

CMIREPORT



Decentralisation and Gender Coordination and Cooperation on Maternal Health Issues in Selected District Councils in Tanzania

Liss Schanke and Siri Lange (editors)

In cooperation with PMO-RALG and the Royal Norwegian Embassy, Dar es Salaam

R 2008: 9

Decentralisation and Gender

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Contents

Foreword	iv
List of acronyms and abbreviations	v
Executive summary	vi
1. Introduction	1
1.1 <i>Project description</i>	1
1.2 <i>Project objectives</i>	2
1.3 <i>Project background</i>	2
1.4 <i>The Local Government Reform and gender</i>	3
1.5 <i>Limitations of the project</i>	5
1.6 <i>Project activities</i>	5
2. Case one: Ileje District Council	9
2.1 <i>Socio-economic situation</i>	9
2.2 <i>Gender relations</i>	9
2.3 <i>Cooperation within the district council</i>	9
2.4 <i>Cooperation between the district council and other actors</i>	14
2.5 <i>Final remarks</i>	15
3. Case two: Misungwi District Council	17
3.1 <i>Socio-economic situation</i>	17
3.2 <i>Cooperation within the district council</i>	17
3.3 <i>Cooperation between the district council and other actors</i>	19
3.4 <i>Final remarks</i>	20
4. Case three: Moshi District Council	21
4.1 <i>Socio economic situation</i>	21
4.2 <i>Cooperation within the district council</i>	21
4.3 <i>Cooperation with other actors</i>	26
4.4 <i>Final remarks</i>	28
5. Case four: Serengeti District Council	29
5.1 <i>Socio-economic situation</i>	29
5.2 <i>Cooperation within the district council</i>	30
5.3 <i>Cooperation with other actors</i>	31
5.4 <i>Final remarks</i>	33
6. Case five: Pangani District Council	34
6.1 <i>Socio-economic situation</i>	34
6.2 <i>Cooperation within the district council</i>	35
6.3 <i>Cooperation between the district council and other actors</i>	36
7. Observations and challenges	38
7.1 <i>Maternal health – entry point to governance issues</i>	38
7.2 <i>Maternal health – entry point to gender issues</i>	38
7.3 <i>Cooperation between government structures</i>	39
7.4 <i>Coordination between government and civil society</i>	39
7.5 <i>Best practice method – exchange of experience</i>	40
7.6 <i>PMO-RALG ownership - a key to sustainability</i>	41
7.7 <i>Project working methods and concerns</i>	41
7.8 <i>Follow-up</i>	42
8. Appendices	43
8.1 <i>Maternal health challenges and solutions</i>	43
8.2 <i>Team members</i>	44
8.3 <i>Field visit programs and persons met</i>	45
8.4 <i>Districts with lowest MMR</i>	52
Consulted literature	53

Foreword

In contrast to the majority of CMI reports, this report is not the result of a research project or an evaluation. The report is the end product of a project aimed at improving coordination and cooperation within local authorities in Tanzania as part of the ongoing decentralisation by devolution. Maternal health was used as an example and entry point. The methodology used was to first map good practices in four district councils with a relatively low maternal mortality rate (MMR), and then to facilitate learning between different local authorities within the country.

The team is grateful for the outstanding support that was granted from regional and district authorities during the five field visits for this study. We wish to thank all the people who shared their time and view points with us both during the field visits and during the workshops that have been conducted as part of the project.

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

Bergen, 24.09.08

Liss Schanke
Siri Lange

List of acronyms and abbreviations

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 (UNICEF programme)
D by D	Decentralisation by Devolution
DC	District Council
DED	District Executive Director
DMO	District Medical Officer
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
NORAD	Norwegian Agency for Development Cooperation
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
SIDA	Swedish International Development Agency
TASAF	Tanzania Social Action Fund
TBA	Traditional Birth Attendant

Executive summary

By Liss Schanke and Siri Lange

This report is a presentation of the PMO-RALG initiative on “Gender and Decentralisation. Looking at Coordination and Cooperation in LGAs on maternal health”, which the Norwegian Embassy in Dar es Salaam supported in the period January 2007 to June 2008. The project’s ending coincided with the close of Local Government Reform Programme (LGRP). By then twelve districts had been involved in the project.

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.

Decentralisation and gender

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 as decision making are key gender issues.

Gender has consistently been a weak performance area of LGAs. The project has used maternal health as an example and entry point to look at the ways in which LGA coordinate and cooperate to reach goals that are gender related. Using maternal health as an entry-point was a method to make the discussion more concrete and practical compared to the classical focus on gender mainstreaming in general.

The objective of the project has been to:

- contribute to the strengthening of D-by-D and 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

In the process to reach these goals, the project has sought 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

The main activities of the project have been:

- Mapping of MMR statistics of all districts
- Selection of four districts with relatively low MMR
- Visits to these four districts (Ileje DC, MisungwiDC, Moshi DC and Serengeti DC) – interviewing stake holders on coordination and cooperation, using maternal health as an example
- Workshop to share the findings and chart out a way forward (Dar es Salaam)
- Visit to a district with high MMR (Pangani DC)

- Zonal workshops to share experiences between districts and make plans for addressing maternal health using district's own resources (taking place in Chunya and Mwanza)
- A final workshop where the involved district councils presented their new plans, and the project rationale and achievements were summed up (Mbeya)

Since PMO-RALG funds were more limited than envisaged when the project was planned, it was decided to concentrate the learning experiences between districts within the same zone. This means that some of the poorest areas of the country were not reached – since the study started out with the good practice districts (districts that scored well on MMR statistics). Nevertheless, even within the zones, there were quite large differences in terms of MMR statistics and ways of working in the district councils.

Good practices in terms of coordination and cooperation to enhance maternal health that were found in one or more of the case study councils with low MMR:

Council level

- Council Management Team has a daily meeting (should be reduced to once a week if replicated to save time)
- Basket funds have been used on widespread sensitisation, among other things on “birth preparedness” (i.e encourage families to set aside money for transport etc)
- District health extension workers have separate meetings with TBAs
- District Council has prioritized to use its own resources to buy ambulances
- District Council staff is willing to meet citizens without cumbersome bureaucratic procedures

Village level

- Village level institutions, like Village Health Committees and voluntary Village Health Workers (VHW), are active and have been strengthened through health basket funds, and/or donor initiatives like the UNICEF CSPD project and CARE programmes
- Village health workers have created a network where they can meet to discuss and learn from each other
- Village health workers monitor and register pregnant women, deliveries, children under 5 and maternal deaths, by recording data and submitting reports on a quarterly basis
- Village health workers are exempted from voluntary/self-help activities and monetary contributions (since they are not paid a salary, this may function as a motivation)
- Pregnant women are exempted from voluntary/self-help activities (this is an incentive to register their pregnancy with Village Health Workers)
- Regular village Health Days where health experts in the village interacts with the community members and vaccination etc takes place (initiated by UNICEF project)

Health facilities

- 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.
- Maternity waiting home at the hospital to serve people from remote areas
- 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.
- TBAs and community health workers have been trained on detecting signs of pre-mature delivery – number of BBA (Birth before Arrival) has gone down
- 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.

