax." According to some staff members, the conflict between staff and councillors had been a personal conflict: some of the councillors felt that some of the staff members supported the opposition: "The Councillors did not understand that we staff members are not politicians."

It was stated by several staff members and councillors that there had been a joint workshop for staff and councillors that had helped to improve the relationship.

In contrast to other districts in Tanzania where most of the councillors have form 4 or 6, or standard 7 only, the councillors of Moshi rural are very well educated. Many of them have Master degrees, the rest have Bachelor degrees. According to one staff member, "The councillors here understand everything - they need very little explanations."

#### **Relationship within the parties in the Council**

After having been dominated by the opposition (TLP and NCCR) for the two previous terms (1995-2000, and 2000-2005), the Council is now dominated by CCM. There are 4 members from opposition parties –According to the chairman, the role of the opposition party has changed:

*"The 2 previous terms were difficult. The opposition parties are stronger in our region than in many others. Earlier, the opposition party was discrediting everything that CCM did. Now it is different, they are also fighting for development. Now the whole Council is working very well. We have very good councillors. The old ones had a low educational level, some had only completed form 4 or 7, and very few had completed secondary education. The 4 opposition members are now very positive. They vote positively to the motions. They give their opinion, but always support the motions and find compromises. All resolutions are unanimous, we have no special votes."*

#### **5.2.4 Cooperation and participation at community level**

All informants underline that the Chagga are hard working and ambitious, used to interacting with outsiders, fast to learn and willing to adapt to new customs. This creates a positive basis for interacting with all outsiders, including donors.

##### Tradition of financial contributions

The Chagga have a tradition of contributing financially. Even people who have left Moshi care for the society they left behind and contribute financially. If somebody does not contribute they are sanctioned. An example was given:

*"We need 15% local contribution to build schools It happens that someone does not want to contribute, then we go and see them individually. If they say that they don't have children who will go to that school, we tell them that your children were*



*educated by earlier funds - now you should contribute. If they still don't want to pay we take something from their house and sell it, i.e. chair. Then they will learn that it is better to pay."*

Poor members of the community are excused. In some cases the village leaders contribute on their behalf, and then the poor are asked to work for the families of those who paid for them for a certain period of time.

Donors are impressed by the community efforts. Informants said that it sometimes happened in Moshi that donors got so impressed with community members efforts that subsequent phases' funds were released before the proceeding phases had been completed.

The team was informed by several inhabitants that in Moshi rural people can come directly to the district council, without going through a lot of bureaucratic procedures. The villagers would then collect money for transport and send one or more representatives to the district council, either directly to the DED, or to the DMO, if the issue in question was connected to health. The villagers and the staff then discuss the matter together.

### **5.2.5 Cooperation with NGOs/donors**

Moshi has very many NGOs. UMRU-NGO is an umbrella organisation for NGOs in Moshi rural district with 43 members that work in 4 clusters namely:

- Education
- Marginalised people i.e. youth and women
- Health
- Environment

The team was told that initially, a donor funded the umbrella network and that the members then met regularly. However, when the funding ended, they only meet in clusters. Individual network members submitted proposals to donors without submitting a copy to the umbrella organisation. With the new local government system, each NGO is asked to submit a copy of proposal to local government.

The NGOs are invited to Council meetings, and cooperation is good according to the Council Chairman:

*"Earlier, NGOS were not cooperative; they were very secretive and not transparent. They applied to donors for funding and received funding – without informing the local governments or sending the reports to the local government. Then, it was impossible to coordinate the NGO plans with LG plans. This has now started to change, the NGOs are starting to see themselves as development partners and the local government is now doing an inventory of the NGOs, to know who is doing what. For HIV-AIDS funds, there is a compulsory coordination as funds are allocated to the Local Governments, and then distributed from the local governments to the NGOs."*

According to other staff members, there is still room for improvement:

*"We are supposed to get the plans of the NGOs and integrate them in the local government plan, but very often we do not receive them. I personally think it is because the NGOs don't want us to find out who is funding them and how much they are receiving".*

### 5.2.6 Relationship with the private sector

The DED underlined that the district is aware of the need for closer cooperation with the private sector and that they have received letters from PMO-RALG regarding this:

*"Within the few months I have been in Moshi as a DED there has been two joint meeting with NGOs, CBOs and private sector, one regarding tree planting, one regarding HIV/AIDS. I have only experienced one such joint meeting with NGOs and private sector during all the 16 years I have been an agricultural officer in other districts; that was re. agricultural input, seeds, machines and fertilizers.*

The Moshi community contributions also attract private funding for community initiatives. An example was given by a female councillor:

*"After the people had voted for me, I went back to them and said thank you very much and asked them how we women want to develop. We agreed that we needed small business projects and decided to hold another meeting. We invited some business men in town as guests of honour and told them that we have collected money ourselves, but we have a gap compared to what we need. The businessman said "If you have tried your best, then we will top up." Not all businessmen would have agreed, but we invited businessmen whom we know are kind hearted."*

While this cooperation between women's income generating projects and businessmen is positive, one should bear in mind that contributing to women's projects may also be a way for businessmen to advertise themselves – and in some cases even be the starting point of a political career.

### 5.2.7 Relationship with religious institutions

The team was told that cooperation between local government and the religious groups was very close:

The council found that because 80% of the people go to church or mosque every week, it is better that the religious leaders are in Council Committees. They are well respected. In the Primary Health Care Committees of each ward there will be a religious leader. The government uses the religious leaders actively to spread information – because it is practical and because the leaders have such a high credibility. Important local government information is given to the community after the religious services.<sup>31</sup>

*"After service the religious leaders announce any service that is due, for example vaccination. The community respects the religious leaders. If the leaders say go, they go. If the religious leaders say 'please don't go', they will not go. There is one example. It was announced that Tetanus vaccination should be given to children up to 15 years. The religious leaders thought that it could lead to sterility and asked the communities not to go. This happened in Kibosho and Kilema, and the idea spread almost all over Moshi district."*

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<sup>31</sup> The team knows that this takes place in many churches. One informant, when asked if information is disseminated in Mosques as well, answered affirmatively.

### 5.2.8 The role of traditional authorities

So-called influential elders and clan leaders (in most cases men) are often given special invitation to community meetings. This was the case of the community meeting which was arranged for the team in Bokomu. Traditional authorities have no formal political role.

## 5.3 Health situation

Moshi rural score well on all social indicators. Still, 16.6 percent of pregnant women in rural Moshi were found to be HIV positive in 2002.<sup>32</sup>

### 5.3.1 Maternal health

The initial research of this study concluded that the published figures regarding low maternal mortality are reliable and that they have probably been so for many years.

Several factors seem to have contributed to the low maternity rate:

- There are a large number of health facilities and the distance to a health facility is rarely more than 5 kilometres; most women give birth at health facilities
- Women and men are generally educated and claim services
- Women are sensitized through the antenatal clinics on pregnancies, deliveries, nutrition, hygiene – as well as on the ten dangers signals to be watched when a woman is pregnant.
- In places where there is no nearby health facility there are trained TBS.

There has been systematic training to all groups involved. Since Moshi rural is an area where FGM is a tradition, there have been many campaigns in the period 1997-2001 to stop the practice. In one of the campaigns, influential women in the communities were given bicycles to control FGM practices.

Informants say that traditional birth attendants used to do FMG and that they were entitled 'Mangariba'. They have had to hand over their equipment. TBAs have been trained and they now help health workers to identify pregnant women and to send them to professional help if needed. TBAs have been given delivery kits containing gloves, disinfection, and scissors during training, free of charge. The district health administration emphasise that this is not to encourage delivery at home. Less than 10 percent of the pregnant women deliver at home.

All those who received training, TBAs, village health workers and community health providers, were taught to recognize the ten danger signals for pregnant women (*vidokezo vya hatari*). The essence was to be able to inform the pregnant women and tell her about the signals and that she should go to a health facility if or when they appear. The TBAs and health workers were also trained to detect signs of pre-mature delivery. After this training they observed that very few BBA (Birth before Arrival) occurred.

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<sup>32</sup> <http://www.biomedcentral.com/1471-2458/6/109>

**Table 17. Maternal mortality rates for Moshi rural 2001-2005**

Year	MMR (per 100,000)
2001	
2002	
2003	
2004	
2005	

### 5.3.2 Health facilities

The district has a large number of health facilities:

- 4 hospitals: 2 designated hospitals and 2 church owned hospitals
- 5 clinics
- 56 dispensaries, 32 government dispensaries and 24 private (22 faith based, 2 profit based.)

52 of the health facilities have delivery services; caesareans have to be referred to one of the four hospitals. The most well known hospital in the area is the mission hospital Kilimanjaro Christian Medical Centre (KCMC) which offers high quality services (fees apply).

### 5.3.3 Donor supported health projects/programmes

The DMO's office informed the team that the office has established mobile and outreach maternal health services to the areas where there are no or few facilities. Every fourth month, the mobile clinic (a car) will come to each of the 44 scheduled areas with around 3-4 health personnel (one staff member from the DMO's office, as well as staff members from the health facilities closest to the area targeted for outreach). (The team lacks information on which donor that sponsors this project). The DMO's office has two cars, which they find insufficient. In 2006 the office therefore bought 20 bikes for the use of health facility workers.

## 5.4 Conclusion

Moshi rural has the lowest MMR in the country, 39/100,000. This number is 13 times as low as the national average. The main explanatory factor is that the district is wealthy. However, according to official statistics, more than one in four (28%) live below the basic needs poverty line. This percentage is higher than in for example Kagera, which has a poverty percentage of 18, but a much higher MMR, 62/100,000. Education, good roads, and high number of health facilities appear to be the most important factor behind the low MMR.

