ASSESSMENT OF PUBLIC PRIVATE PARTNERSHIP ON HEALTH SERVICE DELIVERY IN DODOMA MUNICIPAL AND DISTRICT COUNCILS IN TANZANIA

BY

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ABSTRACT

The thesis answers the question: "what is the nature, motive, model, contribution and effects of Public Private Partnerships (PPPs) on health service delivery?" The general objective of the research was to assess the effects of PPPs on public health service provision in Dodoma. The specific objectives were to explore the nature and motives of PPPs, determine PPP models, stakeholders' contributions, and effects. The PPP continuum model and stakeholder theory are used to generate independent and dependent variables. The independent variables constitute the nature and motives of PPPs and the optional PPP models available. The dependent variables are distance travelled, service costs, service types, service time, profits and service reliability. Cross- sectional case study design is used to guide the study of thirteen PPP cases purposefully sampled. Themes, patterns, clusters and finally tables are used to present qualitative data while content, pattern matching, narratives and cross-case analysis techniques are used for analysis. Frequencies and pie charts are used to assess stakeholders' contributions to the partnerships. To determine the influence of PPPs on dependent variables, Analysis of Variance (ANoVA) is utilised at the level of 0.05 significance. To separate the effects of PPPs on the continuous variables, t- test is used to compare pairs of PPP cases. For categorical variables, frequency analysis applies. The findings show that: firstly, the nature and motives for PPPs were centred on the need to share scarce resources in order to improve public health. Secondly, PPP models range between simple collaborations to joint ventures. Thirdly, stakeholders' contributions included labour, expertise, materials and cash. Fourthly, despite limitations in the initiation and management of the collaborations, the effects of PPPs were significantly positive for all stakeholders. It is recommended that, firstly, the

government should establish specific regulations that can be used as guidance in initiating and managing various forms of PPPs in the health sector. Secondly, there should be one responsible unit for managing PPPs in all health projects in the country. Thirdly, there should be more resource decentralisation to the local level to support both public and private initiatives in PPP projects.

DECLARATION

I, Josephat Stephen Itika do hereby declare to the SENATE of Sokoine University of Agriculture that this thesis is my own original work and it has not been submitted for degree award in a college or university.

26/11/2007

Josephat Stephen Itika
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Date

The above declaration is confirmed by

27/11/2007

Prof. Eleuther Mwageni
(Supervisor)

Date

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perseverance. However, much as this acknowledgment is made, I remain entirely responsible for omissions, and misinterpretations that might be observed in this thesis.

DEDICATION

To my late grandfather Ndetembia Itika Matemu who not only inspired me to pursue the world of knowledge through the education system but also laid the foundation of which I am proud.

To mothers and children in Tanzania, who have been waiting for too long since independence without enjoying the benefits of public private partnership in health care, and to the anticipation that the emerging hopes in this thesis are cherished with the common understanding of saving human health.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ALPDA	Agricultural and Livestock Production Development Association
AMREF	African Medical Research Foundation
ANoVA	Analysis of Variance
ARI	Acute Respiratory Infections
BP	Blood pressure
BRAC	Bangladesh Rural Advancement Committee
CBO	Community Based Organisation
CDA	Capital Development Authority
CHE	Community Health Education
CMSR	Centro Mondialita Svillupo Recipproco
CVP	Children's Vaccine Programme
DCT	Diocese of Central Tanganyika
DDC	Dodoma District Council
DDH	Designated District Hospital
DHS	District Health System
DMC	Dodoma Municipal Council
ECE	Economic Commission for Europe
GDP	Gross Domestic Product
HBC	Home based Care
HIV	Human Immunodefiency Virus
HM	Her Majesty
HSR	Health Sector Reform
ICCO	Interchurch Cooperation Organisation
IMF	International Monetary Fund
IRI	International Research Institute
IMCI	Integrated Management of Childhood Illness
NGOs	Non Government Organisations
MCH	Maternal Child Health - (Reproductive and child health)
MHHC	Mackay House Health Centre
MHHCACP	Mackay House Health Centre AIDS Control Programme
MoH	Ministry of Health
MoH SW	Ministry of Health and Social Welfare

(MDGs)	The Millenium Development Goals
MSD	Medical Stores Department
MTUHA	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya (Swahili)
NACP	National Aids Control Programme
NBI	National Banking Initiative
NIMR	National Institute for Medical Research
ORS	Oral Rehydration Salts
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
PPC	Public Private Collaboration
PPP	Public Private Partnership
RCH	Reproductive and Child Health (famous as MCH)
SADC	Southern Africa Development Co-ordination
SAPs	Structural Adjustment Programmes
STI	Sexually Transmitted Illness
TFR	Total Fertility Rate
USAID	United States Agency for International Development
USRP	Urban Sector Rehabilitation Programme
TB	Tuberculosis
TBAs	Traditional birth attendants
THs	Traditional healers
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
US	United States
USA	United States of America
URT	United Republic of Tanzania
VCT	Voluntary Counselling and Testing
VEO	Village Executive Officer
WB	World Bank
WEF	World Economic Forum
WHO	World Health Organisation

CHAPTER ONE

1.0 INTRODUCTION

1.1 An overview

Public private partnership (PPP) in public service delivery is a fashionable phrase in public policy with deep historical roots. At the international level, collaboration between government and the private sector dates back to the 5th century A.D. (UN/ECE, 2000). It continued to change forms and rigour to date because of the need to address new challenges in public service delivery. In Tanzania, the PPP concept started to appear in government policy papers in the mid -1980s but more commonly in the 1990s through to the 2000s as part of government reforms to improve public service delivery.

Public – Private Partnership (PPP) is defined narrowly or broadly depending on the context and preference of a particular user (Bennet *et al.,* 1999; Fiszbein, 2000; Buse and Walt, 2000; Brinkerhoff, 2002; USAID, 2006; Hemming, 2006; Rosenbaum, 2006; and British Columbia, 2007). As a starting point in this thesis, PPP is defined as *continuum of collaborative* arrangements for public service delivery between the public and private sector organisations (Fiszbein, 2000; Reich, 2000; Commonwealth, 2003). This continuum provides a range of PPP option models available for choice, which are simple cooperation, joint venture, direct contract, lease, concession, and complete privatisation. The partners to the collaboration are attracted and bound together by the need to share resources, risks, rewards, responsibility and accountability in the process of delivering public services to the citizens (Commonwealth, 2003, USAID, 2006; and British Columbia, 2007).

PPP in service delivery is important when the public sector alone does not have the capacity to deliver such services effectively. While the private sector alone may not

have the capacity or interest to provide public goods or services (KMPG International, 2002; Commonwealth, 2003; Rosenbaum, 2006). Even where the public sector has the capacity in terms of resources, the partnership may be required because experiences have shown that there are tendencies for the public service providers to divert resources from the most in need (Milburn, 2004; Rosenbaum, 2006).

Globally, there are different PPP models. They constitute a continuum of collaborative arrangements. The models range from simple cooperation and joint venture, to direct contract, lease, and concession. For example, in response to public service delivery gaps, let us say in a municipality, the starting point could be simple cooperation between the government or government organ and the private sector. This could include a situation in which a local authority invites ideas from the business community to improve by-laws for regulating certain service delivery mechanisms. In this case the role of the private sector is just advisory.

Joint venture entails the government organ collaborate with a private party where they take joint responsibility for the overall delivery package. The parties have to balance their roles, interests and risks and hence strong accountability mechanisms, transparency in decision-making, equitable costing and spread of financial profit and risks are necessary. Direct service contract is another PPP arrangement. The client may contract out a public service to a private provider to an agreed level within defined specifications, payments, and for a fixed period. Contracts are awarded through competitive bidding. The client retains ownership of all assets and is accountable to the public for ultimate performance. Under lease arrangement, the government leases

infrastructure and facilities to a private firm for a fixed period of time, but the government remains the owner and hence accountable for such public service delivery. The private sector will have exclusive rights to operate, bears commercial risks for non-payment of fees and charges by the service beneficiaries.

Concessions entail the government organ transferring full responsibility for service delivery in a specified area in a specified time to a concessionaire. This will include everything concerning construction, maintenance, collection and management. The concessionaire is responsible for all capital investment to build, upgrade or extend the system. The client will generally retain responsibility for establishing and monitoring performance standards, regulation of price and service volumes. The main difference with lease is the additional responsibility for capital investment. Therefore, PPP is all about bringing different stakeholders from the public and private sector to address social problems.