- In areas with limited cell phone coverage, dispensaries have been provided with radio calls and hand sets.
- High level of commitment among health personnel
- Campaigns on maternal health appear to have resulted in a higher percentage of women giving birth at health facilities.
- Training of health personnel and TBAs. TBAs escort pregnant women to the health facilities where they collaborate in the delivery.
- Referral to the next level of health facility as soon as they detect or foresee maternal complications
- 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.

Relationship between councils and civil society

- Activities of NGOs are included in the comprehensive District Development Plan.
- Yearly meetings between councillors and NGOs

Several of the participating councils were inspired by the good practices from other districts, and included them in their own plans.

Identified problems in terms of coordination and cooperation to enhance maternal health that were found in the case study council with high MMR:

- Weak systems for information sharing among staff – and for ensuring that knowledge is institutionalised, not individual.
- Some of the council staff had negative attitudes towards local communities
- Hard to get qualified staff to stay in the district council
- Some informants said that the relationship between councillors and council staff was difficult

In addition, there was a large amount of obstacles in terms of infrastructure and the general economic situation of the districts, but this is not the focus of the present report.

1. Introduction

By Liss Schanke, Siri Lange, and Lesley Saunderson

This report is a presentation of the PMO-RALG initiative “Gender and Decentralisation. Looking at Coordination and Cooperation in LGAs on maternal health”, which the Norwegian Embassy has supported since May 2006. The project ended mid-2008, coinciding with the close of LGRP. By then twelve districts had been involved in the project.

Chapter two of the report describes the background for the project, former Norwegian-Tanzanian initiatives in the field, project approach, objectives, and limitations. The section also gives some general background to decentralisation by devolution in Tanzania and briefly describes the various project activities. Chapter four presents the findings from visits to the five case study councils: Ileje DC, Misungwi DC, Moshi DC, Serengeti DC, and Pangani DC. The chapter draws on a report that was circulated among stakeholders in Tanzania in 2007 (unpublished). Finally, chapter five summarises the observations and challenges for coordination and cooperation on gender issues in district councils.

1.1 Project description

Project approach

The project has used maternal health as an example and entry point to look at coordination and cooperation within LGA. Using maternal health as an entry-point was a method to make the discussion concrete and practical - in order to avoid a general discussion on gender mainstreaming, cooperation and coordination. The strategic issues were to be in focus rather than health-issues per sé. The assumption has been that more cooperation and coordination in the field of maternal health will motivate different actors to work together and create an environment for organising around other women’s issues as well.

Maternal health is an important issue for all women, families, and employers. Like many other African countries, Tanzania has great challenges in this regard:

- Every hour of a day, one woman dies of pregnancy related complications.
- The maternal mortality rate (MMR) of Tanzania has not gone down over the last decade. It was estimated at 578/100 000 in 2005, up from 529/100 000 in 1996.
- Less than half of all Tanzanian women receive skilled attendance during childbirth.
- 10 000 qualified health staff is required to fill current gaps.

(NBS, 2005)

Measuring the MMR in Tanzania is very complicated, since around half of all births take place outside of health facilities, and the women who *do* give birth at health facilities tend to leave shortly after the delivery – when the risk for complications is still there. The district level MMR figures used in this report were provided by district authorities, and are in the majority of cases based on registered deaths at health facilities. Some districts have a system for registering deaths outside of health facilities at village level (through village health workers), and this gives more reliable data. In most cases, the MMR statistics are based on recorded data, and not on surveys. The latter result in far more accurate information.

The official MMR figures vary enormously between the different districts of the country. In some districts the recorded MMR is almost twenty times as high as in the district with the lowest rate (730/100 000 against 39/100 000). The method of work used in this project has been to let LGAs with a high MMR learn good practices from LGAs with a low MMR.

1.2 Project objectives

The objective of the project has been to:

- contribute to the strengthening of D-by-D and 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

In the process to reach these goals, the project has sought 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

1.3 Project background

One of the planned outcomes of the Local Government Reform Programme’s Medium Term Plan (MTP) (2005-2008) is “Gender issues mainstreamed in local government”. The activities under this outcome have been to draw lessons from area based programmes on gender mainstreaming and thereafter, based on these lessons, develop and operationalise a framework for mainstreaming gender. The Norwegian Embassy, as a member of the CBF and the Governance Task Force¹ has assisted PMO-RALG in this work since 2006. Tanzanian women’s organisations, The Norwegian Association of Local and Regional Authorities and the Chr. Michelsen’s Institute have provided technical assistance to this work.

The work started in May 2006 with a study on Gender Mainstreaming in LGRP and Local Government that took place in Dodoma, Kondoia and Manyara. Findings from this study showed that there is a gap/missing link between the planning and budgeting process. Whereas the planning provides for the opportunities to identify the key issues, the budget guidelines do not prioritise gender to be a central element in resource accountability. As a result gender and women issues do not get adequate resources.

The study was followed up in December 2006 recommending the start-up of an initiative on Coordination and Cooperation for Gender Mainstreaming in LGAs using maternal health as an entry-point. The aim was that this initiative be relevant for the work on gender-issues, but also support the MTP outcome on accountability of politicians and public servants towards service users and stimulate horizontal cooperation and coordination in LGAs between politicians, public servants and NGOs and in this way support the decentralisation by devolution policy of GoT.

¹ The Task Force identified three initial priorities: Downward Accountability and Public Expenditure Tracking, Gender Mainstreaming and LLG.

Project on cooperation between local government and civil society on service delivery

The Norwegian Association of Local and Regional Authorities, KS, and the Norwegian research institution, Agder Research, AF, conducted a project on cooperation between local government and civil society on service delivery in Tanzania in the period 2003-2005. The aim of the project was to develop methods for cooperation on service delivery.

The project focused on the following questions:

Why should co-operation take place, what would be the added value?

Which sectors are relevant: technical infrastructure, social welfare, and private trade?

How and when should cooperation take place?

Who would be responsible for the initial steps?

What would be the specific challenges?

Which factors encourage and discourage co-operation?

What would be the optimal level of co-operation in each case?

In the project, the concept cooperation is understood as a continuum of five different elements: Contact, Exchange of Information, Division of Services, Collaboration on Service Delivery, and Coordination of Services.

The project also distinguishes between horizontal and vertical cooperation, where, on the one hand, *horizontal co-operation* describes the link between local government and NGOs, and *vertical co-operation* on the other hand, describes the link between local government and NGOs and local communities.