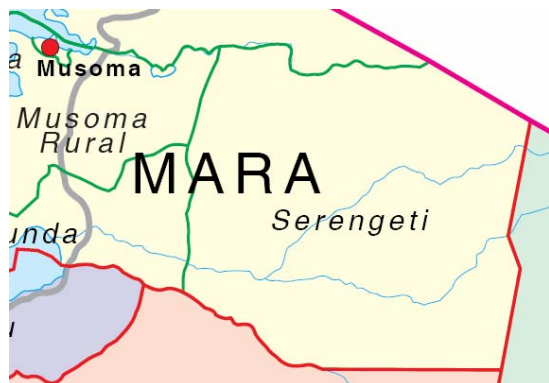
### Issues that are specific for Moshi, not easily transferred

- One of the most wealthy districts of the country
- Women and men are generally educated and claim services
- Women control income from milk and bananas
- Majority of councillors have college/university degrees
- High number of health facilities and the distance to a health facility is rarely more than 5 kilometres
- Tarmac roads to many villages
- Close to Moshi town with a number of private hospitals, including Kilimanjaro Christian Medical Centre (KCMC) which has high quality services

**Good practices from Moshi**

- District staff is willing to meet citizens without cumbersome bureaucratic procedures
- Council staff are highly qualified
- The large majority of women give birth at health facilities, less than 10% deliver at home
- Women are sensitized through the antenatal clinics on pregnancy, delivery, nutrition, and hygiene – as well as on the ten dangers signals to be watched when a woman is pregnant.
- In places where there is no nearby health facility there are trained TBS
- TBAs and community health workers have been trained on detecting signs of pre-mature delivery – number of BBA (Birth before Arrival) has gone down
- Village health workers have created a network where they can meet to discuss and learn from each other

## 6. FINDINGS FROM SERENGETI DISTRICT



### 6.1 Socio-economic situation

#### Geographic conditions and climate

Serengeti District is one of the five districts constituting Mara Region. The district is on the eastern part of the region. The district has an area of 10, 373 sq.km. of which national parks/reserves occupy almost two thirds.<sup>33</sup> The

open area of the district is 2, 456 sq.km. Only around 659 sq.km is arable land used for human settlement, agricultural and livestock keeping activities.

#### Economic activities

The main economic activity in the district is small scale agricultural production, where cultivation is mostly done by using ox-ploughs. Main crops include millet, sorghum, cassava, potatoes, maize, legumes and groundnuts. There is limited production of cash crops such as cotton, coffee and to a very small extent tobacco. Other activities include livestock keeping, and to a small extent, small scale mining. The tourism industry mainly involves the Serengeti National Park, the Grumeti Fund (a so-called 'VIP' tourist facility), and Ikorongo Game Reserve.

#### Infrastructure

The district has critical shortage of staff and limited budget for health facilities and other institutions. The roads are in a bad state, especially during the rain seasons.

#### Population, religious and ethnic composition, education

According to the 2002 National Population and Housing Census, Serengeti district had a population of about 176,609 people (men and women were 84263 and 92346 respectively). The largest ethnic group of the district is Kuria. Other groups include Ngoreme, Taturu, Ikoma, Nata, Isenye, Jita, and Sukuma. tribe is Kuria. The district has a high number of Christian denominations, including Mennonites (USA), Lutherans, Anglicans, Seven Days Adventists, Roman Catholics, and Pentecostals. There are also some Muslims.

#### Gender relations and community issues

The Poverty and Human Development Report 2005 ranks Serengeti District as one of the poorest districts in Tanzania, with 61 % of the households living below the basic needs poverty line. The population is poor in terms of registered cash income, but the district has surplus in food-production, and the team did not get the impression that the district's population was particularly poor.

<sup>33</sup> Serengeti National Park, 7000 sq. km., Ikorongo Game Reserve close to 190 sq.km, Grumeti Game Reserve around 66 sq.km.

A large portion of Serengeti district became inhabited only 50 years ago, which means that the land is fertile. With good rains, the district normally produces excess food which is exported to other districts within the Mara region. Most of the households are also livestock keepers and cattle, goats, and sheep are sources of protein through milk as well as meat. Since the district borders to the Serengeti National Park, the people occasionally have access to game meat. Because of the above factors, the nutritional status of people in Serengeti district is quite good.

Women in most households in the district own and have control over some cattle, milk and cash from the sales of milk, cattle and other agricultural produce. They are also involved in income generating activities and are able to control incomes from these activities. Women can own cattle from dowry paid for the marriages of their second and other daughters.

Among the Kuria tribe it has been a common view that the women are strong and courageous, and that they should prove this by giving birth at home. Women who went to deliver at health facilities were considered to be timid and coward. In some of the polygamous families wives compete to win their husband's love by giving birth to many children. The increased number of pregnancies increases the chance of maternal complications, which might result in death.

The practice of Female Genital Mutilation (FGM) still exists although it is said that the practice is declining. According to the Reproductive and Child Health Services Report (2005), more than three quarters of the examined women had undergone FGM.<sup>34</sup>

**Table 18. Basic facts of Serengeti District Council**

Population (2002 census)	(84263 male and 92346 female) 176,609
Size (sq. km)	10,373
Wards	18
Villages	71
Percentage living below the basic needs poverty line	61
Maternal Mortality Rate (of 100,000)	115
Under five mortality	0.7

**Table 19. Gender Composition of Serengeti District Council 2007**

	Male	Female	Total	Vacancies
Council Management Team	11	21	32	-
District Health Committee	7	5	12	-
Key Department staff situation	4	1	5	-
Councillors	19	9	28	-

**Table 20. Health budget of Serengeti (in million Tshs.)**

	Ministry of Health	Own resources	Donors	Total
Health budget	816,877,424	350,000,000	179,920,950	1,346,798,374

<sup>34</sup> 2137 women in Serengeti were examined, and 1625 were found to have undergone FGM.

**Table 21. Own resources, Serengeti District Council 2006**

	Revenue from fees etc	Tax/donations from industry, tourism and individuals	Other	Total
2005	219,824,833,890	-	-	219,824,833,890
2006	204,613,881,460	-	-	204,613,881,460

## 6.2 Decentralisation by devolution

Administratively, Serengeti district has one constituency, 4 divisions, 18 wards, 71 villages, 318 hamlets and 31,213 households. The district has obtained Local Government Capital Development Grant (LGCDG) in the two last years. There has been O&OD planning in all the 71 villages, and women's health has been discussed in the planning. The national planning system is adhered to. The District Medical Officer compiles all the requests from the health facilities at lower levels (Dispensaries and Health Centres), and then submit a comprehensive plan and budgetary requests for all health facilities in the district to the Council Health Management Team (CHMT) for discussion and approval. The CHMT is made up of 5 women and 7 men. The plan is then sent to the full Council for planning and budgeting processes.

### 6.2.1 Cooperation among district staff

The collaboration and coordination between the district hospital, health centre and dispensaries is good. The Council Health Management Team (CHMT) holds a monthly meeting with Health centres and dispensaries in charge to discuss issues regarding service provision, drugs and complicated issues. The CHMT also discusses personnel issues, materials and matters raised since the last meeting. A quarterly evaluation of activities and expenditures is done every three months to involve representatives of health centres and dispensaries.

The CHMT also organizes for an annual planning workshop which is done once at the beginning of the year to incorporate Health centres and dispensaries plans to form one comprehensive council health plan which is later discussed by the full councils before it is finalized. The people in charge of the health centres and dispensaries also form part of the planning team in the planning workshop. This year's CHMT planning workshop was taking place at the time when the study team was visiting Serengeti district

### 6.2.2 Cooperation between councillors and council staff

The council consists of 26 persons: 8 women and 7 from the Kuria tribe. The district council has 75 % votes for CCM and 25% for others. In the 18 wards, 11 are headed by the ruling party and 7 by the opposition. The district has a very active MP who is a trained medical doctor and who played a role in getting ambulances to the district.

The level of education in the council is low. Even if all the council documents are in Swahili, the language is very technical, especially within the health sector; this is a challenge for councillors. The use of language creates barriers in coordination and cooperation. Regardless of their political differences, all councillors cooperate and work together for development - party politics do not interfere with development work. Councillors from the opposition



underline that they have to forget their political differences until the next election. “We are cooperating as a team”, as one of the female councillor told the team.

The councillors have been actively involved in public meetings and campaigns to create awareness on the necessity of women in the reproductive age group to attend reproductive health education conducted by health personnel. There has also been a media-campaign telling women to come and give birth at the health centres. The councillors were involved in these campaigns also. The female councillors were in the fore front of this campaign.

The campaign meetings also aimed to educate pregnant mothers to attend antenatal care services, and the necessity of delivering their children at health facilities, where they are supported by trained health personnel or trained TBAs.

### **6.2.3 Cooperation with local communities and TBAs**

The full council meeting minutes are available to all citizens at the District Resource Centre. The centre is open everyday from 9:00 to 15:00.

At Kisaka dispensary, the research team was informed that the Dispensary Committee which is composed by 12 members (7 men and 5 women) selects the village health workers. Normally there are 2 Village Health Workers and 2 Traditional Birth Attendants from each village are trained on MCH/RCH issues. The VHW and TBAs also work at the dispensary twice per week. The VHW and TBA are supposed to work as a team, because in most cases, the TBAs are illiterate. The VHWs assists them in keeping their records. Each VHW and TBA has a register. When a TBAs escorts a pregnant women to a health facility, she takes part in the delivery.

When the dispensary health personnel are not present (some times it happens that both staff members are away), they leave the dispensary key to the village Health Worker so that in case of emergency she/he can use the Radio Call to call the ambulance.

### **6.2.4 The role of traditional authorities**

Some years ago there were a lot of conflicts among the different ethnic groups in the district, including theft of cows and fighting. The elders from the different ethnic groups came together and decided on methods of conflict resolution, among them the use of punishments. They have a curse towards those who starts conflicts. They also informed the team that people who create conflicts will be isolated from their community. No-one will be allowed to visit them, and if you do, you yourself will be isolated. The conflict makers are not allowed to fetch water from the well and they cannot go to the market. The whole family can be isolated and this puts pressure on the family to control conflict-elements inside their family. The verdict by the elders is stronger than a high-court ruling and it is respected. After this intervention all forms of criminality has been reduced.

