



A good news case study: Tanzania Essential Health Interventions Project

Introduction to the case

This case study considers the process that led to the implementation of a series of essential interventions on the Tanzanian Health System that brought about evidence based health planning and practice in two districts, Rufiji and Morogoro. Through TEHIP these interventions have provided a series of management tools that have allowed district health teams to vastly improve their health systems and bring about startling health improvements. In a nutshell, these tools are designed to allow health planners to do more with less (or what they already have).

The idea is directly related to the World Bank's World Development Report 1993: Investing in Health, which focused on health systems, suggested that health could be significantly improved by adopting a minimum package of health interventions to respond directly and cost-effectively to evidence about the burden of disease. In 1993, at a conference hosted by IDRC, representatives from the World Bank, WHO, UNICEF and others agreed to test the WDR hypothesis. IDRC and CIDA provided the funding for what became known as the Essential Health Interventions Project (EHIP). In 1996, Tanzania, that had initiated its own health reform around the same time as the WDR 1993 was launched, was chosen to test the assumptions made by the WDR.

The type and extent of policy change

TEHIP has brought about a change in the way that local health policy and practice is planned and resources are allocated across geographical and technical areas. At the district level health care workers and managers are more in control of resources and processes. This has also contributed towards a more robust decentralisation of the health care provision.

In both districts, the introduction of TEHIP tools significantly improved budget allocation. Before TEHIP, STDs received a negligible share of total health spending (about 3%). However, evidence about the burden of STDs provided by the Demographic surveillance system (DSS) to health planners resulted in the increase of the share to about 9.5%. Large proportional increases were also seen for malaria interventions and Integrated Management of Childhood Illnesses. These changes were made possible by new tools and a judicious use of new incremental funding from a Sector Wide decentralized basket fund (on average less than US\$1per capita extra funding). Absolute per capita funds for other essential health interventions which were previously adequately funded such as immunization, remained at their previous level.

Some thoughts on the explanation of the policy change

Political leadership

The country's health reform was receptive to decentralised, evidence-based planning and needed to find ways in which it could be implemented. Hence the opportunity to join TEHIP was welcomed at the policy level. The Tanzanian health situation and health system structure also provided an attractive context for the work of TEHIP. Tanzania's unique background, however, provided an excellent window of opportunity.

After independence, political commitment developed a dynamic and strong health infrastructure and system throughout the country. However, resource limitations (mostly as a consequence of debt burden and the fall of international commodity prices) as well as fatigue of the central planning structure, added to the appearance and spread of HIV/AIDS in the mid-80s, brought about an unfortunate reversal of the health gains made during the 70s and 80s. The initial solution promoted by the World Bank, to inject funds into the system by introducing user fees and other cost-recovery mechanisms, further drove Tanzanians away from the health system.

Evidence and policy-relevant research

In 1996, sentinel Demographic Surveillance Systems were used to provide data for the districts on the burden of disease presented in terms of a health services profile. This then became part of the routine information used by TEHIP to feed into a tool kit for health managers. These tools were then put in the hands of the Tanzanian District Health Management Teams (DHMTs) in the two districts who were then given a free hand in the use of the tools and resources. Additional funding to the DHMTs was marginal, amounting to about US\$1 per capita annually. Such funds were used by the district for support to both health services and for capacity building of the health system. The information on the intervention addressable burden of disease, together with a budget mapping tool, allowed the health managers to allocate funds with better alignment with health needs. The management tools provided by TEHIP facilitated their work and processes thus reducing costs of production and delivery of services. The tools used to plan health evidence based interventions included:

- District burden of disease profile tool to repackage population health information from the DSS in a way that the district officials can easily understand;
- District health accounts tool to analyse budgets in a standard way to generate easy-to-use graphics that show how plans for spending coalesce as a complete plan;
- District health service mapping tool to allow health administrators to access a quick visual representation of the availability of specific health services or the attendance at health facilities for various interventions across the district;
- Community voice tools to promote community participation and inform health planning, and to promote ownership.

An underlying principle and result of these health system interventions was that there was a need for integrated solutions to the problem focusing on the needs and guidance of community-level health workers and managers. TEHIP, therefore, had to develop a structure that provided a fertile ground for innovations that could be integrated into the routine of the community health case workers and managers; thus making research an intrinsic part of its work.

External influences

Internationally as well as locally, there was a recognition that sudden increases in funding, although necessary, would not bring about significant improvements if not accompanied by reforms in the systems that managed them. Unfortunately, these improvements involved a reform that not many governments were ready or prepared to undertake.

Fortunately, external influences turned in favour of Africa, and Tanzania, in the late 1990's. A renewed focus on Africa has translated into specific initiatives such as the GFATM, and the appearance of other private and multilateral initiatives such as the Roll Back Malaria Partnership which have contributed to make health care a priority in Africa (killer diseases are at the top of the DFID research agenda). These global health initiatives significantly increase available resources for selected interventions. However it remains to be seen whether such increases in funding will be used, in part at least, to effect the necessary strengthening of health systems to deliver these interventions - a key lesson of TEHIP.

The impact and lessons learned

The impact of these interventions can now be observed. Child mortality in the two districts fell by over 40% in the 5 years following the introduction of evidence-based planning; and death rates for men and women between 15 and 60 years old declined by 18%. During the same period, the health indicators for other districts in Tanzania, and in fact across Africa, have become stagnant. This suggests that the project provided the Tanzanian health reform with the appropriate tools needed for development of an evidence-based health system and policies.

The key lesson from this experience is that the burden of disease can be significantly lowered through relatively low-cost investments in strengthening health systems by providing incremental, decentralised, sector-wide health basket funding and a tool kit of practical management, planning and priority-setting tools that assist an evidence-based approach. Other lessons regarding research-policy issues are:

- Funding research and development simultaneously, and encouraging researchers and development specialists to be aware of and involved in each other's specific areas of concern, produces multiple benefits.
- Development plans can benefit from the continuous input from researchers.
- Links to concrete development agendas afford researchers greater credibility.
- Funding and implementation priorities must be increasingly based upon locally owned, evidence-based plans that aim to develop the health system, maximise health, and reduce inequities: this involves having exit strategies in place and health observatories to facilitate the involvement of local actors.
- Demographic surveillance can inform policy and planning, monitor progress, and also provide accountability for government and donor spending priorities and patterns.

Sources of Information

This case study is based on the Description of the TEHIP project on the [IDRC website: www.idrc.ca/tehip](http://www.idrc.ca/tehip).

See also:

- Don de Savigny, Harun Kasale, Conrad Mbuya, and Graham Reid (2004) *Fixing Health Systems*, Ottawa: IDRC.
- Stephanie Neilson and Terry Smutylo (2004) *The TEHIP Spark: Planning and Managing Health Resources At the District Level, A Report on TEHIP and its Influence on Public Policy*, Evaluation Unit, IDRC. http://web.idrc.ca/uploads/user-S/10826578841TEHIP_FINAL_April_20041.doc
- Images courtesy of TEHIP project. If you would like to view the images with captions, see the slides shows on: www.idrc.ca/tehip