The project identifies the following main challenges:

Challenges to vertical cooperation

- Responding to needs
- Ensuring bottom up approaches
- Achieving knowledge – through the grass roots
- Reaching common understandings
- Mobilising the grassroots for development
- Cooperating with and exploiting informal networks

Challenges to horizontal cooperation

- Ensuring information and coordination
- Creating openness and communication
- Clarifying of roles between NGOs, private sector and local government actors
- Preventing overlap between NGOs and the private sector
- Preventing overlap between NGOs and local government
- Balancing urban, peri-urban and rural areas
- Ensuring services to the poor

1.4 The Local Government Reform and gender

The Local Government Reform Agenda (1996) set out the Government of Tanzania's vision, objectives, strategies and key activities for the reform of local authorities.² The governance problems (page 6 of the Agenda) identified at that time were:

² This sub chapter is written by Lesley Saunderson, PMO-RALG.

- relations between political leaders at national and local level, civil society organisations and the councils;
- weak representation at central government level of the views from the councils, through associations such as ALAT, in matters of vital interest for the local authorities and especially with regard to their ability to provide services;
- local government financial and personnel management, i.e underfunding and weak capacity and management.

The Government went on to publish its Policy Paper on Local Government Reform (1998), and developed the Local Government Reform Programme (LGRP) as the vehicle to implement the policy of decentralisation by devolution. The LGRP was designed to address political, fiscal and administrative decentralisation and changed central-local relations. The policy paper and the LGRP illustrate how devolution is a governance reform in itself.

A Framework Paper on Governance was produced in 1998 which informed the design of the governance component of the Local Government Reform Programme (LGRP), i.e. the activities that were articulated as specific inputs to improve governance. In order to distinguish these from the overall programme and other components, the governance component of LGRP was defined as:

- political decentralisation/democratically elected leaders
- rule of law
- equity
- public participation
- accountability
- integrity
- transparency
- civic education

The LGRP has been one of the main features of the National Framework on Good Governance. The LGRP governance work was focussed at local authority level. Overall the *objective* of the Governance part of the LGRP has always been: *To establish broad based community awareness of, and participation in the reform process and promote principles of democracy, transparency and accountability.*

The *purpose* of the Governance element in the LGRP Logical Framework is *principles of good governance adhered to at all levels of local government.* This is also in line with the PMO-RALG Strategic Plan; objective K is *good governance enhanced and internalised at all levels of PMO-RALG.* The good governance principles above are also a core value of PMO-RALG. The Governance elements of LGRP and the Strategic Plan of PMO-RALG are consistent in their scope and objectives.

Implementation of the governance element of LGRP at LGA level has been spearheaded by the Local Government Specialists of (six) Zonal Reform Teams (ZRTs). They have routinely visited the LGAs within their zones, giving advice and support. They have also 'benchmarked' LGAs to monitor performance in accordance with good governance and good practice. LGAs have action plans to address weaknesses identified between benchmarking exercises.³ The benchmarking system is constructed around ten areas:

- Democracy
- Community Participation

³ More information and LGAs scores are available at www.pmoralg.go.tz.

- Rule of Law
- Integrity of Leaders and Workers of LGAs
- Transparency and Accountability
- Executive/Administrative Efficiency
- Gender Mainstreaming
- Planning Procedures
- Planning Skills/Resources Available
- Planning Interventions

Gender has consistently been a weak performance area of LGAs.

In line with devolution, and promoting diversity, the Government has also been making space for the private sector and civil society to participate in decision making, service delivery and monitoring. Council Reform Teams and reform processes related to devolution have invited these stakeholders to participate routinely in setting priorities for LGAs. LGAs are also collaborating for synergy and value for money in service delivery locally, e.g. contracting out. Collaboration with CSOs is promoted through the governance benchmarking system as well.

Collaboration and coordination with civil society is also happening at national level. Since early 2006 PMO-RALG has been working with civil society organisations through the Governance Task Force. There are three civil society representatives on this Task Force, including one gender and advocacy specialist (Tanzania Gender Network Programme). Other members are from LGAs, development partners and PMO-RALG. PMO-RALG also has a core group of CSO representatives it meets with regularly to identify areas of cooperation. This group is looking at Public Expenditure Tracking Systems, Participatory Service Delivery Assessments and Access to Information. Gender features in all these topics.

1.5 Limitations of the project

The project's goal has been to facilitate learning between districts with high MMR and districts with low MMR. Initially, twinning was envisaged. Unfortunately, PMO-RALG funds were too limited to allow for such twinning, particularly because the districts with low MMR in most cases were located far from districts with high MMR. It was also questioned whether it was feasible to twin districts in different regions with very different socio-economic realities. It was therefore decided to concentrate the learning experiences between districts within the same zone. This means that some of the poorest areas of the country were not reached – since the study started out with the good practice districts (districts that scored well on MMR statistics). Nevertheless, even within the zones, there were quite large differences in terms of MMR statistics and ways of working in the district councils.

1.6 Project activities

Collecting statistics

The first step of the project was to collect and analyse information on MMR from all districts of Tanzania Mainland in order to make a selection of the five best performing districts in the country and the ten districts with the highest maternal mortality. This work was done by a Tanzanian consultant hired by the Norwegian embassy. The report included a profile of each of the selected districts, and proposed a methodology for how best practices should be studied; which actors, institutions that are/or should have been involved in the work around maternal mortality, and who should be interviewed at district level (Warioba, 2007).

Mapping and collecting good practices

Based on the consultant's report, four LGAs with relatively *low* MMR were picked for closer reviews:

- Moshi rural 39/100 000
- Ileje 97/100 000
- Serengeti 115/100 000
- Misungwi 116/100 000

Four study teams visited these districts and conducted interviews with public servants, politicians, villagers, and representatives of NGOs (February 2007). A pilot study was later conducted in Pangani, which has a relatively high MMR of 523/100 000 (May 2007).

Planning and sharing workshop

PMO-RALG arranged a workshop in Dar es Salaam to share the findings and chart out a way forward (May 2007). The participants came from PMO-RALG, Regional Secretariats, Ministry of Finance, Ministry of Community Development, Gender and Children,⁴ other public servants, development partners, Governance Task Force, as well as NGOs and politicians from Moshi, Ileje, Misungwi and Pangani. At the workshop the "good practises" from the districts were presented and discussed. The "good practises LGAs" were invited to participate in the project and share their experiences with districts with high MMR.

Workshops to share good practises

The Chunya workshop

The sharing of "good practises between LGAs on cooperation and coordination on maternal health" started in Chunya district in Mbeya Region during a workshop in September 2007. Staff from PMO-RALG's Governance section and Service Delivery section (of the Division of Local Government) organised and facilitated the Workshop, with support from the Zonal Reform Team. The workshop was conducted in Swahili. Three district councils were present: Ileje DC, Chunya DC and Sumbawanga DC, represented by District Health staff, Councillors, Village Health Workers and SCOs. Both Chunya DC and Sumbawanga DC have relative high MMR. After the workshop the LGAs made action plans on how to reduce the MMR in their districts. PMO-RALG has received copies of these action plans and will follow-up on them.