### **6.2.5 Relationship with international donors**

SIDA is a major donor to Serengeti district. This donor sponsors a District Development Programme (DDP) which cooperates with the Community Health Rehabilitation and Promotion Program. DDP is implemented through the government structures, but there is an external technical advisor who supports the local authorities.

The district has also received funding from Marie Stopes and Japan International Cooperation Agency (JICA). It also receives funding from TASAF to help the implementation of community based initiatives.

### **6.2.6 Relationship with NGOs**

#### **Cooperation between the district and NGOs**

The following NGOs are operating in the district (most of them work on issues concerning orphans or the environment):

- Serengeti Environmental Development Research and Environmental Conservation Centre (SEDEREC)
- Red Cross
- Community Based Health Promotion Programme (CBHPP)
- Marie Stopes (provision of family planning services)
- AMREF
- Chama cha Walemavu Tanzania (CHAWATA), [NGO for disabled]
- Serengeti Environmental Protection and Development Association (SEPDA)
- Concern for Elderly (COEL)
- Serengeti Environmental and Cultural Association (SECA)
- Serengeti Farmers Association (SEFA)
- Women's groups, involved with small scale income generating activities, coordinated by the Department of Community Development and NGOs, e.g. SEDEREC.

The presence of NGOs is recognized by the district leadership and they are involved in various meetings, including technical committees. They are also invited to attend the Full Council Meetings, as observers. The activities of NGOs are included in the comprehensive District Development Plan. NGOs enjoy support of the leadership of the District Council and they are issued letters of introduction to all stakeholders and communities in the district. The District Development Programme (DDP) also provides funding to the NGOs, to enable them to implement their programme. Councillors and village leadership cooperate with NGOs at community level when they are implementing their programme activities.

Two meetings between Councillors and NGOs were held in October 2006 and January 2007. The purpose of the meetings was to facilitate better coordination between councillors and NGOs operating in Serengeti district. NGOs in the district have started to organize themselves to form an NGO network to enable increased coordination.

### **6.2.7 Relationship with religious institutions**

There is a good networking system in the district between the government and the religious organizations involved in social services. One example is the Community Based Health Promotion Program (CBHPP) of the Tanzania Mennonite Church in the Mara region. The CBHPP programme is integrated into the Serengeti District Council Plan.

### **6.2.8 Relationship with the private sector**

Two prominent tourist institutions, the Grumeti Reserves (VIP tourist facility) and Serengeti National Park (SENAPA), are situated within Serengeti District. In 2002, the Grumeti Reserves established the Grumeti Fund, a non-profit organisation “established to operate community programs, concession area development and wildlife management efforts within

Tanzania.”<sup>35</sup> Grumeti Fund has supported the council with funds for schools and roads, as well as a contribution of Tshs. 85 million per year. SENAPA supports the villages around the park with funds for development projects such as construction of wells, schools and health facilities.

Some of the people interviewed expressed their appreciations for the contributions given by the two institutions through the construction of wells, schools, health facilities, roads, creation of employment opportunities, monetary contributions to the district council, as well as revenues paid at national level. However, it was strongly felt that considering the huge amount of revenue generated by these institutions from the tourism industry, more financial resources could be contributed to the Serengeti District Council. There is limited negotiation skills/capacity at district level. Further more there should be increased transparency during the negotiations with such institutions.

### 6.3 Health situation

The leading diseases affecting inhabitants of Serengeti district are Malaria, diarrhoea, pneumonia, worms, wounds, anaemia, HIV & AIDS, T.B., measles, meningitis and typhoid.

#### 6.3.1 Maternal health

Women in Serengeti district have access to proteins, through milk, meat, and agricultural produce. With a good nutritional status for the pregnant mother, the danger of anaemia, one of the major factors behind maternal deaths, are drastically reduced.

The Council Health Management Team (CHMT) has made efforts to reduce the Maternal Mortality Rate (MMR) with the use of radio calls and ambulances. The MMR was almost halved between 2001 and 2003. In 2005 some of the radio calls were not working properly. According to health staff, this resulted in an increase on MMR during that year (see table \*). This indicates that the use of radio calls and ambulances have contributed to reduce MMR.

**Table 22. Maternal mortality for Serengeti 2001-2005**

Year	Number of deaths
2001	18
2002	14
2003	10
2004	10
2005	16
2006	15

A big campaign on maternal health has been launched by the health personnel in collaboration with district leadership, Village Health Workers and councillors, to create awareness amongst community members on the necessity of giving birth at the health facilities or to be attended by the TBA. Due to this campaign, there has been an increased number of women who give birth at health facilities as well as reduction of MMR. The presence of trained TBAs in villages who monitor pregnant women and refer complicated cases well in advance to the health facilities contributes to the low MMR rates. The campaign has also helped the district get very reliable statistics on place of delivery. In 2004 and 2005, slightly more women gave birth at home or with a TBA than at a health facility (see table below and tables in appendix).

<sup>35</sup> <http://www.go2africa.com/tanzania/grumeti-reserves/eco-tourism.asp>.

**Table 23. District Hospital Level Deliveries Serengeti District**

<b>Year</b>	<b>Total Deliveries</b>	<b>H/F Delivery</b>	<b>TBA Delivery</b>	<b>Home Delivery</b>
2004	8728	3983	1594	3135
2005	9174	4005	1635	3475

### 6.3.2 Health facilities

Hospitals: 1 (Designated District Hospital, owned by the Mennonite church)

Health centres: 2 (government)

Dispensaries: 32 (2 owned by religious institutions)

The Mennonite church owns the District Designated Hospital while the government provides salaries to almost all staff members. Out of 182 employees of DDH, the Mennonite church pays salary for one employee. The Benjamin William Mkapa Foundation pays salaries for three employees and salaries for the remaining employees are paid by the government (Ministry of Health; Regional Administrative Secretary; District Executive Director). The government also provides for all the operational costs of the hospital. The research team was also informed that plans are underway for the construction of a district Hospital which will be owned and managed entirely by the government.

### 6.3.3 Donor supported health projects/programmes

Three donors have health related programs in Serengeti; SIDA, the Tanzania Mennonite Church, and Marie Stopes.

#### **SIDA's District Development Programme (DDP), and Health, Sanitation and Water (HESAWA)**

SIDA has been supporting the implementation of the District Development Programme (DDP) in Serengeti district for the last 6 years. This programme followed the Health, Sanitation and Water (HESAWA), programme which also was supported by SIDA. DDP has supported building of a dispensary and health staff housing, as well as training:

- Gender training at village level (conducted by the Community Development Department)
- Training at health centres
- Training in health issues related to HIV/AIDS in schools

The Sida-supported HESAWA program trained the voluntary village health workers (VHW) in all villages to keep an overview over who is pregnant. The health workers get some allowances in kind from the village to do this work. In addition, they are exempted from participating in other forms of voluntary work. They received a bicycle each when they were trained.

One of the village health workers in a village visited by the team told the team that they were involved in campaigns about mother –child development and protection. They have awareness meeting in hamlets and villages. During the meetings they are trying to find out who is pregnant. The VHW walks from house to house and find out who are pregnant, and follows up the child until it is five years old. If a mother and/or child die, the VHW will also try to find out the reason for the death.

### **Child Survival Protection and Development (CSPD)**

Informants told the team that both the CSPD program and HESAWA had played a critical role in training and capacity building of health personnel and others. The following training was mentioned without differing between sources of funding:

- Medical attendants/nurse auxiliaries have been trained in MCHA/RCH, to enable them to provide the necessary services to the patients, children and pregnant mothers, and refer them to higher level health facilities on time without delaying;
- Traditional Birth Attendants (TBAs) are trained to undertake abdominal examination, recording all births and deaths which occur in the villages, escorting patients to health facilities. Furthermore they are also trained on early detection of complications and recommending referrals to health facility under their escort. On the early detection of complications, TBAs are trained to watch the following as signs and symptoms that require emergency attention of professional health workers: excessive bleeding before delivery, during delivery, after delivery and high fever before, during and after delivery.
- Village health workers are trained in awareness raising campaigns on all health related issues including necessity to attend antenatal care by pregnant mothers, monitoring pregnant mothers and under five children, and keeping a register of births and deaths in the village. Training included skills in writing quarterly reports and submitting one copy to the Village Chairperson, one copy to the Ward Secretary, one copy to the Head of the Health Facility in the Village/Ward, and one copy to the District Medical Officer.
- Health providers at the Health Centres are skilled to administer Intravenous Infusion in case of emergency when they receive a patient who is in a critical condition from the dispensaries and or if a patient is referred to the District Hospital (DDH)
- Other health personnel are also trained in other relevant courses to facilitate safe delivery of mothers.

### **Marie Stopes**

Marie Stopes deals with the provision of family planning services. This organization is based in Musoma town, and Serengeti district is one of its outreach areas. Of late the organization has increased delivery of family planning services in the district due to increased demands from women who need those services. For example, during the last visit by Marie Stopes, its staff spent 15 days in the district providing FP services in the various health facilities compared to the previous years when they used to come and spend only few days because family planning prevalence was quite low. At Iramba Health Centre, the research team was informed that there has been an increase in the use of condoms which also acts as a family planning method.

Increased access to information and use of Family Planning services have been provided by the health facilities within the district. In addition, there is increased cooperation and coordination between the health facilities and a non-governmental organization,

However the research team was also informed that although there has been an increase in the family planning prevalence, some of the men are not yet in agreement with their wives using family planning. As a result, these women use family planning services without the knowledge of their husbands.

### **Tanzania Mennonite Church's Community Based Health Promotion Programme (CBHPP)**

This program works with people living with AIDS and their families and caregivers. Community Based Health Promotion Programme (CBHPP) has been operational in the district since 1992. CBHPP owns 3 dispensaries in Serengeti District, as well as in Bunda and Musoma Rural District. Collaboration with councillors, village leadership and VHW during maternal health campaign meetings has increased number of pregnant women to access ANC services and deliveries at health facilities and/or to be assisted by trained TBAs. The programme works in collaboration with AMREF in the implementation of the Angaza Project on Voluntary Counselling and Testing on HIV & AIDS. It also supports a Home based Care and a programme to support orphans in 5 villages. CBHPP has been providing transport facilities to health personnel for outreach activities and has been cooperating with the DDH in getting medical supplies used in the outreach programme.