Stakeholder theory suggests that partnership between the government and the private sector has potential to create a window of opportunity for addressing problems of both government and market failures in social service provision(Jones, 1995; Reed, 1999). It is anticipated that partnership in public service delivery will lead to a win-win situation for all key stakeholders. This will include improved access to private capital, service variety, quality, reliability, and profits (Fiszbein and Lowden, 1999; Fiszbein, 2000; World Bank, 2004).

Although this positivist outlook of the power of PPPs in enhancing public services provision is strongly supported by empirical work worldwide (Birmingham, 2000; Austin, 2000; Fiszbein, 2000; World Bank, 2004), there are also frequent warnings that PPPs are not necessarily a panacea for public service provision. PPPs become ineffective in situations where the government and or the private sector are weak in resources and cannot engage in effective partnerships, particularly in areas of regulatory framework (Humes, 1999; Reich, 2000; Hartwich *et al.*, 2003; Rosenbaum, 2006).

Prior to independence, Tanzania's health system was concentrated in urban areas and services were essentially curative in nature to serve colonial administration (URT, 2001). After independence and particularly in 1967, the Arusha Declaration stated that the government would finance and provide free medical care to all of its citizens as part of fundamental human rights (Abdallah, 2002). As a result, an expansion strategy for primary health care was adopted.

By 1978, a clinic was located within 10 kilometres of 90 percent of the population (Benson, 2001). In line with its free-health-for-all policy, private for-profit health services were forbidden. The private sector for profit was particularly hard hit by the enactment of the Private Hospitals Regulations Act of 1977, which banned health services for profit in the country.

Despite inadequate revenues, the government adhered to these policies throughout the 1970s and 1980s. Under funding led to shortages in supplies of drugs, deterioration of

facilities, low staff morale, and poor quality of care (MoH, 1998). The importance of the private sector in health service delivery and the move towards market-based economic reforms resulted in the establishment of the Private Hospitals Regulation Amendment Act of 1991. Therefore, government initiatives to open doors for private sector participation in health service delivery started in 1991 and have kept pace (URT, 1999; 2002; MoH, 1998; 2000; MoH/PORALG, 2001; 2005)

So far there is only a limited number of studies available which have documented some PPP activities in the country. A study conducted jointly by the then Ministry of Health (MoH) and the National Institute for Medical Research (NIMR) found various activities of collaboration between the public and private sector in Tanzania (MoH and NIMR, 2000). They include supervision of private hospital staff by District Health Management Team (DHMT), involving private hospitals in preventive and curative care, supervising private hospitals, involving private health service providers in meetings, data collection, training, service delivery, and sharing of resources.

Other studies have unearthed the regulatory problems facing PPPs and proposed the need of further studies for informing policy and legal framework in the country (Mapunda, 2005; MoH/PORALG, 2005; MoH, 2005; Itika, 2005; MoH/PORALG, 2006). By referring to these introductory remarks and the details covered in the literature review and the methodology deployed in the study, the following section establishes the research problem.

1.2 Statement of the problem

Although many studies already conducted in PPPs are informative in terms of establishing the meaning, rationale and effects of PPPs worldwide, they lack a holistic approach and understanding of PPP issues offered by using stakeholder theory in the form of a process analytical model (Freeman, 1984: Monroe, 1995; Mitchell *et al.*, 1997; Reed, 1999; Rosenbaum, 2006).

The studies also lack the level of rigour in terms of methodology that is gained by combining both quantitative and qualitative methods in understanding the dynamics of PPPs where multiple variables need to be captured (WHO, 1999; Haran et al., 1994; Weakliam, 1994; Warioba, 1999; Yin, 1994; Huberman and Miles, 1994; Denzin and Lincolin, 1994). More importantly, Tanzania started to mainstream the private sector in health service delivery in terms of policies and regulations in the 1990s and more concern has come to the fore in the 2000s (URT, 1998; 1999; 2000; 2003; 2005; MoH, 2000; 2003; MoH/PORALG, 2001; 2005; 2006). However, the few studies available have generated only limited knowledge on the nature, motive, models, contributions and effects of PPPs as perceived and experienced by the key stakeholders at the local level (Humes 1999; Acar and Robertson, 2004; Hartwitch *et al.*, 2003; Reinikka and Svesson, 2003; MoH/PORALG, 2005; Mapunda 2005; Itika 2005; and Burnert, 2006).

Therefore, this thesis addresses the question: "What is the nature, motives, models, contributions and effects of Public Private Partnerships (PPPs) on health service delivery in the Councils?" The main objective is to come up with a detailed understanding of PPPs and their performance in health service delivery in relation to stakeholder theory because it explains the nature of stakeholder relationships, PPP

models and discourses for the purpose of comparison with study cases, and regulatory framework in Tanzania which defines the nature and motives of PPPs.

1.3 Justification of the study

The justification for the research was based on the theoretical issues raised in the literature, the need to inform policy decisions on PPP programmes and better use methodological approaches in studying PPPs

The literature advocates the need to use stakeholder theory in situations where the government, private and community work together. This thesis has attempted to utilise that theory. Also, since there is no data to locate the PPP models in Tanzania within the conventional framework, the study has managed to do that job. PPPs in health service delivery in Tanzania are in line with various policies and ongoing government reform programmes to improve the health sector in the country. The policy and programmes include Millennium Development Goals (MDGs), National Strategy for Growth and Reduction of Poverty (NSGRP), Local Government Reform Programme (LGRP) and Strategy 7 of health sector reforms. The findings offer useful inputs to these policies and programmes by creating learning grounds for continuous improvement. Therefore, the study was justified from many perspectives. These are:

One, the study establishes the utility of stakeholder theory in assessing PPPs. Two, the study has been the first one to come up with in-depth understanding of the status of the existing PPPs in the study areas in Tanzania. Three, it has helped to understand how government's intention to work with private sector has performed. Four By comparing

Dodoma Municipality and Dodoma Rural District, it will be possible to examine whether PPPs address the problems of rural-urban disparity in the process of public health service provision.

1.4. Objectives of the study

The general objective of the study was to assess the practice and effects of PPPs in public health service provision.

Specific objectives were to:

a) Explore the nature and motives for PPPs in health service provision in Dodoma Municipal and District Councils.
b) Identify and characterise the PPPs models used in Dodoma
c) Identify stakeholders' contributions to PPPs
d) Examine the effects of PPPs on the key stakeholders

1.5. Research questions

This research will be guided by the following questions:

a) How are PPPs generally developed, defined and what are their motives?
b) What models of PPPs are used?
c) What are the contributions of each key stakeholder to the PPPs projects?
d) What are the effects of PPPs on the key stakeholders?

1.6 The framework of analysis and variables

The study assessed PPP from the perspective of stakeholder theory, PPPs, and motives. This revolves around the need to pursue common objectives, sharing of resources,

expertise, risks or others. The assumption is that knowledge and motives in these areas facilitate the choice of a specific and relevant PPP model. The proposed menu could be simple cooperation, joint venture, direct contract, lease, concession or other. These are the independent variables, which will determine the mode of contribution to the partnerships. The effects on the stakeholders could be service access in terms of distance, service costs, service types, time, profits, information sharing, risk sharing, and reliability (dependent variables). Details of the analytical framework and variables are found in Figures 1, 2, and 3 in Chapter Two. The list of variables, indicators and measurements are attached as appendices 1 and 2.

1.7 The scope of the study

The study was restricted to the assessment of PPPs from the angle of stakeholder theory. For the purpose of manageability of the study, partnerships that were managed outside the boundaries of the local authorities were not considered. These included, for example, agreements between the Ministry of Health and Social Welfare and the donor community. Although local pharmacies/drug shops, traditional healers and traditional birth attendants also contribute to public health service provision (Cesar *et al.,* 1994, Goodman *et al.,* 2004, de Savigny *et al.,* 2004), they are outside the scope of the study. This is mainly because there is no sufficient supporting evidence from the literature, both worldwide and in Tanzania, that these organisations are substantially involved in PPPs at micro levels (Verhallen, 2001).

CHAPTER TWO

2. 0 LITERATURE REVIEW

2.1 Meaning, origin and models of Public Private Partnerships (PPPs)

Public Private Partnership (PPP) as a catchy phenomenon is used differently by different scholars and gained momentum, particularly in the 1990s. Some authors share a common understanding of PPPs as collaboration between the public and private sector organisations (Fiszbein, 2000, Reich, 2002, Common Wealth, 2003). Here the private sector constitutes a myriad of actors outside the government (purely private for profit organisations, religious and non-religious organisations (NGOs), community-based organisisations (CBOs), traditional healers, (THs) and traditional birth attendants (TBAs)). Although these organisations do not belong to the public structure, they arc assumed to promote public interests (Reich, 2000). This perspective considers PPP as

> ...any arrangement between the public and private sector where there is pooling together of resources (financial, human, technical, and information) from public and private sources to achieve a commonly agreed social goal (Fiszbein, in Collins, 2000).