The Mwanza-workshop

The sharing of "good practices" was then organised at a workshop in January 2008 to cover districts in the North West. The Mwanza workshop⁵ included four districts: Mwanza City Council, Bunda DC, Kahama DC. Misungwi DC participated as a "good practise" district. PMO-RALG/ The Norwegian Embassy had invited three national NGOs; Care International, Women's Dignity Project and White Ribbon Alliance - and their local partners from Mwanza region for this workshop (see Appendix 3).

According to the conclusions from the workshops in Chunya and Mwanza, PMO-RALG was supposed to follow up the action plans elaborated by the LGAs. This was not done as planned, due to financial reasons.

⁴ The Ministry of Health was involved in the design of the initiative but did not participate in the workshop.

⁵ Report given to the Governance Task Force.

The Mbeya workshop

A final workshop was conducted in Mbeya in April 2008. It brought together participants from the districts six months after they had had an opportunity to apply their learning, and gone through their annual planning and budgeting⁶. This workshop was prepared and facilitated by PMO-RALG. The participants were PMO-RALG, LGAs NGOs/ CBOs that work in the field of gender, maternal health or advocacy, key MDAs and development partners' representatives.

Dissemination of results

Project reports

After the first phase, a 63 page long report (excluding annexes) was distributed to all stake holders, including participating districts.⁷ This final report will be disseminated by PMO-RALG, the Royal Norwegian Embassy, CMI and KS.

PMO-RALG Leaflet

PMO-RALG has designed a series of public information leaflets on rights and responsibilities of LGAs and service users. A leaflet on gender has been added, using the knowledge from this study.

Film

Lars Johansson from Maweni Farm Film Company is producing a film shedding light on the challenges of cooperation and coordination within LGA in relation to maternal health. The film will also be produced as a power point presentation. In addition, there will be a publication to be used with the film, containing photos and stories from the film as well as comments. A draft version was presented at the Mbeya workshop in May 2008 for general discussion and comments.

Councillor Training

The next Councillor capacity building initiative (HR&OD Outcome of LGRP) will have an improved element on gender and gender mainstreaming. The knowledge and findings from this study will be used as examples.

Gender mainstreaming guidelines

PMO-RALG is elaborating gender mainstreaming guidelines.

⁶ Governance Section submitted notes to the DLG as inputs to the annual Planning and Budgetting Guidelines on improving gender mainstreaming, with lessons from this MMR study.

⁷ PMO-RALG, RNE, KS and CMI. Decentralisation and gender. A study on coordination and cooperation in LGA for maternal health. May 2007.



Photo 1. Poor infrastructure is one of the greatest challenges for reducing maternal deaths. In what ways do district councils cooperate with local communities to ensure that the road is passable? The picture is from Ileje DC where rain has washed away parts of a bridge (by Siri Lange)

2. Case one: Ileje District Council

By Siri Lange and Rehema L. Mwateba

2.1 Socio-economic situation

Ileje district is situated in the Southern Highlands, in the South East of Mbeya region.⁸ The district borders to both Malawi and Zambia, and there are frequent interactions across the borders. The district covers almost 2000 sq.km. of which half is arable land. 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. The majority of the population are subsistence farmers. The level of income generating activities is low, but there is some cash crop cultivating, particularly of coffee, cardamom, bananas, and sun flowers.

The population of Ileje is estimated to have been around 113 thousand in 2004. 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.

2.2 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”.⁹ Traditionally, women are not allowed to keep their own income, but the practice varies, and the workload for women is said to be lower than in many other districts. 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.¹⁰ Most women in Ileje do not have a say regarding how many children she should have. Only 21% of adults made use of family planning techniques in 2005.¹¹

2.3 Cooperation within the district council

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,

⁸ 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).

⁹ UNICEF/Ileje District Council 2004.

¹⁰ 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.

¹¹ CSPD Annual Plan 2004 and 2005. Ileje District Council 2004). Tanzania Government and UNICEF new country programme.

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.

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.

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".¹² 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. The district has 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 District Executive Director (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.

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 an obstructed labour to the nearest health centre.

The District Reproductive and Child Health Coordinator (DRCHC) 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 six days. The focus was on HIV/AIDS and pregnancy and how to give ARVs to babies born to 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

¹² 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.

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 result in 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 what is locally described as “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 prioritised. 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.

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. One of the interviewed councillors had been a councillor since 1988. With the exception of the first years, when they had removed a staff member who misused alcohol, there have never been any conflicts with the staff, but the councillor confirms that the LGR has brought changes:

“They (the staff) used to hide the financial records (Ukaguzi wa vitabu). They didn’t explain to 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’ counsellors 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).¹³

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, 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 of the citizens 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.¹⁴ 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’.

¹³ 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.

¹⁴ 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.



Photo 2. Women in Ileje doing ‘voluntary’ work for the construction of a secondary school. The male hamlet leader to the left is organising the women’s work. Pregnant women who have registered their pregnancy are exempted from this kind of work (by Siri Lange).

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 Ward Executive Officers, 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.¹⁵ Some VEOs ask to be transferred to another place, where they can fulfil their role more easily.

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:

¹⁵ VEO’s have Form Four or Form Six education. The VEO’s salary is Tshs 76,000 per month (used to be Tshs 55,000). VEOs salary scale ranges between Tshs 114,000 to Tshs 166,000. They must have completed form 6 or have a two years course (Agriculture or Community Development).

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.

2.4 Cooperation between the district council and other actors

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*).

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.

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.

Major donor projects: UNICEF's Child Survival and Protection Development

UNICEF's CSPD program appears to be the intervention that has had the greatest positive impact on maternal health in the district. 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 Decentralisation 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 offered to 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 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. Reports now go through the WEO, and that the registration system is reported to function 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 planning 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.¹⁶ 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 to the village by the WEO when he/she visits the village. The District Community Development officers can therefore easily detect if there are problems in any specific ward. Ideally, men who do not support their wives during pregnancy are reprimanded.

2.5 Final remarks

The maternal mortality rates in Ileje were close 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
- Relatively good food stability and workload of women is low compared to other districts
- 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

¹⁶ Village Health Workers fill in forms to register births and deaths in the village.

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
- District health extension workers have separate meetings with TBAs
- Out-reach is conducted following a set time table.
- Maternity waiting home at the hospital to serve people from remote areas

3. Case two: Misungwi District Council

By Liss Schanke, Amina Lwasa, and Juliana Myeya

3.1 Socio-economic situation

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. 74 percent of the Misungwi labour force are engaged in agriculture. 26 percent are employed in other areas, e.g. fishing. The district is also relatively rich in natural resources (sand, stones, mineral deposits etc.). Misungwi is one of the most populated areas in the region with a population of almost 260,000. The main ethnic group is the Sukuma who accounts for almost 95 percent, while other ethnic groups include Kerewe, Jita and Ha. The water situation is critical – only one third of the district population has access to safe water.