### **6.4 Conclusion**

The team has the impression that the MMR data for Serengeti are correct. There are many factors that might have contributed to the low maternal mortality rates in the district, and some of the factors are assumptions which might require further empirical research to prove the point:

#### **Issues that are specific for Serengeti, not easily transferred**

- The district has a very small population compared to other districts in the region.
- Inhabitants of Serengeti District have adequate food supplies from the agricultural produce most of the time.
- Most women own some cattle and have control over cash from the sales of milk, cattle and other agricultural produce. They also control income from other income generating activities, as well as dowry.

#### **Good practices from Serengeti**

- The activities of NGOs are included in the comprehensive District Development Plan.
- Yearly meetings between councillors and NGOs
- Availability of transport and communication facilities at the health centres and dispensaries have facilitated easy transport and communication regarding patient's referrals to health facilities at higher levels. Pregnant women and mothers don't pay transport costs. The District has 4 vehicles/ambulances. The dispensaries are provided with Radio Calls and Hand sets.
- Health facilities are in a good condition and well equipped, e.g. high number of beds with mattresses.
- Campaigns on maternal health appear to have resulted in increased number of women give birth at health facilities.
- Training of health personnel and TBAs. Most of the TBAs escort pregnant women to the health facilities where they collaborate in the delivery.
- The monitoring and tracking system of pregnant women, deliveries, children under 5 and maternal deaths, by VHW who record data and submit reports on a quarterly basis
- Referral to the next level of health facility as soon as they detect or foresee maternal complications
- Good obstetric care provided to mothers

## DECENTRALISATION AND GENDER

- Improved access to family planning information and services
- Outreach and Mobile Services provision with antenatal care, vaccination for children, family planning, SP (malaria prophylaxis), iron supplement and Vitamin A, insecticide treated bed nets for children under five and pregnant mothers as well as weighing children.
- Committed health personnel and other people, high level of commitment.
- The district has prioritized to use its own resources to buy ambulances

## 7. MAIN FINDINGS AND GOOD PRACTICES

### 7.1 Main findings

#### **Fruitful approach**

The identification of a specific entry point for analysing gender at local level was found to be very useful. The focus on maternal health made it possible to get specific and concrete information – as opposed to vague and general terms. The low maternal mortality rates in all the four districts visited are reliable. The reasons for the low rates differ in the different districts.

#### **Different reasons for low maternal mortality**

In the case of Moshi, the low MMR is first of all due to the general high level of education, the positive economic situation, women's income, and a large number of health facilities (partly established by missions, partly by self-help activities and wealthy individuals). These are all factors that are hard to replicate in districts that have less favourable socio-economic backgrounds.

Ileje, Misungwi and Serengeti, on the other hand, are more interesting in terms of replication and learning. The three districts are all relatively poor, and the low maternal mortality rates are the result of specific area based donor funded projects and local initiatives targeting maternal health (as well, in the case of Ileje and Serengeti, mission hospitals).

#### **Area based donor funded projects with similar characteristics**

The projects – UNICEF (Ileje and Serengeti), CARE (Misungwi), SIDA's District Development Programme, Marie Stopes, and Tanzania Mennonite Church's Community Based Health Promotion Programme (all in Serengeti only) share some common characteristics:

- Coordination between health facilities at different levels – government or private
- Focus on the voluntary village health workers: training for tracking of pregnancies, collection of data and follow up of pregnancies. In two districts village health workers were exempted from community project contribution and given bicycles.
- Focus on village health committees: discussion of death factors and prevention
- Training of traditional birth attendants on danger signs indicating that delivery should take place at health facility
- Focus on delivery at health facilities
- Improvement of health facilities and equipment
- Improved means of transport for pregnant women, in one district ambulances, in one district stretchers
- Radio communication network in one of the districts with inadequate cell phone network and transport difficulties
- Focus on health workers attitudes/language versus pregnant women, especially young ones
- Mobile clinics and outreach units to isolated areas
- Committed and serious key staff



### **Women's economic empowerment**

Women's control of cash income may be a central factor behind low MMR. In two of the districts, women traditionally keep income from milk. In a third district, a donor project has organized saving groups to prepare for delivery and transport expenses.

### **Male involvement**

Two of the district projects included male involvement, i.e in the savings groups and in the transport on stretchers when pregnant women needed to go to health facilities for delivery.

### **Different access to external funds**

The number of donor projects in the four districts varies greatly. Moshi has a very large number of donor funded projects, the other three relatively few. The existence of projects does not seem to be proportional to the actual needs. In Moshi for example, 64% of the population have access to clean water. The district has still recently been granted a large German funded water project. In Misungwi, on the other hand, only 32% of the population have access to clean water (and no large scale water projects are planned).

### **Important basket funding mechanism**

Several of the districts have profited from the LGCDG – apart from one that was not eligible due to unclear audit reports. All the districts receive funds from the Health Basket Fund, and one district cited the year when those funds started coming (2003) as a turning point regarding maternal health.

### **Cooperation between district departments**

The cooperation between district staff and departments varies between districts, departments and staff members. In all districts the Health Department played a key role, and the coordination with Department for Planning seems to be good, as well as the Department for Works.

### **Missing key department**

In all the four districts the Department for Community Development lacks transport and fuel and depends on transport from Departments of Education and Health to visit communities. They therefore have a limited role re. community mobilisation on maternal health. One of the districts said that lack of funds forced the staff to sit in their offices and do nothing – as they had no funding for activities – apart from four million Tsh. a year for women groups and a similar amount for youth groups. This implies that their key function of this department and their staffs are not adequately fulfilled. However, in one of the district, this department was in charge of compiling UNICEF forms on maternal and child health and deaths.

### **District staff as motors of cooperation**

According to the Government policy on local government (decentralisation by devolution), the LGAs have a critical role in service delivery and coordination. Only one of the four districts, Moshi, seems to have an adequate number of staff – and qualified staff. The three other districts all have shortage of staff with regard to positions filled and qualifications, one of them a very serious shortage. This has a negative impact on the district coordination with NGOs and with the private sector in general.

### **Cooperation with councillors**

District councils are complicated bureaucratic organizations. With the D by D, the councillors' key role in decision making is complex – and probably difficult to grasp for most

councillors with relatively limited education and experience. This does not mean that only people with a high level of education should become councillors, but it does constitute an enormous challenge for councillors' training. Some of the councillors mentioned LGRP training and that this had helped them understand their role better, including their right to control the financial statements.

In some cases, the difference in educational level between councillors and staff seems to have created conflicts: lack of respect for councillors among staff and lack of understanding of the staff members' situation among councillors. In two of the districts, however, the relationship between the two groups was good. The cooperation between councillors from different political parties seems to be relatively good in all four districts.

#### **Cooperation between district and inhabitants**

The formal educational level of inhabitants seem to be a key factor, both when it comes to the inhabitants' demands and the district's understanding of their needs.

#### **Cooperation between district and NGOs**

There still seems to be a potential for improvement in this area. Two of the districts mention that the NGOs were reluctant to share information on funding. With regard to issues like HIV and education the situation was very good, since the funding goes from the national level to the district – and is allocated to the NGOs by the district council. In one of the districts, the district facilitated the work of the NGOs, e.g. through introduction letters to the communities. In one of the other districts, councillors had regular meetings with NGOs.

#### **Cooperation between district and private sector**

One of the districts had had several cases of misuse of funds by staff members. Some of the cases were related to cooperation with private sector, e.g. procurement of goods and services. The team did not go into issues regarding tendering procedures, contracts and follow up of contracts, but this may often be a complicated area to control for both fellow district staff as well as for councillors.

#### **Examples of conflict resolution**

The Terms of Reference for the study included the role of women in conflict prevention and resolution – in line with the UN Security Council Resolution 1325 on "Women, War and Security". The team did not have any specific findings regarding this issue related to cooperation between local governments, communities, NGOs and private sector. There was however an interesting finding re. the role of traditional leaders in the Serengeti district.

## **7.2 Good practices from the four districts**

Chapter three to six have presented findings from the four case study districts. In the conclusion of each chapter, we have listed factors that may explain the low MMR that are specific for the district in question, and not easily transferable. Examples are favourable economic conditions, cultural issues, and donor projects. Separately, we have also listed factors that may be replicable. Several of these factors have been introduced through donor projects, but we have decided to list such practices that are comparatively cheap to replicate in other districts. With D by D, districts can choose to focus on maternal health, and they can choose to use health basket funds and their own resources to implement some of the methodologies that the UNICEF and CARE projects have initiated in other districts. District Councils may design their own programs on the basis of the ideas listed below, and then apply for funding from local NGOs or local business enterprises and foreign owned companies.