In this framework, there is allowance for a broad range of public-private collaborations that qualify as partnerships, that is, from a situation in which all parties participate on the basis of mutual interdependence, to those in which some parties are present only through some form of contribution without being involved or even being recognised as partners in decision-making process. This line of argument considers the widespread use of PPPs language in the 1980s and 90s as nothing new but a continuation and improvement of deep-rooted historical collaborations between the state and the private sector. Therefore, what has changed over centuries is not so much the substance but

the name, and differences in modalities of collaboration between the government and non-government sector. For example, book 50 of the Digest (Public and Private Law Book) published in AD 530 was entirely dedicated to public works (UN/ECE, 2000).

The book shows the existence of concession law. It disappeared during the 5th century after the fall of the Roman Empire and reappeared in the 12th and 13th centuries in France, in particular to guide the construction of fortified towns and occupation of new lands. During the 16th and 17th centuries, European sovereigns, and particularly in France conceded public works to their "financial investors", generally called entrepreneurs. Such works included riverbed and canal construction, waste collection, public lighting, mail distribution and management of opera houses. It was after the world wars and the emergence of socialist ideology, which called for strong public enterprises that the role of collaboration between the public and private sector was, weakened (UN/ECE, 2000).

Pursuing the same position, Walt (2000) observes that up to the 1970s there was a stand –off between the public and private sectors, which resulted in the separation of their activities because of hostility, antagonism and conflict between the public and private sectors. These authors have put forward a point that both a change in the political climate to reduce the role of state in the economy and globalisation have pushed for revamping collaboration between the public and private sector in order to arrive at a win-win situation in public service delivery. In this case, PPPs and Public Private Collaboration (PPC) are synonymous.

However, the previously mentioned outlook has not remained without criticism. Other hard-nosed scholars look at PPPs during the past two decades in a stricter sense in such a way that some forms of collaboration may not qualify as partnerships (Fiszbein, 2000);

Buse and Walt, 2000; Commonwealth, 2003: USAID, 2006). This group of authors considers PPPs as:

> a cooperative venture between the public and private sectors, built on the expertise of each partner which develops or improves facilities and or services needed by the public through the appropriate allocation of resources, and risks" (Commonwealth, 2003).

Such a strong perspective of PPPs is shared by South African government (USAID, 2006). The key words expertise, appropriate allocations of resources and risks are critical. They signify a situation in which both the public organ and the private organisation should have the status of "equal partner" in order for collaboration to qualify as "partnership". This position is also supported by the South African legal definition enshrined in the PPP law which has borrowed heavily from the UK's stringent

> PPP regulatory framework which states that: PPP is a contract between a public sector institution and or municipality and a private party in which the private party assumes substantial financial, technical, and operational risks (USAID, 2006).

However, as much as this strong perspective is more rigorous and focused, it does not seem to match with most literature in both developed and developing countries largely due to inequalities in the partnership relationships (Piere, 1998, Walt, 2000, MoH and NIMR, 2000). Acknowledging the utility of considering PPP as a continuum of

collaboration between governments and non-government organs than fixed and strictly defined relationships, Bennett *et al.* (1999) put an emphasis thus:

> .... There is a spectrum of PPP options ... it could be narrowly defined as joint ownership of business...it is also broadly defined as any form of collaboration between public and private actors.

In support of the same definition, Brinkerhoff (2000) argues that, since PPP has no common meaning for all people and has evolved over years by taking different forms, PPP should be seen as ranging from simple cooperation, more participatory approaches to complete privatisation. Such collaborations could cover a wide range of possible relationships, from contracting the private sector to supply goods, or services, e.g. cleaning and catering through to arrangements where a private company may manage a public hospital. For the conceptualisation of PPP as a continuum.

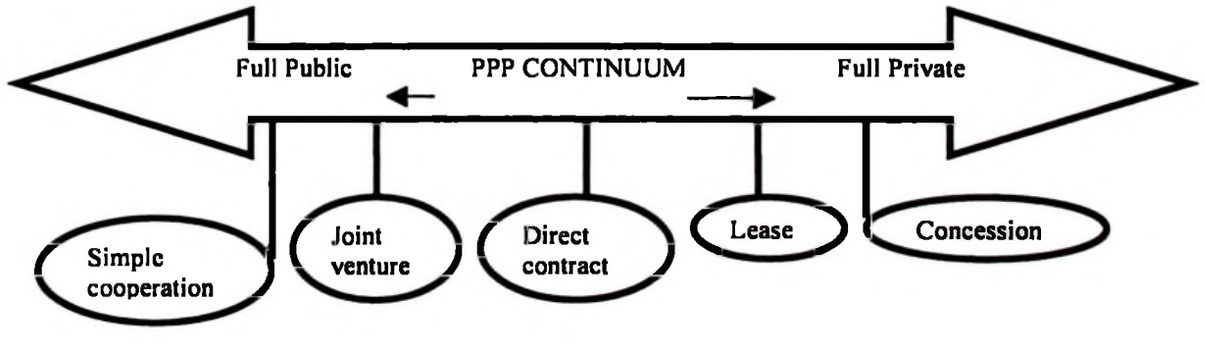

Figure 1: PPP continuum model

Source: Adapted from Bennet *et al.* (1999); Brinkerhoff (2002); Sohail *et al.* (2003)

Figure 1 denotes a continuum of PPPs models from a situation where the private sector is fully passive to where the public role becomes fully passive but, in between the two extremes, there are many models including joint venture, direct contract, lease and concession. In appreciation of the fluid nature of PPPs, Sohail *et al.*(2003:2) comment that:

> ... indeed, the types of partnership that have emerged most often in developing countries contain many variations not found in conventional definitions.... Many partnerships in developing contexts occur to respond to gaps in municipal service provision.

In response to public service delivery gaps in a local authority, the starting point is simple cooperation between the government or government organ and private sector. This could include a situation in which a local authority invites ideas from the business community to improve by-laws for regulating certain service delivery mechanisms. In this case, the role of the private sector is advisory. This is an example of the simplest form of PPP.

Joint venture entails the municipal client collaborate with a private party where they take joint responsibility for the overall delivery package. The parties have to balance their roles, interests, risks, and hence strong accountability mechanisms, transparency in decision-making, equitable costing and the spreading of financial profits and risks are necessary. Direct service contract is another PPP arrangement. The client may contract out a public service to the private provider at an agreed level within defined specifications, payments, and for a fixed period.

Contracts are awarded through competitive bidding. The client retains ownership of all assets and is accountable to the public for ultimate performance. Under lease arrangement, the government leases infrastructure and facilities to a private firm for a fixed period of time, but the government remains the owner and hence accountable for such public service delivery. The private sector will have exclusive rights to operate and bear commercial risks for non-payment of fees and charges by the service beneficiaries.

Concessions entail a local authority transferring full responsibility for service delivery in a specified area in a specified time to a concessionaire. This will include everything to do with construction, maintenance, collection and management.

The concessionaire is responsible for all capital investment to build, upgrade or extend the system. The client will generally retain responsibility for establishing and monitoring performance standards, regulation of price and service volumes. The main difference with lease is the additional responsibility for capital investment.

Therefore, firstly, it is observed that the latter definition is not well supported in most cases, particularly in developing countries, and also PPPs are voluntary by nature and hence subject to flexibility, based on negotiations and arriving at consensus as particular situations demand. The study will explore the possibilities of a better definition, which could be the same as the one adopted here, supports the former or is completely different. Secondly, as we shall see later, in Tanzania there is neither policy nor legal PPP framework that can be used as a basis of analysis of PPPs, although there are various health service delivery activities under partnerships. Therefore, it is only by using the former perspective of PPPs as general collaboration that can better lead us into a position of coming up with a clear understanding of the existing PPPs and their performance in the health sector in the country.

2.2 The underlying theories

In terms of paradigmatic orientation, PPPs of the 1980s to date have emerged because of an ideological shift from state driven development to neo- liberalism (rolling back the role of the state in the economy to allow for the free market to operate). The earlier decades of state dominance in the economy are accused by policy failure theorists to

have caused poor policy choices, bureaucracy, mismanagement, and corruption which led to the socio-economic crisis that have embraced all countries since the late 1970s (Sohail, *et al.*, 2003, Kapinga, 2003).