40 percent of the population of Misungwi lived below the poverty line at the turn of the millennium. There is high illiteracy rate in the communities, and little understanding about the danger of harmful traditional practises.

3.2 Cooperation within the district council

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 Misungwi District Council Strategic plan of 2006 states that the decentralisation 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 only. 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 staff 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.

Misuse of funds in the district has been documented for the following departments/staff:

- 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 met in Misungwi, particularly the staff in the health sector.

Cooperation among district staff

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.

According to several informants the cooperation between district departments could be improved:

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

The Department for Community Development is 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.

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. 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 due to 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.

3.3 Cooperation between the district council and other actors

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”. One reason for this may be the unclean audits which have entailed that the district is not eligible for the Local Government Capital Development Grant. In addition, unclean audits may generally 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 attend joint planning meetings with the district council, while others seem to be less willing to share information. 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”.

Major donor projects: CARE

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 delivery at facilities and planning in case of emergencies

Community mobilisation

- Establishment of savings clubs –saving of money for delivery transport and other issues
- Involvement of men (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

Each case of maternal death at village and district level is discussed and analysed.

3.4 Final remarks

Issues that are specific for Misungwi, not easily transferred

- CARE project which has 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) - these involve men
- Pregnant women are exempted from voluntary/self-help activities

4. Case three: Moshi District Council

By Siri Lange and Betty Muze

4.1 Socio economic situation

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. 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.

Moshi rural has a total population of around 403,000. The majority ethnic groups are the Chagga. 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, and the district has one of the highest per capita coverage of secondary schools in the country. Income from coffee has been drastically reduced in recent years due to falling prices, and around 28% of the population presently lives below the poverty line. This is, however, considerably lower than in the poorest districts, where the percentage is around 50 percent.

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:

"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".

4.2 Cooperation within the district council

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 medicine has also been improved:

"Earlier, we used to get general kits, there was no consideration of 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 two 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.

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 have university degrees. This is a big difference compared to the districts where I have worked before. The fact that the staff are highly educated has helped 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.

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, having bachelor and master degrees. In the words of one of the council staff members: "The councillors here understand everything - they need very little explanations."

Relationship between the political 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 standard 4 or 7, and very few had completed secondary education. The four 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."



Photo 3. From left: A Village Executive Officer, a Ward Executive Officer, and a Village Chairman during a community meeting in Moshi rural (by Siri Lange)

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 for contributing financially to their local community. 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."

According to our informants, poor members of the community are not forced to pay. 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.



Photo 4. Community meeting in Moshi Rural (by Siri Lange)

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.

4.3 Cooperation with other actors

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 (education, marginalised people i.e. youth and women, health, and 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 proposals 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".

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. I also asked them how we women should 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. None of the interviewed people in Moshi mentioned private/community initiatives to improve maternal health.

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, and since religious leaders tend to be well respected, it would be a good idea to have religious leaders in the various Council Committees. 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.¹⁷

"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."

The role of traditional authorities

So-called influential elders and clan leaders (in most cases men) are often given a special invitation to community meetings, but traditional authorities have no formal political role.

4.4 Final remarks

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 TBAs
- TBAs and community health workers have been trained on detecting signs of pre-mature delivery and the 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

¹⁷ 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. Case four: Serengeti District Council

By Christine Warioba, Bodil Maal and Betty Muze

5.1 Socio-economic situation

Serengeti District is one of the five districts constituting Mara Region. The district has an area of 10, 373 sq.km. of which national parks/reserves occupy almost two thirds.¹⁸ Only around 659 sq.km is arable land used for human settlement, agricultural and livestock keeping activities. The main economic activity in the district is small scale agricultural production, where cultivation is mostly done by using ox-ploughs. 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.

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.

According to the 2002 National Population and Housing Census, Serengeti district had a population of about 177,000 people. The largest ethnic group of the district is Kuria. Other groups include Ngoreme, Taturu, Ikoma, Nata, Isenye, Jita, and Sukuma. 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.

A large portion of Serengeti district became inhabited only 50 years ago. Informants say that due to this, the land is fertile, since it has not been exhausted. 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 daughters (according to tradition, mothers do not get part of the dowry from the first daughter, but from the second and onwards).

¹⁸ Serengeti National Park, 7000 sq. km., Ikorongo Game Reserve close to 190 sq.km, Grumeti Game Reserve around 66 sq.km.

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 have been 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.¹⁹

5.2 Cooperation within the district council

Decentralisation by devolution

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.

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.

Cooperation between councillors and council staff

The council consists of 26 persons. 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

¹⁹ 2137 women in Serengeti were examined, and 1625 were found to have undergone FGM.

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, and that they are “cooperating as a 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.

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 every day 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 two Village Health Workers and two 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.

5.3 Cooperation with other actors

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.

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.

Relationship with NGOs

Eleven NGOs are operating in the district, and most of them work on issues concerning orphans or the environment.

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.

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.

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.”²⁰ 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.

²⁰ <http://www.go2africa.com/tanzania/grumeti-reserves/eco-tourism.asp>.

5.4 Final remarks

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

- 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
- 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
- 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

6. Case five: Pangani District Council

By Siri Lange, Liss Schanke, and Rehema Mwateba

6.1 Socio-economic situation

Pangani district is located in Tanga region, 47 km south of Tanga town. It is one of the oldest districts in the country. The district borders to the Indian Ocean and has a great potential for tourism. The district covers 1830 sq.km. The altitude ranges from 0 to 95 meters above sea level. About 45% of the agricultural land is occupied by sisal estates. There is also a game reserve; Saadani National Park, in the southern part of the district.

The main economic activities of the district are agriculture, livestock keeping, fishing, trade and small scale industries. About 90% of the labour force is engaged in agriculture.

Pangani has a good potential for fishery, but the sector is underdeveloped. There are six tourist hotels in the district, ranging from 'economy standard' to more expensive establishments. Transport within the district is difficult for two reasons. First, the Pangani river cuts across the district. Since the ferry is old, it brakes down regularly. Secondly, around 50% of the roads in the district are inaccessible in the rainy season. The district got internet access in 2001, and cell phone coverage in 2003. Only around 50% of the villages are supplied with electricity. Ten of the 33 villages do not have piped water.

Population, religious and ethnic composition, education

The population of Pangani is estimated to be close to 48,000 in 2007. 85% of the population lives in rural areas, while the rest live in urban and peri-urban areas. The main ethnic groups of the district are Zigua, Bondei, Sambia, Pare, Nguu and a small proportion of pastoralists, like Maasai. The district profile states that around 72% of the population are Muslims, but several informants said that the percentage was probably higher. Of Christian congregations, the Lutheran and Roman Catholic church are the largest.

According to the socio-economic profile of the district, the majority of the residents are poor, with an income below US\$ 1 per day. The profile refers to poor participation of community members, socio cultural factors (including beliefs, taboos and "lazyness") as factors that contribute to poor development.