### **District administration**

- Regular meetings for the Council Management Team to coordinate the activities of the different departments
- District councils should do their best to attract highly qualified staff – by offering a conducive and friendly working environment
- District staff should be sensitized to be willing to meet citizens without cumbersome bureaucratic procedures
- The activities of NGOs should be included in the comprehensive District Development Plan
- NGOs can be invited as observers in the full council meeting, and should be encouraged to present themselves and their work at least once a year. Yearly meetings between councillors and NGOs can also be arranged.
- Other departments than health should be willing to let their office cars be used for transport to hospital in cases of emergency
- In areas with low cell phone coverage, district councils can consider equipping health facilities with radio calls
- Access to family planning information and services should be improved, targeting young girls in particular
- If finances allow, districts should establish Outreach and Mobile Services provision. Services can include antenatal care, vaccination for children, family planning, SP (malaria prophylaxis), iron supplement and Vitamin A, insecticide treated bed nets for children under five and pregnant mothers, as well as weighing children.
- Districts with high income from the private sector (industry/tourism) should prioritize the procurement of ambulances to other types of cars

### **Health facilities**

- Community health workers should be trained to detect signs of pre-mature delivery/ BBA (Birth before Arrival)
- Health workers should be sensitized on the need to refer women in labour to the nearest hospital as soon as they detect or foresee maternal complications
- Each health facility has a catchments area to which they provide out-reach following a set time table. Encourage women to give birth at health facilities
- Build maternity waiting home at the district hospital to serve people from remote areas
- Antenatal clinics should sensitize women on nutrition, hygiene and dangers signals to be watched during pregnancy

### **Village health committees, Village Health workers, and community initiatives**

- Activate village level institutions like Village Health Committees and voluntary Village Health Workers. This does not need to entail expenses. Rather than payment, members of the committee and Village health workers could be exempted from voluntary/self-help activities and local taxes (if any). Health basket funds should be used to provide training for these groups.
- Village health workers should register and track all pregnancies on special forms (can be modelled on UNICEF CSPD forms). The monitoring and tracking system can include deliveries, maternal deaths, and deaths of children or any inhabitant. VHWs

submit reports to the Ward Executive Officer who brings them on to the district level on a quarterly basis

- Village health workers can create a district wide network where they can meet to discuss and learn from each other
- Basket funds should be used to widespread sensitisation, among other things on “Birth preparedness”, including the need to put aside money for transport
- Councils/village governments can buy stretchers to transport women to health facilities
- Village Health Days could be arranged where health experts in the village interact with the community members. Can co-incident with vaccination days etc
- Pregnant women should be exempted from voluntary/self-help activities (this is an incentive to register their pregnancy with village health workers)
- In case of death – the factors should be discussed by the Village Health Committee and the Village Health Workers
- Saving clubs can be started to secure money for transport and other delivery expenses (see CARE model with four different locks on the money box)

### **Traditional Birth Attendants**

- In areas where women prefer TBAs to health facilities, use health basket funds to train TBAs to recognize danger signs in pregnancy and signs of pre-mature delivery/Birth before Arrival (BBA). Encourage TBAs to escort women in labour to health facilities and when feasible, assist in the delivery.
- District health extension workers can have separate meetings with TBAs

## **7.3 Good practices from other districts**

### **The Tanzania Essential Health Intervention Project (TEHIP)**

The Tanzania Essential Health Intervention Project (TEHIP) which is being implemented in Morogoro rural and Rufiji districts, demonstrates a best practice in regard to integrating research and development interventions at community level.<sup>36</sup> As a research activity, the project has been able to collect information and data on all deliveries happening at home, including maternal deaths. In addition, data on infant mortality (IMR), under-five mortality (U5MR), and other forms of ‘out of health facilities’ morbidity have been recorded. The MMR of Morogoro Rural District and Rufiji districts therefore, might be based on deliveries at health facilities as well as home deliveries, in contrast to many other districts which only record maternal deaths taking place at health facilities. Within four years of the project child mortality has been reduced by 40 percent. A further investigation can be undertaken to ascertain these facts, the approach and methodology applied in this project, to enable other districts to learn from them. It will be useful to document and use the TEHIP project as one of the best practices that other districts can learn from.

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<sup>36</sup> Savigny, Don de, etal In Focus: Fixing Health Systems, IDRC, 2004

## 8. PLAN FOR PHASE TWO

The purpose of phase two is to disseminate and replicate good practices from phase one to districts where the maternal mortality rate is high. The objective will be to use findings regarding cooperation and coordination that can improve the MMR. A time period of 12 months is being estimated for specific support for phase two districts.

Table 24 lists the eighteen rural districts with the highest mortality rates (from over 300/100,000 live births). Rural districts that used the national MMR of 529/100,000 have not been included in this table.

**Table 24. Districts with highest Maternal Mortality Rate**

District	Region	MMR (per 100,000)	People living under basic poverty line (in percent)	Score on LGA Performance (in percent)
Mvomero	Morogoro	730	26	58
Morogoro (R)	Morogoro	730	31	79
Mbinga	Ruvuma	600-1000	28	92
Kiteto	Manyara	645	28	67
Korogwe	Tanga	530	31	79
Liwale	Lindi	484	38	82
Ngorongoro	Arusha	557	24	77
Urambo	Tabora	474	41	93
Pangani	Tanga	523	22	55
Ulanga	Morogoro	390	28	94
Kahama	Shinyanga	383	37	97
Monduli	Arusha	378	24	70
Manyoni	Singida	372	49	64
Sumbawanga	Rukwa	352	34	88
Mpwapwa	Dodoma	322	28	61
Mkuranga	Coast	320	40	69
Chunya	Mbeya	314	25	67
Bunda	Mara	310	68	72

The team proposes twinning of a Best Practice district with two districts with a relatively high maternal mortality. The team also suggests that the three districts should be geographically relatively close as well as easily accessible. Geographical closeness and accessibility will facilitate and encourage follow-up and exchange of experience between “good practice” districts and districts with a potential for improvement during the twelve months period covered by phase two. The closeness will reduce the costs of travel, and will in many cases also mean that the partners have knowledge about each others’ social and economic conditions, challenges, and working environment.

The team acknowledges that ideally, the twinning districts should be in the same region. An important advantage with a regional approach is that it would be possible to institutionalize the follow-up through the Regional Local Government Technical Advisers. However, only two of the phase one districts are located in regions where there are *also* districts with high MMR. The principle of choosing districts within the same region can therefore not be carried through in all the cases.

Based on the above, the following districts are recommended for phase 2:

**Table 25. Partners for phase 2**

Good practice districts		Districts with potential for improvement	
Moshi Rural	Kilimanjaro region	Ngorongoro Monduli Pangani	Arusha region Arusha region Tanga region
Ileje	Mbeya region	Chunya Sumbawanga	Mbeya region Rukwa region
Serengeti	Mara region	Bunda Kiteto	Mara region Manyara region
Misungwi	Mwanza region	Kahama Urambo	Shinyanga region Tabora region

The team is of the opinion that it is important to include districts from the south-eastern part of the country in the project. There are two options: Mtwara rural and Rufiji. Mtwara rural was originally among the selected 'good practice' districts but the team was unable to visit this district as planned. Rufiji has been part of the Tanzania Essential Health Intervention Project (TEHIP) (see section 7.3), and probably has many good practices to share. We therefore propose that one of the two districts is chosen and twinned with Liwale (MMR 484/100,000) or Mkuranga (MMR 320/100,000).

**Table 26. Optional additional partners**

Good practice districts		Districts with potential for improvement	
Mtwara rural	Mtwara region	Liwale Mkuranga	Lindi region Coast region
Rufiji	Coast region	Liwale Mkuranga	Lindi region Coast region

**Commitment as precondition**

The action plan is based on a written response and a commitment from the districts in question, implying that the actual number of districts accepting the invitation is likely to be less than the number of those invited.

## 8.1 Activities and timetable

The team proposes the following action plan for phase 2:

### Activities at central level

<b>Objective</b>	<b>Activity</b>	<b>Time</b>	<b>Responsible</b>
<b>Ensure PMO-RALG ownership and capacity</b>	Select or appoint persons to be responsible for phase two	Urgent	PMO-RALG
<b>Clarify institutional arrangements</b>	Clarify roles of NGOs, ALAT, and other development partners, national and international consultants etc. in phase two	Urgent	PMO-RALG
<b>Coordination with other Ministries and other national institutions</b>	It is vital to ensure cooperation with other relevant ministries, particularly - The Ministry of Health, e.g. the Reproductive Health Section - The Ministry of Finance - The Ministry of Community Development, Women and Children - Ministry of Planning - Ministry of Regional Administration and Local Government	Urgent	PMO-RALG
<b>Assessment of role in the road map</b>	<i>It is important to ensure coordination with other initiatives regarding maternal health, e.g. the Road Map (Correct?)</i>	Urgent	
<b>Clarification of statistical data</b>	<i>It is important to improve the study report statistics regarding maternal health – taking into account the fact that many districts only report deaths at health facilities – not in the villages.</i>	Urgent	PMO-RALG, MoH and National Bureau of Statistics
<b>Clarification of budget</b>	<i>It is important to clarify the budget limitations for phase two – including possible funding possibilities for kick start of fast track initiatives</i>	Urgent	PMO-RALG and the RNE
<b>Elaboration of new D by D policy</b>	<i>The study is linked to the ongoing elaboration of a new D by D strategy – including relationship between national as well as local actors</i>		PMO-RALG

## 8.2 Activities in the districts

Objective	Activity	Time	Responsible
<b>1. Information</b>	An information package regarding phase two is elaborated by PMO-RALG – including <ul style="list-style-type: none"> <li>- the executive summary for phase 1 – (English/Kiswahili)</li> <li>- the plan for phase two (Eng./Kiswahili) including overview of possible activities</li> <li>- list of available material on maternal health.</li> </ul>	May 07	PMO-RALG
	The information package is sent to the districts in phase 2 (LG, councillors, NGOS/CBOs/FBOs) – informing them of the project and inviting them to participate, asking for <ul style="list-style-type: none"> <li>- information on the situation in their district</li> <li>- needs and priorities re. resources and budget possibilities</li> <li>- need for assistance re. funding</li> </ul>	June 07 – with deadline August 07.	PMO-RALG
<b>2. Assessment and application re. funds</b>	The districts that ask for it are offered assistance by Tanzanian consultants from Health Equity Network or others to: <ul style="list-style-type: none"> <li>- assess their local budget possibilities</li> <li>- assess funding possibilities</li> <li>- apply for funds for improvement of MMR</li> </ul>	August-September-October 07	Funding: for consultants: RNE or PMO-RALG
<b>3. Elaboration of district plan for the activities selected by the district</b>	Elaboration of district plan work plan for improvements – based on good practices in phase 1	Ass. soon as budget is clarified: August 07- May 08	
<b>4. Implementation of selected activities</b>			
Public awareness raising on maternal health needs	Public meetings with NGOs, CBOs, FBOs, and the private sector to create awareness of needs as well as alliances for change		Budget to be elaborated