Struggles to come out of the crisis have taken different faces but most notably through the bitter Structural Adjustment Programmes (SAPs) of the 1980s and 90s under prescriptions from the International Monetary Fund (IMF) and World Bank (WB). However, as argued by Mills (1997) most advocates of the market-led economy have "moderated" their stand in appreciation of the role of non-market-based arrangements, although both governments and markets are often inefficient and make access and equity difficult to achieve.

By taking on board the market modification argument, Weisbrod, (1986) has provided a scenario for a three-sector service delivery model (private, public and voluntary) as an alternative for purely public or purely private service provision. This model is seen as an important step towards addressing the problems of both public and private failures to provide public goods and services. This ideological position in favour of PPPs calls for bringing together different stakeholders with different powers, interests and objectives for the public good. PPP, which is advocated by Weisbroad and many other scholars as an effective mechanism for public service delivery, could be grounded in different theories ranging from economic, sociology or public management.

Such theories include institutional theory (Commons, 1931; Coarse, 1937; Davis and North, 1971; Galanter, 1981), or public choice theory (Buchanan and Tullock, 1962,

Hardin, 1982). These theories put emphasis on institutional arrangements such as policies, rules, regulations and procedures which govern partnerships, and rent-seeking behaviours of public officials, and how they affect their performance.

Much as these theoretical insights are useful in understanding how PPPs are managed, in particular the regulatory framework, the main theoretical stepping-stone in this study concerns stakeholder theory which is more inclusive. PPPs, are about bringing together different stakeholders with different powers, interests and objectives to form partnerships for common benefits. This does not exclude the regulatory framework which is central in institutional theory (Davis and North, 1971; Murdock, 2004, and Scholl, 2001).

There have been substantial discourses as to who are stakeholders and the questions related to power relations and their implications. Freeman (1983) seems to form the basis of today's arguments regarding stakeholder theory (Scholl, 2001, Philips 2004 and Murdock, 2004). The results of debates for 20 years now have culminated in fairly narrow and wide stakeholder definitions. The narrowest sense considers a stakeholder as "any group or individual who can affect or is affected by the achievement of the organisation's mission" (Freeman, 1983). Later in 1984, the word "mission" was interchanged with "objectives" (Freeman, 1984). From this perspective, stakeholders in an organisation would include stockholders, employees, the management, customers, suppliers, the government, and partners.

Since the stakeholders have different stakes in the organisation, the way they affect or are affected by the organisation will differ. This has led to classifying key from non-

key stakeholders, depending on the magnitude of risk shared by the individual or group (Reed, 1999, Clarkson, 1994, Cohen, 1995 and Scholl, 2001). A wider definition takes the term stakeholder to embrace "all those who have legal, moral, or presumed claims or who have the capacity to affect an organisation's behaviour, direction, processes or outcomes" (Mitchell *et al.*, 1997).

The above definition is adopted in this study because it takes care of all possible scenarios of stakeholder relationships under PPPs, particularly where collaborations are still taking shape as is the case in Tanzania. This wide perspective will therefore allow room to explore a better understanding of stakeholders' partnerships in health service delivery in the country.

As noted above, stakeholder theory is primarily a private sector firm theory. It challenges the neo-classical economic theory of the firm and maintains that the firms that are managed for the good of stakeholder satisfaction thrive better than those firms that only pursue purely profit motives (Scholl, 2001 and Marcoux, 2000). Stakeholder theory asks three critical questions. "Who are the stakeholders, what do they want, and how they are going to try to get it" (Frooman, 1999). Despite the fact that stakeholder theory is primarily for the private sector firms, the insights from this area can be applied in part to public sector settings. This line of argument is well grounded by Monroe (1995), that in the public domain public officials often contract out services to organisations (outside government and with different motives) on behalf of clients or end users.

The fact that in effect the beneficiary is not the purchaser is a challenge, which is worth enquiring into. Therefore, here the study is interested in answering the questions: Under PPPs what was agreed to be jointly done, what was done, who is gaining what and to what extent?

Under stakeholder theory, the private sector, the government and the community can all gain from PPP if there is trust and cooperative endeavours rather than opportunistic and selfish behaviours (Jones, 1995). This theoretical underpinning considers the utility of PPPs as being beyond power relations and fulfilling contractual obligations to a caring approach to stakeholders. In this case, as is well argued by Reed (1999), citizens as part of the key stakeholders under PPPs have a genuine stake in, and in our case, accessible, affordable, reliable and quality health services. Following such arguments, let us consider the conceptual framework in Figure 2, which displays the interactive nature of stakeholder theory.

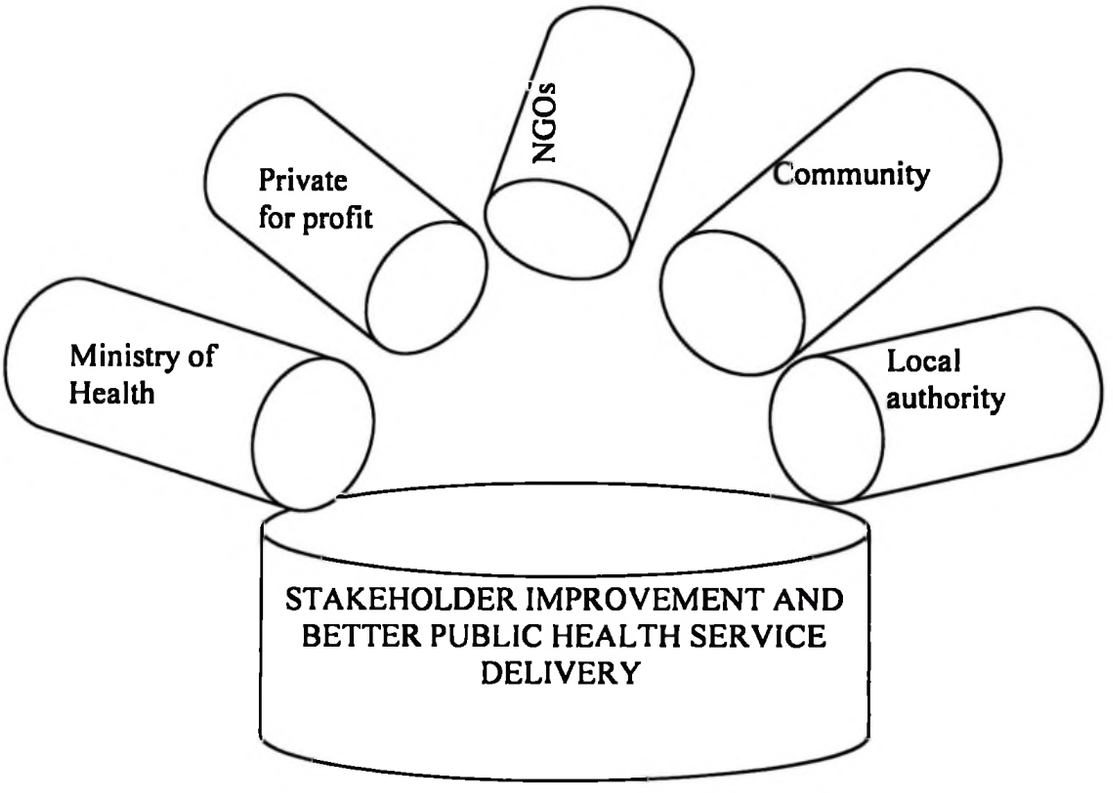

Figure 2: Conceptual Framework for Stakeholder Partnership

Source: Adapted from Bennet *et al.* (1999); Brinkerhoff (2002); Sohail *et al.* (2003).

The framework presented in Figure 2 considers a scenario for a win-win situation for all stakeholders. The government may gain through enhanced capacity to deliver health services to citizens while NGOs will also improve capacity to deliver and achieve value for money and any humanitarian goals (Fiszbein, in Collins, 2000).

The private sector will equally improve capacity because;

e) It is assumed that it has the skills and resources that will benefit public sector services.

f) It has commercial incentive, which will lead to increased efficiency.

g) It will focus on customer requirements.

h) It has new and innovative approaches and business management expertise (HM Treasury, 2000).

The community and individuals will have better types of access to quality and reliable health care services (Fukunyama, 1995, Fiszbein and Lowden, 1999). The central government and Ministry of Health are expected to provide policy and other regulatory frameworks and hence have indirect links with the private sector. The local authority is an implementer and monitor of partnerships.