There is a great shortage of teachers' houses (the requirement is 270, while only 43 have been built). Up to 1993 there was no government secondary school in the district and less than 4% of the primary school leavers got the chance to go to secondary. At the moment, there are two government secondary schools in the district, and one private, with all together around 500 students. Pass rates of primary school leavers vary between 16 to 30%. There used to be a fisheries training centre in the district, but it closed down and at the moment there is no institution offering tertiary education.

Gender relations

Some women have income from Seaweed farming or small business project and informants say that women keep the income from their own economic activities. Divorce is not uncommon, and being divorced is not a hindrance for women to take various political positions or being elected.

Generally, women are more positive towards family planning than men, but health workers report that men are also changing their mindset on this issue. Traditionally, women went to their mother's home for delivery. Although the practice is declining, it is still fairly common. Informants said that if a woman did not go to her mother for delivery, the husband could get the reputation of being "stingy" or poor since traditionally, he is supposed to cover the travel expenses.

6.2 Cooperation within the district council

Decentralisation by devolution

Pangani has reached the 7th step of the Local Government Reform. The first step was data collection, the second was data analysis, the third was data organization, and the fourth step a stakeholders' workshop for 30 people who came from the ward and district level. Later, another workshop was conducted around 100 participants to broaden the number of people who had participated. A strategic plan was then developed.

Cooperation and coordination within the district council

The team was informed that there is a general shortage of staff in the district administration. There is shortage in almost every sector, especially at higher levels. The general shortage of staff was said to be about 25% - a dramatic change from two years ago when it was more than 50%. According to the council staff, it was hard to recruit new staff because "the environment is not attractive" and because "Tanzanians has a very negative attitude towards working in Pangani." Recently, five vacant posts in the Department for Community Development Service and Gender were advertised in Pangani and national newspapers, but only one person applied. According to the guidelines, there could be no selection and interview with only one candidate and no person appointed. The staff shortage means that many posts have been filled by people who are not qualified. For example, the acting District Medical Officer (DMO) is not a medical doctor and the last four DMOs have all left after a relatively short while.

The majority of the staff members are from outside Tanga region, mainly from Kilimajaro and Arusha. The reason for this is that the posts are advertised nationally, and the most qualified person is hired. Since there was no secondary school in the district until 1993, few people from the district have had the opportunity to take higher education.

There were many cases where the staff gives very different answers to the same questions, e.g. regarding the maternal health situation, whether women give birth at health facilities or not and which percentage. This may indicate that the district has a weak system for sharing information among staff – and for ensuring that knowledge is institutional, not only individual. In several cases there were different perceptions between administration and councillors as well. When it came to secondary schools for example, the administration stated that drop-outs was a big problem, due to early pregnancies and early marriages. The councillors on the other hand, said that the level of 'drop out' was not very high, and that when it happened, it was due to the school fee of 20.000 shillings per year, as well as expenses for books, uniforms and deks.

When it came to community contributions, the councillor stated that "There is always a division of pay between the council and the community – generally approximately 70-30. The community pays in kind, carrying sand, making bricks etc. It is not too difficult to make the communities contribute." The administration stated that community contribution was a problem.

Staff houses

Lack of staff housing is a problem – and probably one of the key reasons for the recruitment problems. One of the staff members originating from outside the region explained that he had been living in a guest house of poor quality – at his own expenses – for 6 months. The informant ended by asking "For how long can this torture continue?" The same staff member informed the team that the LGR program is strict with the open performance appraisal for staff members, but that this process does not give a chance to the employees to comment on their working conditions, e.g. housing situation.

Councillors

The council has 19 councillors, 17 from CCM, and 2 from CUF. 14 of the councillors are men and, five are women (all are 'special seats'). The team met councillors from both CCM and CUF, and they said their working relations were good. According to district staff, the educational level of councillors is very low. In the words of one staff member: "Some times there are misunderstandings due to low education. The councillors do not understand the full consequences of their decisions and it may take a long time to make them understand." The councillors did not answer questions re. cooperation with administration during the formal meeting, but did express a certain scepticism outside the meetings. The councillors underlined that the council is the link between the administration and the inhabitants, and that the councillors' main duty is to mobilize the inhabitants – including mobilizing them for the necessary community work.

6.3 Cooperation between the district council and other actors

Contact with NGOs or CBOs

The administration stated that there was no formal forum or meeting between the district and NGOs/CBOs, but that they were invited to meetings with necessary, for instance during the process of making district plans when the administration needed the views of all the stakeholders. This was also done to promote transparency. The team was informed that Pangani has a good score on transparency.

The district administration mentioned that they were cooperating with four NGOs (Tanga AIDS working Group, UZIKWASA, Power Health, BAPRU). According to information on the Internet, there is supposed to be an NGO in Pangani tracking local government expenditures, funded by the World Bank. None of the district staff met knew the organisation, but it is briefly mentioned in the District Profile.

Cooperation and participation at community level

The team was frequently met with statements that indicated a certain level of scepticism from the administration staff members that were not from the area towards people from the area. It was indicated that behaviours and culture in the coastal areas were different than in other areas, that discussions took longer time than in the hinterland, that persons worked less and relaxed more, even that the population was lazy. The district socio-economic profile refers to poor participation of community members, socio cultural factors (including beliefs, taboos and "lazyness") as factors that contribute to poor development.

This attitude among staff may be perceived by the local counterparts as criticism, and would probably not be conducive to the optimal relations between administrative staff from the outside and the local communities.

The team had the impression that most of the staff from the outside had relatively limited knowledge about the coastal culture and limited knowledge on where to get accurate information.

The team was given contrasting information as to community participation; some saying the mobilization was a big problem, some saying it was not. As to the Village Health Workers are working on a voluntary basis, this system seems to work relatively well. The VHW are receiving very little compensation apart from monthly transport money to go to Pangani and pick up First Aid kits.

Cooperation with the private sector

The administration seemed to perceive the business climate as difficult, that many persons did not show the necessary private initiative and eagerness – maybe due to the fact that fish was easily available. Many people from other areas buy land in Pangani because the process are low. It was stated that there is a danger that people from outside will buy land, and that the people from the area in the future will be “refugees”.

7. Observations and challenges

By Liss Schanke and Siri Lange

7.1 Maternal health – entry point to governance issues

The project has encouraged Local Government Authorities to see maternal health as a structural problem that can be approached as a governance issue, rather than an individual health issue.

The governance component of the Local Government Reform Programme (LGRP) was defined in 1998 as: Political decentralisation/ democratically elected leaders, rule of law, equity, public participation, accountability, integrity, transparency, and civic education.

The project has looked at to what degree questions of maternal health have been approached in terms of these governance issues in the participating councils. The findings show that neither male nor female elected leaders raise maternal health as an issue in council meetings, but overarching issues that have an effect on maternal health, like health facilities and infrastructure is regularly on the agenda. In terms of accountability, there is no sign that citizens use any of the official channels to claim better services or that poor services is addressed through these channels.