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Targeted exchange of experience with Best Practice districts	Exchange visits – based on specific needs as well as plans for learning and implementation		Budget to be elaborated by PMO-RALG
Implementation through the uses of the political system	Awareness raising for political representatives on practical ways to improve Maternal Health – from councillors to sub villages - preferably as integrated parts of regular trainings and meetings		Budget to be elaborated by PMO-RALG
Awareness at village level	Traditional authorities (including TBAs), and influential persons		
Awareness raising in district administration	Awareness raising for the District Health Management Teams		
Improvement and strengthening of village health workers	Implementation of the Best Practices from Misungwi, Ileje and Serengeti – e.g. training of village health workers (VHW), tracking of pregnancies, improved communication, supply of stretchers, exemption from communal labour for VHWs and pregnant women		Budget to be elaborated by PMO-RALG
Use of local NGOs projects or programs – if already in place	In the districts where NGOs or CBOs are already involved in maternal health projects it would be important to build on these experiences and resources		
<b>5. Monitoring of results</b>	Establishment of indicators and Implementation of initial Base Line study	Base line study – showing the present situation - by Tanzanian institution	
	New study – based on the baseline study	May 2008	

### **Overview and development of information material**

*There exists a large amount of information material re. issues related to Maternal Health in Tanzania, elaborated by different NGOs and Development partners, video, booklets, leaflets etc. It would be important to get an overview of this material.*

*PMO-RALG has developed/sponsored material for Television and radio as well as a theatre play that can be used by drama groups.*

*In addition, the Royal Norwegian Embassy is presently planning the elaboration of additional material on Maternal Mortality, a video as well as a leaflet.*

## **8.3 Financial arrangements**

### **Use of existing funds**

There are a large number of funds going to the districts. The report "The Annual Assessment of Minimum Conditions and Performance Measures for Local Councils under the LGCDG System for the Financial Year 2007-2008 (December 2006) gives a total overview of the available funds and the exact amount going to the different districts.

Not all funds would be relevant for maternal health interventions, but some of them are definitely relevant, e.g. the Local Government Capital Development Grant and the Capacity Building Grant.

In addition, there are specific funds allocated to health interventions, e.g. the Community Health Fund or the Health Basket Fund.

### **Challenge regarding existing funds**

Based on the table above, it might be argued that all the districts participating in phase 2 ought to be able to fund their participation in phase two from the existing funds, e.g. the Local Government Capital Development Grant and/or the Capacity Building Grant.

There are, however, certain challenges:

- The sums allocated to the districts show great variations – as they are based on the number of inhabitants as well as performance indicators
- Many of the districts may already have made specific plans for the funds

Some of the districts may not have the necessary administrative capacity for assessing the funding possibilities and may therefore need assistance; this is provided in the plan, see paragraph 3.1.

### **General challenge regarding use of funds**

*Another issue is of course how the funds are being used. There seem to be a tendency in Tanzania that a large part of the funds are used for work shops, allowances and per diems, and that only a relatively small part is actually being used in the villages where action is most needed.*

### **Other funding possibilities**

The Norwegian Agency for Development Cooperation, Norad, is developing a Norway-Tanzania Partnership Initiative (NTPI) focusing on maternal health and child health. Within this framework, it might be possible for PMO-RALG to ensure some funding for the following:

- the implementation of activities in districts where no other funding is available
- the PMO-RALG follow up and coordination
- the initial base line study and the final assessment

## **8.4 Challenges**

### **Challenges for PLMO-RALG**

#### Ownership and capacity

A key challenge for PMO-RALG is the ownership and capacity of phase 2. It will not be possible to go ahead with phase 2 if this ownership is not established and if PMO-RALG does not appoint persons that will be following and coordinating the process.

#### Institutional arrangements

This includes clarification of the institutional arrangements, i.e. the role of national NGOs, national consultants and foreign consultants.

#### Coordination with other ministries

The initiatives should be coordinated with the other relevant ministries:

- The Ministry of Health, e.g. the Reproductive Health Section
- The Ministry of Finance
- The Ministry of Community Development, Women and Children

#### Budget clarification

Phase 2 will need additional funding for the exchange visits, for both the five best practice districts and the other eleven. This may be funded through various mechanisms. This key issue has to be clarified as soon as possible and realistic budgets elaborated. As the time span for the phase two is only twelve months, the matter is urgent.

### **Challenges for the Best Practice districts**

When it comes to the participation of the Best Practice districts in the twinning, it should be discussed

- whether this is realistic; do Best Practice districts have the time to assist other districts
- how it should be done and by whom – depending on the activities selected.

### **Challenges for the districts with a potential for improvement**

#### Motivation

The idea for phase two is based on the transfer of Best Practices from some district to others. The team was initially uncertain whether institutions, organisations and

persons in the districts with a potential for improvement would actually be interested in participating in this transfer of experience, but based on the pilot visit to Pangani, this does not seem to be a problem.

All key institutions met in Pangani showed an interest in participating in the transfer of knowledge re. maternal health in phase two:

- the council
- the DAS
- the Council administration
- the council – male and female councillors, CCM and CUF
- the Bakwata

## **8.5 Method for transfer of experience**

### **Integration in the planning and budget cycle**

It is vital that the plans and initiatives are integrated in the planning and budget cycle – at district, ward and village level.

### **Importance of local culture and traditions**

The team observed during our visit to Pangani that issues related to maternal health seem to be strongly related to traditional cultural attitudes and values where local civil society informal organisations and leaders play a key role. In the case of child birth, the team was told that women traditionally went home to their mothers or mothers in law to give birth. Despite the fact that an increasing number of women now prefer to give birth at a health facility, some women prefer to deliver with TBAs or family members because they are shy to undress in front of health workers that are younger than themselves. Some people also believe that a husband is stingy if he does not send his wife to her mother for delivery. Fear of stigma may therefore compel men to send their wife to their mother for delivery rather than to hospital.

The district administration cannot change traditional cultural attitudes to child birth, but it can influence the choice women make by providing safe quality facilities and services at a reasonable price (the need to bring rubber gloves and clothes for delivery at hospital was also mentioned as something that made women choose other, cheaper, alternatives).

### **Focus on civil society and religious organisations**

The importance of traditional cultures in matters related to maternal health implies that phase two must have a strong focus of civil society, informal as well as formal. This implies that civil society organisations and religious organisations must play a leading role. This is particularly important in Pangani where few members of the district administration staff are from the district. At present, none of the Head of Departments are from Pangani (although a woman from Pangani was recently acting Head of Community Development and is now a senior Community Development Officer). Most of the staff seems to be from Kilimanjaro and Arusha. This is a consequence of the high level of education in those areas, but it is nevertheless a challenge for the cooperation between the district administration and the communities.

At a practical level, the above will imply that at least 50 percent of the persons involved in phase two exchange visits and seminars should represent elected representatives (councillors, including women special seats), as well as NGOs, CBOs and FBOs.

### **Focus on women**

Maternal health is very much seen as a women's issue. This implies that approximately 50% of the persons involved in phase two exchange visits and seminars should be women. The team believes that women who participate in the project will have a greater chance of reaching women for mobilisation than men.

### **Methods for transfer of knowledge**

Study visits between districts do not in it self necessary lead to transfer of knowledge, or the implementation of new knowledge. Even if information, experiences or ideas are received by the council members or others, they will not automatically be transmitted to the villages or the communities. It will be important to integrate a focus on this through a process of planned steps, based on mutual commitment, clear plans, realistic actions and systematic assessment of how the information and activities are being brought down to the local level.

At village level, the project should be anchored in the village government and its health committee. At the sub-village level, sub-village chairpersons (who are also members of the village government) should arrange separate meetings for men and women, led by a male and female village health worker respectively.

### **Planning and documentation of learning**

When it comes to the use of twinning, exchange visits do of course – in themselves – not guarantee learning or later implementation.

Before any exchange visit, the visiting district will be asked to discuss and describe – in specific not general terms:

- what they see as problematic regarding the present
- what kind of things they would be interested in seeing and learning
- how they are planning to use this knowledge.

After the visit, the visiting district will be asked to describe:

- what they saw and learnt
- how this will be implemented

After a number of months the district will be asked:

- whether they were able to implement any of the new ideas
- if yes – how?
- if no, why not?

## 8.6 Way forward

The first steps are the following:

1. PMO-RALG and RNE will clarify the urgent issues
  - ensure PMO-RALG ownership and capacity
  - clarify institutional arrangements
  - coordination with other Ministries
  - clarification of budget
2. PMO-RALG- with the possible assistance of the consultant team – elaborate the information package for the selected districts
3. PMO-RALG sends out an invitation letter and the information package to the selected districts

## 8.7 Activities and time timetable

The table below provides an overview over objectives, activities, time frame, and budget needs for the study, completing Phase 1 and Phase 2. Most of the budget items are to be elaborated by PMO-RALG and/or the Royal Norwegian Embassy.

Objective	Activity	Time	Budget
<b>PHASE 1</b>			
Discuss draft report phase 1 and discuss plans for phase 2.	General workshop with all 4 district, key NGOs, PMO-RALG, Ministries, Development partners	May 2007	Budget to be elaborated by PMO-RALG
Test different methods of replication	Conduct pilot study phase 2- visit to one district	May 2007	Budget to be elaborated by RNE based on Moshi test study  Int. consultants 2 x 2 man weeks National consultants 2 x 2 man weeks
Finalize report phase 1 and plans for phase 2	Distribution of final report 1 and final plan for phase 2	May-June 2007	Int. consultants 2 x 2 man weeks
<b>PHASE 2</b>			
<b>Development of general material</b>		March-September	
Elaborate material to be used in phase 2 districts — as well as in workshop and general media	Video production on a specific maternal health case – focusing on cooperation	March-September	Budget to be elaborated by RNE
	Small booklet on coordination and cooperation	March-September	Budget to be elaborated by RNE

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	regarding maternal mortality <sup>37</sup>		
	Television programs, radio programs or theatre plays	March-September	Budget to be elaborated by RNE
<b>Possible activities in the 10 districts</b>			
General focus on maternal health for stakeholders	Public meetings with Foundation of Civil Society – NGO, CBOs, private sector		Budget to be elaborated by PMO-RALG
Discuss and elaborate district plan for improvements – based on good practices in phase 1			Int. consultants 2 x 2 man weeks National consultants 2 x 2 man weeks
Stimulate and inform 10 districts through exchange of experience with 4 good practice districts	Send persons from good practices to new districts e.g. Misungwi DMO/RHCHC		Budget to be elaborated by PMO-RALG
	District twinning		Budget to be elaborated by PMO-RALG
	Training for councillors (preferably part of regular training)		Budget to be elaborated by PMO-RALG
	Study visits – for women NGOs (where applicable)		Budget to be elaborated by PMO-RALG
Replicate selected elements of good practice projects to other districts			Budget to be elaborated by PMO-RALG

It will be essential, as part of the mobilisation of Phase 2, to create the monitoring and evaluation framework for Phase 2. It is the intention to do this in two ways:

- i) Using existing data on LG performance and health indicators;
- ii) Examining aspects of cooperation and coordination in Phase 2 districts for the baseline situation. These will be re-examined in 12 months.