Although these positivist outlooks applaud the power of PPPs in enhancing public service delivery (IRI and NBI, 1998; Birmingham, 2000; and Austin, 2000), there are also frequent doubts from anti-globalisation movements and the moral version of stakeholder theory (Gray and Hay, 1986). These two schools of thought provide a critique of the utility of PPPs, particularly where the government and or the private sector are weak in terms of motivation and resources required for partnerships and forging effective responsibility and accountability mechanisms (Humes, 1999; Reich, 2000; and Hartwich *et al.*, 2003). Such limitations are likely to make the most powerful stakeholders gain at the expense of the general public (poor, less informed, less influential) but also there is a theoretical opportunity for every stakeholder to perform better under PPPs than working alone. Field data is expected to shed light on this aspect of a rather knife-edged balance of interests and expectations between stakeholders.

In order to get more groundwork on this theoretical pursuit, let us now turn to the global vision for public health improvement.

2.3 Global vision for health improvement

The Millenium Development Goals (MDGs) have placed the community (citizen) at the centre of the agenda, with responsibility for improving health resting on the government and private sector working together. In terms of child health, there is a target to lessen child mortality by two-thirds by 2015, a goal that will require substantially expanded efforts. It was estimated that in 1999, 10.5 million children died before reaching their fifth birthday, most of them from developing countries (Ahmad *et al.*, 2000). A large proportion of these deaths were due to a few conditions, namely pneumonia, diarrhoea, malaria, measles, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), and malnutrition. With the exception of HIV/AIDS, these conditions could have been relatively easily prevented and treated, as illustrated by the insignificant number of child morbidity and mortality cases in developed countries (Bustreo *et al*; 2003).

The role of the private sector in health has always been appreciated by the public and governments in developed, developing and less developing countries, although there have also been some instances of limitations in terms of meeting stakeholder expectations. The position of the private sector in health service provision is briefly reviewed.

2.4 The role of the private sector for profit and NGOs in health service provision

Although international institutions and governments in developing countries have concentrated on working with and through the public sector (Hanson and Berman

1998; Brugha and Zwi, 1998), an increasing amount of data highlights the private sector's critical influence on health in developing countries, including the health of poor children. Indications are also emerging that it is possible for governments in poor countries to achieve better health outcomes by working with the private sector.

For almost two decades now there have been consistent accumulating indications that private and non-governmental health care providers are more commonly consulted than those in the public sector for diseases that commonly affect children (Waters *et al.*, 2002; Sharma, 2000). In Vietnam, research revealed that the private sector provided 60% of all outpatient contacts (Ha, 2002).

In India, more than 90% of children affected by diarrhoea were taken to private health care providers (Rohde, 1997). In Nepal, more than 50% of children suffering from diarrhoea and acute respiratory infections (ARI) were treated outside the public sector (Kafle *et al.*, 1992). Similarly, a large proportion of children affected by these conditions received services from a range of private providers in Bolivia (Berman and Rose 1996), Egypt (Waters *et al.*, 2002), Guatemala, and Paraguay (Berman and Rose 1996). Also, like diarrhoea and ARI, identification and treatment of malaria was frequently done outside the government health sector in many countries (McCombie, 1996). It is anticipated that PPPs will enrich rather than weaken the supposedly good job done by the private sector.

It has also been found that even poor households often seek health care from private practitioners, oftentimes, pharmacists, drug-sellers, and traditional practitioners. Gwatkin *et al.* (2000) established that in most countries children from poor and rich

households are taken to private providers. A study conducted in 38 countries on the treatment of ARI and diarrhoea for children from the lowest income quintile shows that the proportion of the poorest children receiving care from private providers ranged from 34% to 96% for diarrhoea and from 37% to 99% for ARI. Whereas private providers render a large proportion of curative and preventive services, research has raised concerns regarding the technical quality of private health services and the effects on children's health and nutrition status (Alubo, 2001). The same study shows that the prescription practices of private providers are often worse than of those in the public sector and yet are more trusted than the public providers.

There are also abundant publications which describe the widespread unnecessary use of antibiotics for treatment of diarrhoea diseases and non-complicated ARI (Muhuri *et al.,* 1996; Langsten and Hill 1995). Inadequate usage of oral rehydration salts (ORS) for treatment of dehydration by private providers has been raised in a number of countries, including Bangladesh, Nigeria, Pakistan, Sri Lanka, and Yemen (Siddiqi *et al.*, 2002; Igun 1995; Tomson and Sterky, 1986). In another study in Mumbai India, it was found that most private practitioners used diagnostic and treatment practices for malaria that were discrepant from guidelines from WHO (Kamat, 2001). In Vietnam, research has revealed that under-dosing of anti-malarials was common and there was lack of knowledge of the suitable nutritional therapy (Cong *et al.,* 1998).

When the private and NGOs are compared, NGOs are indisputably credited for moving beyond service delivery and making a significant contribution to the construction of dispensaries and health centres, mother and child survival/programmes, HIV/AIDS counselling centres and curative medical services (Landin, 1987; Mollel,

1999). With such a preference for private sector health service providers, it is anticipated that more focused harnessing of these efforts and those of other actors would lead to gains for each partner and even more so, the general public. A survey of experiences worldwide reflects success as well as limitations in working through partnerships. Let us delve into these areas in more detail.

2.5 Experiences in PPPs in health service delivery in developing countries

2.5.1 PPP success cases

It was noted at the concept level that, globally, PPPs have been initiated to achieve a number of objectives. They would include improved quality, coverage, reduced costs, cquity, and reduced administrative burden. There are many success cases of institutional arrangements of PPPs in health service provision. Regulations and standards are used to improve the quality of health and related goods and services under partnerships.

Non-compliance with regulations has been addressed differently depending on the nature of the problem at hand. For example, when the private sector promoted the unnecessary use of infant formula, WHO and UNICEF developed an international code for the marketing of breast-milk substitutes.

A number of countries have applied related regulations to the production and distribution of such substitutes (WHO, 1985). For example, this strategy was successfully used to decrease the distribution of free and low-cost infant formula in the Philippines (Popkin *et al.*, 1990). Today, most developing countries have some form

of basic regulations concerning health personnel, such as registration and licensing requirements, restrictions against dangerous or unethical health services, and legislation on the production and distribution of drugs (Bennett *et al.*, 1994).

Accreditation of health-care-providing institutions and medical staff has been suggested as an option to assure the quality of private sector health services (Brugha and Zwi, 1998). Bangladesh utilised professional experts and NGOs leaders to develop policies for the best management of PPPs in 1998, although as will be noted later, formulation of policies and regulations is one thing, but making them work is another.

In El Salvador, the Ministry of Health joined with a private sector organisation (the Foundation for Health and Social Development) to promote a new model of primary health care provision based on the integration of the private service model with that of the San Julian municipality. The result was that health care was extended to rural areas which public services never reached (Jacir de Lobo, 1999; in Fiszbein, 2000). Similarly, in the state of Lara in Venezuela, the nutrition programme reached 300,000 children daily, four times the number reached without partnership with the private sector. The partnership was between the government (financier), two pasteurising companies (provided below the market rate for pasteurised milk, invested in oral nutritious products, distribution support) and mothers who were distributors (Bilbao and Pochano, 1999; in Fiszbein, 2000).

In Bangladesh, (Ahmed, 2000) found that the Bangladesh Rural Advancement Committee (BRAC) assisted the government health care activities through social mobilisation and delivered basic services such as child immunisation, and reproductive health.

In terms of modalities, some public health services were delivered more efficiently through contractual agreements with the private sector in some areas of Zimbabwe, while in South Africa, the overall costs were comparable or higher than direct provision by the government agencies (Mills 1998; Mills *et al.*, 1997). When government service provision in India and South Africa were compared, data suggest that the quality of services provided by contracting with private actors was similar or better in some cases. For example, cleanliness was improved but it was lower for nutritional services (Mills, 1998). No sufficient data exist to suggest that contracting out improved service coverage (Abramson, 2001).

Contracting out in Madagascar and Senegal was reported to be successful in the provision of nutrition services to poor households. Marek *et al.* (1999) has found that in Senegal, severe malnutrition went down from 6% to 0% among children aged 6 to 11 months and moderate malnutrition among children aged 6 to 35 months decreased from 28% to 24%. Similarly, in Madagascar, the proportion of malnourished children in the contracted region decreased from 30% to 10% between 1994 and 1997.