7.2 Maternal health – entry point to gender issues

The project has used maternal health as an example. Using maternal health as an approach has prevented the vague and academic discussion on gender issues that is difficult to grasp and understand for the large majority that are not “gender specialists.” Training in gender sensitization and gender mainstreaming at a general level is often difficult to grasp and it is often difficult for the participants to see the implications for the work on the ground.

The participants in the project have been a mixture of men and women. Maternal Health has been seen as a problem for men as well as for women. Traditional gender meetings, in contrast, have had a tendency to have a majority of female participants – many men seem to feel that this do not regard them and don't feel comfortable. However, a problem throughout the project has been to keep the focus on gender and decentralisation – exemplified by maternal health – and not to fall into a maternal health focus per sé.

In the local governments in Tanzania, women are generally underrepresented when it comes to political representation, administrative posts and key areas as health and education. An action oriented focus on gender balance in those areas will therefore have to imply a specific focus on the promotion of women:

Political representation

- Increased quantity of political representation in districts, villages and wards: Motivating and supporting women to stand for elections – and motivating stakeholders to support women candidates
- Improved quality of political representation: Networking, capacity building and mentoring for elected women

Administrative representation

- Increased number of female LG staff at professional and management level: Follow up LG guidelines stating that a qualified woman candidate should be given priority over a male one.
- Strengthened administrative representation: Networking, capacity building and mentoring for female professional and management staff in Local Governments

Focus on key women's interests

- Education: Access to secondary education, retaining of pregnant girls and young mothers in secondary school
- Economy: Access to formal work, Access to loans and micro credits
- Agriculture: Access to land, loans, tools, fertilizers and seeds
- Health: Give women access to a full range of maternal health services, such as family planning, health care during pregnancies, skilled care at birth, birth assistance to those who develop complications – as well as care for sexually transmitted diseases and abortion complications. Prevention of corruption and bribes in health services

7.3 Cooperation between government structures

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 appear to be good. Cooperation with the Department for Community Development was less pronounced, apart from one of the districts, where a UNICEF Child Survival Protection and Development project was carried out. Department for Community Development is central to enhance participation and include the lower local government levels. These departments often lack transport and fuel, and therefore have a limited role regarding community mobilisation on maternal health.

7.4 Coordination between government and civil society

Improving the relations between local governments and civil society has been one of the objectives of the project – as this cooperation is an important part of D by D.

The project activities have included participation from various NGOs at the meetings and workshops:

- White Ribbons Alliance
- Women's Dignity Project
- Tanzania Gender Network Program
- Care
- Health Equity Network

While we see that the cooperation between local governments and civil society organisations seem to function well in some of the specific Best Practice areas, we doubt whether the project will lead to sustainable cooperation in this field – at the central as well as the local level. We have observed lack of confidence and negative attitudes between local governments and NGOs on several occasions.

There are probably structural problems behind this; partly linked to financial issues. Local Governments and PMO-RALG do not seem to have funds for civil society participation at meeting and seminar – only for government representatives.



Photo 5. Members of a Village Health Committee, Chunya District (by Siri Lange)

7.5 Best practice method – exchange of experience

The project has focused on good practices and on the potential for learning from other districts' good practices. Being invited to present good practices and good results is a reward itself for district staff and politicians who have a genuine wish to achieve good results.

The project document envisaged exchange visits between the districts. This could not be carried through since PMO-RALG did not have the resources to facilitate it. However, it gave participants from different districts a chance to meet and learn from each other, rather than being presented with new solutions that have perhaps not been tried and tested in Tanzania before.

District representatives who attended the workshops arranged by the project appeared to be genuinely interested in learning from the other districts during the workshop. Unfortunately, the number of best practices that can be replicated is limited due to regional differences and lack of resources in the district. Nevertheless, during the last workshop, several of the districts presented new plans where low cost 'best practices' from other districts had been incorporated: combining information on maternal health with one of the full council meetings, and to encourage village governments to find ways to mobilise local resources to pay village health workers a token of appreciation for their work.

The perhaps most important “good practice” is work ethics, i.e. the willingness of staff to provide ordinary people with as good services as possible without any extra reward or payment, despite difficult working environments. This is an issue that is hard to replicate within a project like this, but the Norwegian Tanzanian Partnership Initiative (NTPI) is planning to implement a performance-based funding system for health services at the district level. The background for this initiative is that the Ministry of Health has “indicated that there is a need to motivate individual health workers to take increasing responsibility for improving health services”.²¹

7.6 PMO-RALG ownership - a key to sustainability

When it comes to PMO-RALG involvement and ownership, there has been significant change during the project period.

During the first phase, the Norwegian consultants were in the driving seat, supported by private Tanzanian consultants. Persons in PMO-RALG participated, but did not play a leading role. In the second phase, on the other hand, PMO-RALG staff played a far more central role.

This development indicates that this objective “Ensuring sustainability and PMO-RALG ownership” has been partly fulfilled and that there is a very good basis for continuing the project focus. However, proper monitoring of the project has been a challenge. First, PMO-RALG funds for travelling have been very limited. Second, involved PMO-RALG staff have had other obligations that have made it difficult to participate in all activities, and there has been a problem within PMO-RALG ensuring the permission for involved staff to set aside the necessary time. This indicates that PMO-RALG is seriously understaffed, and that it is difficult for managers and staff to fulfil all demands.

The work burden on PMO RALG is likely to increase after the closing up of the Local Government Reform Programme on 1st July 2008 – implying that a lot of reform program staff will have to leave. This will mean an increased work burden for the PMO-RALG staff and will also mean a certain level of job insecurity for all persons involved for the last six months.

7.7 Project working methods and concerns

The project has been based on seminars and workshops. Several recent reports from Tanzania have raised concerns regarding government financial management in Tanzania. A recent external audit report of the Management of Natural Resources Program 1994-2006 indicates that as much as 50-70% of the total amount of Norwegian support of totally NOK 300 million to the program has been used for capacity building, travel expenses and per diem related to seminars and work shops for the Ministry, Local Governments and Civil Society representatives. The audit report points to several challenges regarding the funding of seminars and work shops:

- Seminars are shorter than budgeted – without revising the expenses.
- Participants receive per diem without participating – or participating part of the time
- The per diems are high, and per diem is paid out even if all costs are covered
- The actual costs for seminars and work shops are over priced, e.g. meals and hotels
- Seminars and workshops are located in distant places to allow maximum per diem and travel allowance

²¹ Ottar Mæstad (2007): “Rewarding Safe Motherhood. How can performance-based funding reduce maternal and newborn mortality in Tanzania?”. CMI Report 2007:11.

We have no specific reason to believe that this has been a problem in our project, but are aware of the general challenges regarding these issues. Sustainability is always a core interest in development work. We do hope that the participants of the workshops have picked up something that will have lasting results.

7.8 Follow-up

The LGRP is ending 1st July 2008, and most donors in this field, including the Norwegian Embassy, draws back the technical support in mid 2008. A new program is under appraisal.