<sup>37</sup> The booklet

## 9. ANNEXES

### 8.8 Overall program

Date	Activity
Sunday 11.02.07	Meeting with Norwegian Embassy and consultant Christina Warioba regarding pre study Lunch meeting team members, Bodil Maal (Norwegian Embassy, and Lesley Saunderson, PMO-RALG.
Monday 12.02.07	Departure for Moshi
Tuesday 13.02.07- Thursday 15.02.07	Interviews Moshi Rural
Friday 16.02.07	Return to Dar es Salaam
Saturday 17.02.07	Elaborate report from test mission and final check list
Sunday 18.02.07	Team meeting: Summing up of Moshi field trip
Monday 19.02.07- Friday 23.02.07	Visit to Ileje, Misungwi and Serengeti See separate programs
Saturday 24.02.07	Writing of summaries and report.
Sunday 25.02.07	Writing of summaries and report.
Monday 26.02.07	Team meeting. Summing up of phase 1 and discussions re. phase 2
Tuesday 27.02.07	Final team meeting Debriefing at PMO-RALG. Debriefing at the RNE with Councillor Kristin Sverdrup International consultants departure for Norway
Monday 05.03.07	Deadline for first draft report
Tuesday 27.03.07	Deadline for second draft report

### 8.9 Field visit programs and persons met

#### 8.9.1 Field visit to Ileje

Dr. Siri Lange, Team Leader, Rehema L. Mwateba

Day and Date	Institution	Name	Title
Monday 19.02.07	Mbeya Regional Hospital	Dr. Tusibwene Malambu	Doctor (private visit)
Tuesday 20.02.07	Mbeya Regional Secretariat	Richard Kimei	Acting Coordinator of Southern Zone
	Ileje District Council	Jonathan Katunzi	District Treasurer
		Harry Kasege	District Council Accountant
	Itumba Health Centre	Jonathan Katunzi	Acting DMO
Nebart Mwashuya		Health officer	



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Wednesday 21.02.07	Ileje District Council		DED
		Peter Nathaniel Kinyasi	District Planning Officer (DPLO)
		Harry Jonas Sinjela	District Community Development Officer (DCDO)
		Daniel Kamwela	District Agricultural and Live Stock Development Officer (DALDO)
		Victor Z Kabuje	TASAF coordinator
	Ileje Ward	Visit to two TASAF projects	Women who were doing voluntary work
		Lutusyo Samweli Mbembela	Councilor
	Morovian church	Angetile Yesaya Musomba	Reverend
Thursday 22.02.07	Market	Anonymous	Two market women
	Restaurant	Anonymous	Widow who escaped being inherited
	Itumba Health Centre	Dr. Gwamaka Mwambulambu	District Medical Officer (DMO)
		Monica Kapungu	District Reproductive and Child Health Coordinator
	Bupigo dispensary	Josiah Sambo	PHM.B
		Yunes Gambi	Medical attendant
	Isoko Hospital	Dr. A.J Kapungu	Former Director
		Dr. M.A. Shibanda	Present Director
Friday 23.02.07	Departure to DSM		

### 8.9.2 Field visit to Misungwi

Ms. Liss Schanke, Team Leader, Ms. Amina Lwasa, and Ms. Juliana Myeya

Day and date	Institution	Name	Title
Monday 19.02.07	Regional Administrative Secretariat	Mr. Yahaya Mbila	Regional Administrative Secretary RAS
	Courtesy visit	Mr. Steven Kasoga	Assistant Administrative Secretary
		Mr. Athanas T Munda	Ag social service support sector
		Mr. Christopher Luhanyila	Assistant Administrative Secretary – Engineer

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		Mr. Andekile Mwakyusa	PAO
		Ms. Sania Mwangakala	Local Govt officer
		Mr. Kitandu Ugula	Labour Officer
	Misungwi District Council	District Officials, planning the program	Act. DED, DPLO, CDO, DRCHC, DMO
Tuesday 20.02.07	Misungwi District Council	Mr. Francis Mutasigwa	Acting DED
		Mr. J M Kazimili	Acting DPLO
		Ms. Gaudencia Bamugileki	DMO
		Mr. Abdalla Ahamed	Acting CDO
		Ms. Bertha Yohana	District Reproductive and Child Health Coord.
		Ms. Ngolle S Mabeyo	District Nursing Officer
Wednesday 21.02.07	Misungwi District Council	Mr. Bernard Polycarp	Chairman of the council
	Lubuga community, CARE village saving and loan		Community members
	Ms. Christina Jilala		Council member, special seat
Thursday 22.02.07	Visit Igokello dispensary		Community groups
	Isamilo dispensary	Ms. Bertha Yohana	Senior medical Attendant
	Bukumbi hospital	Ms. Sr Felicia Minja	Administrator
Friday 23.02.07	Misungwi District Council	Ms. Rose K Elipenda	DED
		Mr. Dr Bonavebturo Bisuro	DMO
		Ms. Scholastica Masolwa	MCHA
		Mr. Abdalla Ahamed	Acting CDO

### 8.9.3 Field visit to Moshi

#### Team members

Ms. Liss Schanke, Team Leader, Ms. Amina Lwasa, Dr. Siri Lange, Dr. Betty Muze, and Ms. Rehema Mwateba

Day and date	Institution	Name	Title
Monday 12.02.07	RAS	Mr. Elibariki Tondi	Regional Local. Government Officer
Tuesday 13.02.07	RAS	Ms. Ruth Malissa	Act. RAS
	Moshi District Administration	Ms. Sipora Liana, Cortesy visit	Acting DED
	Pomoja Trust (NGO)	Mr. Johnson Mbalwe	CEO
	UMRU (NGO)	Mr. Ezekiel Mbubiri	Executive Secretary
Wednesday 14.02.07	Moshi District Administration	Mr. Saleh Mahiza	Head of Community Dev. Department
		Ms. Jane Kabogo	Community Dev. Officer
		Ms. Sipora Liana	DED
		Mr. Leon Bureta	District Nursing Officer
		Mr. Basel Kowinga	District School Health coordinator
		Mr. Anders V. Komo	District Cold Chain coordinator
		Mr. Vula J. Sam	Act. Dist. Repr. and Child Health Coord.
		Mr. Fausta Shio	Act. Dist. MHC coordinator
		Mr. Joab Mtagwaba	District engineer
		Mr. Elifadhili Mrutu	Ass. Water engineer
		Ms. Esther Mabachiani	Dis. Planning Officer
		Mr. Stewart Lyatuu	Council chairman
Ms. Anna Lyimo	Council committee chairman		
Thursday 15.02.07	Prev. Corruption Bureau	Ms. Mere Kedima	Director
		Ms. Catherine Kilinda	Communication officer
	Uru Government dispensary	Mr. Pascal Mkumbwa	Clinical Officer in charge
		Ms. Akwilina S.Mushi	MCH Aide
		Ms. Hermana Mumbuli	Senior nurse Auxiliary
	Uru mission Dispensary	Sister Restituts Shirima	Staff member
		Sister Leah Masawe	Staff member
	Mbokomu community	Mr. Kimambo	Ward Councillor
		Mr. Emmanuel	Village Executive Officer

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		Kimombo	
		Mr. Ekiniongoze Kimambo	Village Chairperson
Friday 16.02.07	Kyomo Dispensary, Kahe	Mr. Bupina Kasana	Clinic Officer in charge
		Ms. Juseline Mani	Assistant nurse Auxiliary

### 8.9.4 Field visit to Serengeti

Team members: Ms. Christine Warioba, Team Leader, Ms. Bodil Maal, Dr. Betty Muze

Day and Date	Institution	Full Name	Title
Monday 19.02.07	Musoma Regional Secretariat	Mr. Chrisant Rubunga	Regional Administrative Secretariat
		Mr. Edward Mulemwa	Regional Assistant Secretariat
	Musoma Regional Hospital	Dr Valentino Bangi	Regional Medical Officer
		Dr Costa Muniko	Hospital Medical Officer in charge
		Dr Justin Ngenda	Medical Officer
	Serengeti District Council	Nachoa Zacharia	District Executive Director
	Serengeti DDH	Dr. Maungo Kaawa	Ag District Medical Officer
Tuesday 20.02.07	Serengeti DDH	Neema Nyamageni	District Pharmacist
		Mr. Benedicta Mwjarubi	District Nursing Officer
		Mr. Mugendi Maneno	District Laboratory Technician
		Mr. Mahemba Bituro	District STIs Coordinator
		Robert Chipopo	BMF Fellow
		Ms Naleth Kajuna	BMF Fellow
		Ms Neema Mechaba	Hospital Natron
		Ms Winfrida Mwole	DRCHCO
		Dr. Majaliwa Marwa	BMF Fellow
		Dr. Amos Kitto	Hospital MO in charge
	Mr. Joette Masinde	District Cold Chain Coordinator	
	Serengeti District Council	Mr. Philbert M Masaba	District Executive Secretary
		Mr. Edward. Olelenga	District Commissioner
		Ms.Emaculata Muniko	Female Councilors special seat
		Ms. Penina Geka	Female Councilors special seat
		Mr. Manyerer Andrew	District Agriculture and Livestock Officer
	Wednesday	Serengeti	Mr. Elikana Juma