A combination of strategies, which involved health care experts and the community, was one of the reasons for success. Community nutrition were contracted out to

provide growth monitoring of children; education sessions for women; referral to health services for children and pregnant women; home visits; and food supplements for malnourished children. The institutional arrangement included a process of community participation in the selection of contractors. Lack of capacity to manage and supervise the contracting process is often put forward as a major bottleneck. To alleviate this problem, in Madagascar and Senegal, NGOs were used as the intermediate actors in managing and supervising contracts. Universities and other research institutions were also utilised to carry out operations, research and impact studies. The mechanism through which this strategy aimed to improve children's nutritional status was an increase in the supply and quality of nutritional services. One of the potential constraints in the replication of this project was that it used a project management unit for implementation and monitoring, which cost between 13 and 17% of the total budget (Marek, *et al.,* 1999).

In Cambodia, contracting out was successfully applied to increase access to child health services. NGOs were contracted to deliver a package of services at the health centre level, which consisted of preventive services such as immunisation, family planning, antenatal care, and nutritional support, and curative care for diarrhoea, ARI, and tuberculosis. Utilisation of facilities and coverage for services such as immunisation and antenatal care improved for the population that used contracted services compared with the control group, which used services provided by the DHS and the Ministry of Health (Loevinsohn, 2000, Bhushan *et al.,* 2002). Better management, supervision, and higher salaries addressed the problem of health staff not

coming to work regularly. The Ministry of Health was involved extensively in designing, monitoring, and managing the contracts.

The main targets of the PPP intervention included the contracted NGOs and their health workers. The mechanism of this approach was an expanded supply of health services. A potential constraint in the replication of this project is that the contracted districts received more resources than the others did. Partnerships in information dissemination and training were used to influence the behaviour of both the private sector and the consumers of health and related goods and services. A recent review found that interventions addressing only provider knowledge were unlikely to succeed (Tawfik *et al.*, 2002), and customary classroom teaching could have a limited impact (Ibrahim and Isani, 1997; Choudhry and Mubasher, 1997).

More innovative approaches achieved superior results. For example, interventions in Indonesia and Kenya that included one-on-one meetings between educators and pharmacists and drug sellers achieved significant increases in the sales of ORS and decreases in the sales of antidiarrhoeal drugs (Ross-Degnan *et al.*, 1996). Since private actors are influenced by patient expectations (Paredes *et al.*, 1996; Thaver *et al.*, 1998), approaches that combine provider training with consumer education were seen to be more likely to yield the desired behaviour changes (Chakraborty *et al.*, 2000).

A project in Pakistan combined these two components and achieved important improvements in the clinical case management of sick children, as measured by how

the providers applied the Integrated Management of Childhood Illness (IMCI) approach (Luby *et al.*, 2002).

Another successful example is an intervention to improve the quality of care for sick children provided by private practitioners in the Indian state of Bihar. Substantial improvements in private practitioners' case management of ARI, diarrhoea, and fever were documented (Chakraborty *et al.*, 2000). The quality of care was evaluated through a verbal case review with mothers of children who had recently received care. The mothers were also informed of correct case management practices for different diseases.

Deficiencies in care practices revealed during the review were then addressed with the provider through the following: Provision of relevant information on case management; feedback on treatment practices; negotiation of unpaid contractual agreement specifying changes in practice; and monitoring of compliance. In this case, the intermediate actors included NGOs and community health workers, who were responsible for carrying out the intervention. Private practitioners and mothers were the targets. The mechanism was a reduction in demand from mothers for inappropriate care, and increased receptivity for appropriate services. An inherent constraint in the replication of this strategy is that private providers are extremely varied, so that efforts to identify and inspire priority practice changes will need to be tailored properly.

PPPs through commercialisation and social marketing are also strategies used to improve public health in many countries. They have been applied to issues such as use

of soap for hand washing to prevent diarrhoea (Saade *et al.*, 2001), ORS to treat diarrhoea (Ferraz-Tabor, 1993; Koul *et al.*, 1991), and insecticide-treated bednets to prevent malaria in Tanzania (Schellenberg *et al.*, 1999; Schellenberg, 2001). Research has shown that commercialisation and social marketing have positively influenced the use of ORS by increasing knowledge and motivation for health improvement at the community level (Koul *et al.*, 1991; Ferraz-Tabor, 1993).

Improved hand-washing practices and reduced diarrhoea rates were achieved in Central America using commercialisation. This programme worked with private producers of soap and with the media to encourage better hand-washing practices among rural groups with low socioeconomic status in Costa Rica, Guatemala, Honduras, and El Salvador. Hand-washing behaviour improved and the prevalence of diarrhoea decreased by 4.5% among children under 5 years of age (Saade, *et al.*, 2001).

A project task force developed public health messages, while soap producers used their marketing skills to promote hand-washing with soap. The project conducted baseline market research to analyse the hand washing behaviour of the targeted population. Since this was a multinational initiative, national ministries of health and education were intermediate actors. Additional intermediate actors were NGOs, foundations, and the media, which implemented radio and television advertisements to promote the campaign. Households were the targets of the intervention and were involved through media campaigns, outreach education efforts, and as recipients of soap samples. The

mechanism for reducing the incidence of diarrhoea was to increase the demand for, and the supply of soap for hand-washing, as well as improved hand washing practices.

2.5.2 Limitations of PPPs in health service delivery

These celebrated successes are equally challenged elsewhere (Richter, 2000, Hardon, 2001). There are strong feelings that, since PPPs involve bringing together different stakeholders with different missions, goals and objectives, pursuance of individual motives at the expense of the targeted beneficiaries of the partnership is a possible visible danger. The risk becomes larger if there is no effective institutional framework for stakeholder accountability. For example, the aim of Baby Milk Action, an NGO based in the UK, was to save infant lives and end the avoidable suffering caused by inappropriate infant feeding by supporting the implementation of independent, transparent and enforced controls on the marketing of baby food.

In contrast, Nestlé, which manufactures breast milk substitutes, was to participate in industrial, commercial and financial enterprises, particularly in food and related industries (Rundall, 2000). These incompatible organisational objectives are worth examining before PPPs are suggested, because profit-seeking behaviours may be hidden behind doors and often under the umbrella of international NGOs and or drug companies. Regulations could assist to reduce extremes in profiteering tendencies. This has always been an uphill endeavour.

Research has shown that inadequate resources are often allocated to monitoring and enforcing regulations (Brugha and Zwi 1998; Birungi *et al.*, 2001; Ibrahim and Isani, 1997). It is also very difficult to have regulations that are robust and at the same time flexible enough to take on board all stakeholders' interests. This makes regulatory potholes in any PPP arrangement a common phenomenon (Birungi *et al.*, 2001; Kumaranayake *et al.*, 2000).

Most powerful stakeholders, regardless of whether they are strong or weak, may capture policy and regulatory frameworks (Ngalande-Banda and Walt 1995; Soderlund and Tangcharoensathien, 2000). For example, in supporting major NGOs in Bangladesh, foreign donors were at times alleged to put pressure on the government to reduce or withdraw state regulations and controls that were essential for ensuring the accountability of NGOs to the citizens and the government (World Bank, 1996). The pressure on the government may become tenser if both international and local NGOs use the local elite and the influential politicians to pursue self-centred interests.

Given that NGO leaders are not elected and hence not directly accountable to the citizens, and the elected leaders may work for the interests of the more powerful stakeholders because of some gains, the citizens who are the core expected beneficiaries would be left unprotected. Even where local leaders may have influence, services under partnerships may be structured and distributed on the grounds of patronage and clienteles. Although this tendency is common in third-world countries (Humes, 1999), these countries are not alone. In the USA, James Curley, the Mayor of

Boston, strengthened his political base by concentrating public services through contract arrangements in order to benefit Irish Catholics at the expense of Protestants (Glaeser and Shleifer, 2002).

In Mexico, Dianz-Cayeros and Magaloni (2002) found that, when the government spent 1.2% of GDP on water, electricity, nutrition and education in poor communities in 1989, they did not work as expected, mainly due to patronage practices. Municipalities dominated by the party in power received significantly higher per capita transfers than others. This discriminatory approach led to a target achievement of only 3%, against an expected 64% and 13% if the poor had been targeted.

Other limitations of PPPs include less programme participation on the part of service recipients and hence lack of sustainability (Hardon, 2000). Unfortunately, such critical issues may not be discussed and agreed upon during the partnership initiation period and may surface later when it is too late, particularly when the government is in urgent need of health support from whatever source is available.