We hope that PMO-RALG with assistance of the relevant NGOs will follow up the project. We strongly recommend that the project approach will continue, that is integrating governance, gender and maternal health – rather than seeing them as three separate issues.

8. Appendices

8.1 Maternal health challenges and solutions

The project has used Maternal Health as an entry point to look at gender and decentralisation. Maternal Health was chosen as an entry point for strategic reasons; it is one of the MDGs as well as one of the Mkukuta indicators. In addition, the issue has a strong international focus. Research on maternal health in Africa has identified a number of interventions that work: Midwifery, clean deliveries, cesarian sections, medical interventions and drugs like magnesium sulphate and antibiotics, empowerment of women, transport, antenatal care, decentralisation of services, educating health staff, as well as general economic growth.²²

During visits to best practice districts, the project has identified a number of practices that informants say have contributed to a reduction of maternal mortality:

Table 1. Challenges and suggested actions in case study districts

Challenges	Actions
Communication	
Long distances to health facilities	Mobile clinics
Lack of ambulances, cars and fuel	Special schemes to ensure transport for pregnant women – use available council cars disregarding department
Lack of mobile coverage	Radios for dispensaries
Human resources	
Lack of professional health workers	Village staff housing rehabilitation
Unfriendly attitudes from health workers	Training – as well as reporting of negative behaviour
Ensure local and supplementary solutions – especially in isolated areas	Mobilization and training of Village Health Committees and Health Workers and incentives for Village Health Workers (like exemption from community contributions)
Corruption and bribery	
Claims from Health workers to pregnant mothers	Clarification of payment rules and reporting of unlawful claims
Monitoring	
Preparations for delivery	Regular controls and planning for deliveries for all pregnant women Exempt women from compulsory ‘participation’ activities if they register their pregnancy
	Analysis and reporting of all maternal deaths
Traditions and attitudes	
Prevention of pregnancies before 18, the minimum sexual age limit (1)	Enforcement of minimum sexual age, punishment of perpetrator, school life skills program for all grades
Female Genital Mutilation	Information on the negative effects of FGM

²² Johanne Sundby, presentation at Evaluating the Complex Conference, Oslo 29-30 June, 2008.

Possible areas for intervention

- *Family level:* Provide family planning.
- *Community level:* Establish community delivery trust funds
- *Health facility level:* Prioritize financial and human resources for pregnancies and childbirth.
- *Political and administrative level:* Improve women's participation and women's interests in local government and improve working environment for professional health workers
- *National government level:* Promote National Health Budgets as minimum 15% of national budgets.

(Based on the White Ribbon Alliance Action Plan for Tanzania)

8.2 Team members

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

Phase 2 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. Odilia Mushi	PMO-RALG
Ms. Felista Ngua	PMO-RALG

8.3 Field visit programs and persons met

8.3.1 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 Malambugi	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	
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		

8.3.2 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
		Mr. Steven Kasoga	Assistant Administrative Secretary
		Mr. Athanas T Munda	Ag social service support sector
		Mr. Christopher Luhanyila	Assistant Administrative Secretary – Engineer
		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, beneficiary of CARE project		Community members
	Misungwi District Council	Ms. Christina Jilala	Council member, special seat
Thursday 22.02.07	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 Bonavebture Bisuro	DMO
		Ms. Scholastica Masolwa	MCHA
		Mr. Abdalla Ahamed	Acting CDO

8.3.3 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 Buretta	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
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 Kimombo	Village Executive Officer
		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

8.3.4 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 Mwijarubi	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
	Mr. Edward. Olelenga		District Commissioner
	Ms.Emaculata Muniko Ms.Penina Geka		Female Councilors special seat
	Ms. Penina Geka	Female Councilors special seat	
Mr. Manyerer Andrew	District Agriculture and Livestock Officer		
Wednesday 21.02.07	Serengeti District Council	Mr. Elikana Juma Elikana	District Development 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

8.3.5 Field visit to Pangani

Team members

Ms. Liss Schanke, Team Leader, Dr. Siri Lange, and Ms. Rehema Mwateba. Mr. Yohana Tessua, Regional Secretariat, accompanied the team during the visit.

Date	Institution	Full name	Title
Wednesday 09.05.07	Regional Secretariat, Tanga	Mr. Paul Amanieli Chikira	Regional Administrative Secretary, RAS
	District Commissioner's Office, Pangani	Ms. Zipora Pangani,	District Administrative Secretary, DAS
	District Council, Pangani	Mr. Neneka S Rashid	District Executive Director, DED
	District Council, Pangani	Mr. Pius Ngodi	District Planning Officer
Thursday 10.05.07	District Medical Officer's team	Mr. Josephat Makombe	Acting District Medical Officer, DMO 0784 766743
	"	Mrs Shelter S. Enock	DRACHO. MCH
	"	Mr. Timothy D Mgaya	DCCO
	"	Mr. Waziri J. Mwengere	
	"	Mrs. Fatma Ussi	DMIF, Clinical Officer, Malaria Focal Point
	"	Mr. Frank A Makunde	District Dental Officer
	Pangani district Council	Mr. Samuel Kitime	Human Resource Officer
	BAKWATA	Mr. Hassan Semnangwe	District Cultural Officer
		Ms. Fatima Salim	Teacher
		Ms. Mwamvua Hatibu	Teacher
		Mr. Sheik Sahera Akida Mganga	Secretary
	Pangani council	Mr. Salim Sinani	Chairperson, CCM
		Mr. Aziz S. Zaharani	Councillor, CUF
		Mr. Abdul Ahmed	Councillor, CCM
		Ms. Zainab Omari Ibrahim	Councillor, CUF
		Ms. Memzee Andilahi	Councillor CCM
Stahebu dispensary	Ms. Nazaeli Elienea	Mother and child Health Aid MCHA	
"	Ms. Rehema Abdallah	Nurse	
Sub village council	Ms. Matumu Abubakar	Chairperson	
Friday 11.05.07	Department of Gender and Community Development	Mr. Costa Magali	Community Development Officer
	Finance Department	Mr. Rajabu Lingoni	Treasurer
	Planning Department	Mr. Justin M. Lyattuu	Assistant Planning Officer

8.4 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

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SUMMARY

This empirical study looks at coordination and cooperation within five district councils in Tanzania with a special focus on efforts to reduce maternal mortality. In what ways do district councils cooperate with local communities, civil society organisations and the private sector to improve maternal health? How well do the different departments within the district councils coordinate their work? What is the relationship between district staff and elected councillors and to what degree is maternal health on the political agenda? The project's aim has been to identify good practices in relation to these questions and to facilitate learning between districts with relatively low maternal mortality rates (MMR) and districts with relatively high MMR. The project was organised by the Prime Minister's Office for Regional and Local Authorities (PMO-RALG). The Royal Norwegian Embassy in Dar es Salaam co-founded the project.

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