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21.02.07	District Council	Elikana	Program (DDP)
	Kisaka Dispensary	Ms Mkami Makore	Nurse Attendant
		Mr.Musagu Nyaruba	Assistant Clinical Officer
	Iramba Health Centre	Mr. Bets hazari Busima	Clinical Officer In charge
		Mr. Peter R. Ngelema	Councilor for Iramba Ward
		Mr. Basil Mahemba	Village Health Worker
		Ms Suzana Wanyancha	Traditional Birth Attend
		Ms. Filomena Wambura	Traditional Birth Attend
		Ms. Ihumbwe Nchana	Village Health Worker
		Ms Rucia Christopher	Polygamous marriage Wife
Mr. Mahemba Bituro		District STIs Coordinator	
Thursday 22.02.07	RED CROSS	Mr. Emmanuel Funga	NGO Chairperson
		Mr. Dishoni Mugaya	NGO Secretary
	SEDEREC NGO	Mr.Damian Thobias	SEDEREC Program Officer
		Mr.Damian Thobias	SEDEREC Coordinator
	CHBPP NGO	Mr. Mbenga Magomera	CBHPP NGO Dept Coordinator
		Mr. Lotti M. Misinzo	CBHPP NGO Coordinator
Friday 23.02.07	RELIGIOUS NETWORK	Mr.Daniel Mwambella	Coordinator

**Table 26. Health Centre Level Deliveries Serengeti District**

Year	Total Deliveries	H/F Delivery	TBA Delivery	Home Delivery
2002	315	106	55	154
2003	257	120	60	77
2004	348	152	93	103
2005	434	159	138	137
2006	259	118	58	83

**Table 27. Kisaka Dispensary Level deliveries, Serengeti District**

Year	H/Facility Deliveries	Home Deliveries	Referred cases
2006	36	129	3

### 8.10 Selected health indicators for all mainland districts

From Christine M. Warioba's consultancy report (Warioba 2007).

Region	District	MMR *	% People living below poverty line**	% of Score of LGA Performance ***
1. Kagera	Ngara	140/100,000	34	71
	Muleba	132/100,000	27	87
	Biharamulo	105/100,000	48	71
	Bukoba district	62/100,000(2002)	18	79
	Bukoba Urban/Municipal	508/100,000	11	86
	Karagwe District	254/100,000	27	
2. Mbeya	Mbozi		21	83
	Mbeya city	260/100,000	12	82
	Mbeya District	529/100,000	31	79
	Mbarali		13	38
	Rungwe	230/100,000/	32	84
	Kyela	220/100,000	24	80
	Chunya	14/100,000	25	67
	Ileje		31	65
3. Mwanza	Geita	215/100,000	62	76
	Misungwi	116/100,000	40	66
	Sengerema	235/100,000	46	84
	Kwimba	116/100,000	40	81
	Ukerewe	529/100,000	48	47
	Mwanza City	383/100,000	-	66
	Magu		37	95
4. Morogoro	Ulanga	390/100,000	28	94
	Morogoro Mun.	445/100,000	14	78
	Mvomero	730,000,000	26	58
	Kilosa	529,100,000	30	70
	Morogoro Rural	730,100,000	31	79
	Kilombero		29	83

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5. Mtwara	Mtwara District	119/100,000	37	69
	Newala District	121/100,000	43	76
	Tandahimba District	266/100,000	34	69
	Masasi District	189/100,000	37	82
	Mtwara Municipal	-	38	80
6. Dar es - Salaam	Kinondoni	529/100,000	14	86
	Temeke	529/100,000	29	87
	Ilala		16	73
7. Pwani	Bagamoyo	122/100,000	40	86
	Kibaha	3 deaths in 2005	32	69
	Rufiji	186/100,000 (8 deaths out of 5742 live births)	34	81
	Kisarawe	8 deaths out of 2 547 live births	51	69
	Mkuranga	320 / 100,000	40	69
	Mafia	5 deaths out of 866 live births / 253/100,000	43	81
8. Mara Region	Serengeti	115/100,000	61	69
	Bunda	310/ 100,000	68	72
	Tarime	255/100,000	32	51
	Musoma Rural	120,100,000	64	81
	Musoma Urban	257/100,000	38	82
9. Lindi Region	Lindi Rural district	166.3/100,000	51	71
	Nachingwea	186/100,000	41	84
	Liwale	484/100,000	38	82
	Ruangwa	279/100,000	30	73
	Lindi Urban	-	18	69
	Kilwa district	-	35	65

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0. Iringa Region	Iringa Municipal	705/100,000	18	41
	Mufindi	193/100,000	32	72
	Njombe	255/100,000	30	85
	Makete	167/100,000	24	91
	Ludewa district	224/100,000	24	81
	Iringa district	121/100,000	31	65
	Kilolo district	125/100,000	29	0
11. Shinyanga	Meatu	229/100,000/260/100,000	53	69
	Maswa	189/100,000	44	76
	Bariadi	245/100,000	46	61
	Shinyanga Municipal	513/100,000	22	88
	Kishapu	181/100,000	46	9
	Shinyanga Rural district	181/100,000	43	74
	Bukombe	173/100,000	48	89
	Kahama	383/100,000	37	97
12. Tanga Region	Korogwe	530/100,000	31	79
	Handeni	-	38	79
	Lushoto	-	16	78
	Tanga city council	299/100,000	17	79
	Kilindi	-	38	0
	Muheza	-	33	96
	Pangani	523/100,000?	22	55
13. Kigoma	Kibondo	267/100,000	39	79
	Kasulu	-	40	76
	Kigoma / Ujiji Municipal	142/100,000	27	89
	Kigoma District	137/100,000	39	85



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14. Kilimanjaro	Rombo	84/100,000	37	91
	Mwanga District	68/100,000	27	79
	Moshi Municipal	529/100,000	18	89
	Moshi District	39/100,000)	28	85
	Same	-	34	79
	Hai	3 deaths out of 6548	22	84
15. Ruvuma Region	Mbinga	600-1000,000	28	92
	Songea Municipal	313/100,000	32	64
	Songea Rural	-	41	82
	Tunduru District	215/100,000	39	67
	Nantumbo	210/100,000	55	0
16. Arusha	Monduli District	378/100,000	24	70
	Ngorongoro District	557/100,000	24	77
	Arusha Municipal	191/100,000	12	85
	Arumeru District	-	18	86
	Karatu District	247/100,000	39	53
17.Manyara Region	Mbulu	279/100,000	49	58
	Kiteto	645/100,000	28	67
	Babati District	157/100,000	50	74
	Hanang District	-	49	73
	Simanjiro	-	24	40
18. Dodoma	Dodoma Municipal	320/100,000	27	59
	Dodoma Rural	8 maternal death out of 11 997 deliveries at health facilities	43	63
	Mpwapwa	322/100,000	28	61
	Kongwa	-	40	62
	Kondoa	140/100,000	28	50
19. Singida	Manyoni	372/100,000	49	64
	Iramba	126/100,000 ? 166/100,000 ?	43	77
	Singida Municipal	461/100,00 485/100,000	46	83
	Singida District	30/100,000	56	66

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		0.08?		
20. Rukwa	Sumbawanga district	352/100,000	34	88
	Sumbawanga Municipal	-	27	70
	Nkasi	-	38	88
	Mpanda	-	32	67
21. Tabora	Igunga	186/100,000	48	67
	Nzega	189/100,000	35	46
	Urambo	474,100,000	41	93
	Sikonge	212/100,000	43	77
	Tabora district Conc.	156/100,000	27	84
	Tabora Municipal	559/100,000	23	80

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PMO-RALG Website-District Finance Information

### 8.11 Districts with lowest MMR

**Table 28. The five districts with the lowest Maternal Mortality Rates in the country**

District	Region	MMR (per 100,000)	People living under basic poverty line (in percent)	Score on LGA Performance (in percent)
Moshi (R)	Kilimanjaro	39	28	85
Bukoba (R)	Kagera	62	18	79
Mwanga	Kilimanjaro	68	27	79
Rombo	Kilimanjaro	84	37	91
Ileje	Mbeya	97	31	65

### 8.12 The DAC interactive poverty model

The study shows that maternal mortality can be used an example of the interactive poverty model developed by DAC, the Development Assistance Committee of the OECD countries. The model shows how 5 different described in 7.1., all the 5 DAC aspects are linked to maternal health and the prevention of Maternal Mortality:

#### 1. Protective (Security and vulnerability)

- Attitudes and behaviour towards women
- Vulnerability and prevention of violence against women

2. Economic (Consumption, income and assets)

- Payment for health services
- Alternative income for women doing FGM
- Corruption and misuse of funds in the health sector
- Tracking of expenses in the health sector
- Saving clubs for women
- Government vouchers
- Availability of telephones or radio

3. Political (Rights, influence and freedom)

- Legislation, re. the age of women for marriage and inheritance
- Political participation and mobilization of women
- Local Government Authority By Laws, e.g. re. violence against women, delivery in health clinics
- Mechanisms for grievances and appeals
- Community participation in planning and management
- The functioning of Community Health Service Boards and Health Facility Committees
- Top down and authoritarian health workers
- Access to information

4. Human (Health, education and nutrition)

- Access and transport to health institutions
- Establishment, equipment and staffing of health clinics and hospitals
- Life skills school education for young girls
- Access to education, in general, as well as re. pregnancy, delivery family planning
- Nutritional status of the mother during pregnancy
- Well-being/morbidity during pregnancy and childbirth; HIV/AIDs and malaria are risk factors
- Distances to health facilities and transport possibilities

5. Socio Economic (Status and dignity)

- Cultural and traditional practices, attitudes and beliefs around pregnancy and child birth.
- Age of the mother; both very young and older mothers are at risk
- Female Genital Mutilation, which may lead to complications during child birth
- Assistance re. medical complications, e.g. Fistula

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