2.6 Urban-rural dichotomy in public health service provision

There are differences between what could be termed "urban" and "rural" areas. Such differences are clearer in developed countries than developing ones, mainly due to levels of poverty. For simplicity purposes rural areas are considered to be all those areas outside the jurisdiction of municipalities and townships and here reference is made to the Tanzanian Urban and Local Authorities Act No 7 and 8 of 1982

respectively. Therefore rural areas are village level communities, where most people live that are poorer, less educated, more remote, and more economically vulnerable compared with urban centres (Sigh, 1999). The nature of poverty is often associated with historical developments from primitive societies, colonialism and even after independence (Chambers, 1983; Lipton, 1983; Kapinga, 2003). Systematic isolation of rural areas from active socioeconomic development and wrong and biased perceptions of rural people and their basic needs have by and large aggravated the rural-urban dichotomy.

In terms of public health service provision, urban bias is widely documented. Khoon (2000) has found out that, in Malaysia, PPPs led to the expansion of secondary care hospitals in urban centres at the expense of rural people, and more resources for acute care at the expense of primary health care mostly needed by the poor in rural areas. Negative attitudes towards rural people leading to mistreatment by health practitioners are also noted in many cases including being hit by staff (Mtemeli, 1994) and clients feeling not respected as one commented thus " ... they have their noses up the air and neglect us" (WHO, 2002). There are also differences between private for profit organisations and NGOs working with rural people. Private for profit are more interested in PPPs around town centres, related to curative rather than preventive activities, because of the profit motive, while NGOs are more credited with working with rural people and covering both preventive and curative activities (Reinikka and Svensson, 2003; Kopoka, 2000). To what extent the Tanzanian government has practically addressed these disparities in effecting PPPs is an interesting area of enquiry.

2.7 Assessing PPP performance through stakeholder theory

As observed from the previous sections, former studies have focused on the assessment of health service delivery and not the partnership itself. Most of the indicators used to assess health service delivery depend on the particular taste of the researcher but also in a way include some of those suggested by the World Health Organisation (WHO). These are descriptive in nature and focus on provider/receiver perceptions of the efficiency and effectiveness of the services provided. The indicators include change in monthly average attendance, perceived changes in service improvement, percentage improvement in doctor contact hours, percentage change in waiting time, clinical/technical quality, facility utilisation and geographical distribution of service providers (WHO, 1990). These indicators were also adapted in Ghana (Haran *et al.*, 1994).

Other researchers have proposed other indicators including, availability of medicine, sufficiency, and equal access (Warioba, 1999). In terms of analysis, the common methodology has been descriptive statistics and narratives (WHO, 1990, Haran *et al.*, 1994, Weakliam, 19994). In this study, assessing PPP performance through stakeholder theory implies going beyond service recipients' perceptions. It will involve starting with identifying stakeholders' motives for partnerships and performance indicators and targets. The next step will be to assess the institutional framework set up for PPPs , their contribution and the effects on each key stakeholder.

2.8 PPPs in public health provision in Tanzania

2.8.1 An overview of socioeconomic performance

According to the 2002 national census, Tanzania has a total population of 33.4 million with an annual growth rate of 2.8 percent. The majority of the population (77%) live in rural areas, while 23% reside in urban centres (URT, 2002). Throughout its four decades of independence, Tanzania has remained one of the 10 poorest countries in the world. It is estimated that more than half of the Tanzanian population lives below the poverty line of US$ 0.65 per day. Tanzania's per capita gross national product of US$265 is lower than the Sub-Saharan Africa average of US$500 (World Bank and Government of Tanzania, 2001). The average gross domestic product (GDP) growth rate has been 3.7 percent since independence, despite an average population growth rate of about 3 percent over the same period (World Bank and Government of Tanzania, 2001

2.8.2 National public health status

Health service delivery in Tanzania is provided through a decentralised three-tier pyramidal system, that is national, regional and district levels, where in the latter there are health centres and dispensaries (MoH, 2003). Different organs work together to ensure access to quality health care in the country. The Ministry of Health and Social Welfare (MoHSW) is responsible for policy, governance, financing and quality assurance, while the Prime Minister's Office Regional Administration and Local Government (PMO-RALG) is the implementer. At the national level, Executive Boards manage hospitals. At the regional and district levels, there are Regional and

Council Health Boards respectively, on which private health service providers have representatives.

The 1999 Reproductive and Child Health Survey has revealed the following health status:

i) Infant Mortality Rate was estimated at 99.1 deaths per 1,000 live births

ii) The Mortality Rate of children under 5 years of age was estimated at 146.6 deaths per 1,000 live births.

iii) The Total Fertility Rate (TFR) in Tanzania for women aged 15-49 was 5.6.

iv) There were rural/urban differences – the TFR for rural women was almost twice that of urban women: 6.5 against 3.2 respectively.

v) There were also differences between educated (TFR 4.9) and non-educated women (TFR 6.5)

vi) Antenatal care utilisation was nine out of 10 births which is very good

vii) Among women who give birth, the majority (60.9 percent) in urban areas sought care from a nurse/midwife.

viii) Most rural women (50.1 percent) sought care from a health aide (URT, 2000 c)

Despite high levels of access to antenatal care, only 44 percent of women delivered at a health facility in 1999. This rate has steadily declined since 1992 (53 percent) and 1996 (47 percent). The HIV/AIDS pandemic has shortened life expectancy and is depleting the productive and skilled segment of the population (Guijada and Comfort, 2002). The HIV/AIDS pandemic, coupled with other factors including poverty, has reduced life expectancy to 44 years for males and 46 years for women. This is lower than the average for sub-Saharan Africa (49 years for men and 52 years for women). A study by MoH, (2003) which also covered other indicators has found continuing disturbing patterns as can be observed from the following figures: Infant Mortality Rate was 115/1,000 per live births; crude Birth Rate is 46/1,000 live births Crude death rate is 19/1,000 live births; Maternal Mortality Rate was 500/100 000 live births. Child Mortality Rate was 191/1,000 live births. Population per physician was 1/ 1 8637; and population per trained nurse 1/5 397.

Public health service provision in Tanzania is mainly managed through a bureaucratic network. The health network consists of about 4 990 dispensaries, of which the government through the MoHSW and PMO-RALG owns 3 035. From this number of the government-owned facilities, 409 were health centres providing primary care services. These were linked to 208 hospitals that included district and regional hospitals as well as 4 specialised hospitals.

The remaining health provision facilities belonged to various groups. These are Parastatal Organisations, Religious and Non-Religious NGOs, Community-Based Organisations (CBOs) and private for profit providers. MoH (2003) estimated that there were approximately 65 000 health personnel engaged in the health care delivery

system in the country, of whom 70% are in the public sector and the remaining are employed by NGOs or the private sector. The Ministry of Health is obligated to provide both curative (hospital) and preventive services to the public.

The strategy of the Ministry is to promote good quality health care at primary, secondary and tertiary levels by the provision of cost-effective preventive and curative services to all areas, supported by a network of government, NGOs and private hospitals to provide referral services for more complex health problems. Findings from Dodoma Municipality suggest that health sector performance was not doing well. For example, the infant, child and maternal mortality rates are high because of the prevalence of common diseases including malaria (37%), URTI (17%), eye diseases (15%), Diarrhoea (14), Gonorrhoea (5%) and skin diseases (4%). (Dodoma Municipal Report, 2003).

2.8.3 Trends in public health service delivery reforms in Tanzania

Since independence, health service delivery in Tanzania has been under the government's prerogative. Prior to independence, Tanzania's health system was concentrated in urban areas and services were essentially curative in nature (URT, 2001). In 1967, the Arusha Declaration stated that the government would finance and provide free medical care to all of its citizens (with the exception of grade one and two) and this was made part of community rights and was one of the fundamental indicators of social development (Abdallah, 2002). As part of that declaration, an expansion strategy for facilities, especially in the rural areas was adopted. Results of the strategy were impressive.

By 1978, a clinic was located within 10 kilometers of 90 percent of the population (Benson, 2001). In line with its free-health-for-all policy, private for-profit health services were forbidden. The private sector for profit was particularly hard hit by the enactment of the Private Hospitals Regulations Act of 1977, which banned health services for profit in the country.

Private non-profit health facilities operated by non-governmental organisations, however, continued to provide a large share (currently about one-third) of the health services in the country with subsidies from the government. Despite inadequate revenues, the government adhered to these policies throughout the 1970s and 1980s. Under funding led to shortages in supplies of drugs, deterioration of facilities, low staff morale, and poor quality of care (MoH, 1998). The importance of the private sector in health service delivery and the move towards market-based economic reforms resulted in the establishment of the Private Hospitals Regulation Amendment Act of 1991. It also facilitated the re-establishment of private medical and dental services with the approval of the Ministry of Health in 1991 (Wyss *et al.,* 2000; URT, 2002).

In July 1993, under pressure from the World Bank and the International Monetary Fund, the government started a phased implementation of user fees for health services in its referral, regional, and district hospitals. To ensure that the poor and those who needed care most were not barred from accessing care because of inability to pay, the Ministry of Health developed waiver and exemption guidelines (Mubyazi *et al.*, 2000).

The demand for better services and the need to improve the population's health status, particularly the rural poor, led to the development of Health Sector Reform (HSR) proposals in 1994 and in 1996 the government approved a health sector reform strategy. Later the Health Sector Reform Plan of Action for 1996-1999 was also endorsed. The action plan included six strategies: decentralisation, improvement of central health systems, health management, financing, human resources, and partnership. In 1999, the HSR Programme of Work 1999-2002 and Action Plan were developed.

In order to devolve more power at the local level, Local Government Reform (URT, 1998) was passed as a policy instrument to facilitate decision making and accountability in municipalities and district councils on public health-related matters amongst others. These policy documents made clear the government's intention to work closely with the private sector for profit and NGOs.

Therefore, the health sector reforms are closely linked with Local Government Reform, which aimed to decentralise personnel, planning, and financing decisions of service delivery to the districts. As of January 2000, 35 districts had been decentralised. Forty-five more districts were to be decentralised by January 2001 and the remaining ones by January 2002 (URT, 2001). Districts are responsible for staffing decisions and set service priorities. District health plans are funded through block grants, in addition to donor funding provided through the basket financing mechanism.

A significant emphasis has been placed on human resource development to ensure adequate planning and budgeting of services. This is part of capacity building initiatives stirred by on-going reforms. Implementation of health plans is monitored and additional funds are withheld if standards of achievement are not accomplished. The Ministry of Health retains control of policy, regulatory, and strategic functions and also continues to provide certain essential services, including immunisations, family planning, and the treatment of chronic illnesses, tuberculosis, and leprosy.

In 2000, the Ministry of Health (MoH) developed key performance indicators and outputs for assessing public private partnership in health service delivery in the country. The indicators are the degree of collaboration among partners in terms of numbers, the contribution of the private and public sector in partnerships and client satisfaction rate. The performance of PPPs was expected to be through the following implementation strategies and timeframes. Policy and legal review to be completed by 2001.Mechanisms for promoting PPP discipline in place by 2002. Guidelines to private providers to enable them qualify for government support, and mechanisms for joint inspection of health facilities and employees, to be in place by 2002 (MoH, 2000).

Much as these general and disjointed policy intentions are useful, there is no solid national policy and legal framework for PPPs in health service delivery which could be compared with other countries, including the UK, Morocco, Bangladesh and South Africa. Although it may not be necessary to have a national policy and legal

framework to guide PPPs at the local level because local needs and capacities may not require it, such a framework is still necessary for a poor country like Tanzania.

The first reason is that the government is still in the process of shaking off the socialist mindset and the remnants of reverberations of conflict and suspicion between the public and the private sector that had prevailed for about 30 years. Secondly, natural differences in values and goals between the more powerful private sector and the weaker government, which needs to protect the public, cannot be left without a solid regulatory framework. The need to balance stakeholders' interests through policy and regulatory mechanisms is forcefully supported worldwide (Gilson and Thomas, 2003, Batley, 2004, World Bank, 2004). It is therefore difficult to avoid taking a skeptical position regarding the existing PPPs in health service delivery in the country and hence the call for initiating decisive process of enquiry.

The above PPP assessment indicators will be useful but require refinement and modification in order to be able to capture sufficient indicators of PPP assessment at the level of each key stakeholder. This will become clearer in the methodology section. The third level of assessment will be assessing individual stakeholder performance before and after the PPP as guided by individual objectives, performance indicators and targets.

Since the ultimate aim of PPPs is better efficiency and effectiveness of public health service delivery, the last level of assessment will be a comparison of stakeholders' perceptions of public health service improvement before and after PPPs.

2.8.4 Health service delivery and the role of the private sector in Tanzania

A few studies available provide limited information on the role of the private sector in health service delivery. For example, a study by Kavishe (1990) shows that 75% of the modern health service provision system was under the government, while the private sector shared the remaining 25%. However, despite the strong role of government in service delivery, peoples' attitude was in favour of the private sector for profit and NGOs when the quality of services was used as a criterion of performance. Furthermore, UNICEF (1997) found out that 80% of patients could not get drugs from public hospitals compared with 40% in NGOs- managed health centres and hospitals.

Long waiting times, corruption and costs have been the major concerns of people regarding public health service delivery systems (Tibandebage *et al.,* 2001 and Mackintosh and Tibandebage, 2002). While government service delivery is often accused of unnecessary bureaucracy, delays, corruption, lack of resources and commitment, the private sector and NGOs are more credited with inter alia, flexibility, motivation, innovation, and sustainability. In rural areas of the United Republic of Tanzania social marketing of insecticide-treated bed nets reduced child mortality due to malaria by almost 30% (Schellenberg *et al,* 1999) and reduced the prevalence of anaemia by 63% (Abdullah *et al.,* 2001). Treated bed nets were packaged and branded after research had identified household perceptions of malaria, and preferences regarding mosquito nets and net treatment. Health workers, shopkeepers, religious leaders, and village government members were recruited in each village as sales agents (intermediate actors). Bed nets were sold through both public and private outlets and a

system of community door-to-door selling. Bed net producers and households were the targets of the strategy.

Competition between producers was encouraged and taxes were removed from both netting material and treated bednets. Households were sensitised through a comprehensive information, education, and communication campaign. The mechanism to achieve reduced malaria mortality was the increase in production, demand for, and use of treated bed nets. A study conducted jointly by the Ministry of Health (MoH) and National Institute for Medical Research (NIMR) found various forms of collaboration between the public and private sector in Tanzania. They include supervision of private hospital staff by District Health Management Teams involving private hospitals in preventive and curative care, supervising private hospitals, involving private health service providers in meetings, data collection, training, service delivery, and sharing of resources. However, the knowledge of how such partnership arrangements facilitate each stakeholder in accomplishing individual and joint values and objectives through the process of health service delivery is lacking (MoH and NIMR, 2000).

Having reviewed PPPs and stakeholder concepts alongside service delivery experiences worldwide, and in Tanzania for that matter, it is now important to turn to the summary of what has been achieved both in theory and practice and what remains to be done, which is the substance of this thesis.

(b) At the theory level, it was noted that Stakeholder Theory is based on assumptions about the nature of private sector organisations, the reasons for their existence and their *modus operandi*. The application of this theory to situations where private for profit, NGOs and government collaborate for public goods and services has been proposed in the literature (Monroe, 1995, Jones, 1995, Reed 1999, Fiszbein and Lawden, 1999, Fiszbein in Collins, 2000, Hartwich *et al.*, 2003). They also remind that the primary objective of purely private organisations is profit while on the other hand NGOs are more interested in increased capacity to deliver and give value for money.

In regards to governance, the government would expect to have improved capacity to deliver services in terms of access, better variety, and reliability, which are necessary for effective political ends (Fukunyama, 1995, Fiszbein and Lowden, 1999). This is also the wish of the citizens as primary stakeholders of PPPs. At the empirical level, it has been observed that the assessment of PPPs has been disjointed, perhaps in order to capture specific issues. The main concern has been on strategies, successes, limitations and challenges of partnerships in terms of governance and quality improvement, using a wide spectrum of indicators.

A substantial number of cases of PPPs has been reviewed earlier on and there is no need to recapitulate them here, but they include those in: UK, (Rundall, 2000, Milburn, 2004) and USA (Hardon 2000, Kimble, 2004, Glaeser & Schleifer, 2002). Others are Latin America (Plaza *et al.*, 2001, Bilbao and

2.9 Summary, research gaps and the analytical framework

From the beginning of this chapter, the focus has been to define key concepts, locate this study within the stakeholder model and review PPP experiences worldwide. Therefore, it is now important to briefly summarise what has been done so far and what remains to be done in PPP research and discourses, which is exactly what is achieved in chapter four, which is a useful contribution to academia, public policy and PPP practices.

(a) At the concept level it was noted that there is no one acceptable definition of Public Private Partnership. Some prefer to label PPP as any collaboration between government and non-government actors to share resources for a common goal (Fiszbein in Collins 2000, Buse and Walt, 2000). This rather soft outlook of PPPs is based on the idea that PPPs are by nature voluntary and hence cannot be rigorously managed by using strict policy and regulatory frameworks.

There are also those who define PPPs in a stricter sense whereby the words effective allocation of resources, shared risks and expertise are more emphasised, implying a situation where there is rigorous PPP enforcement mechanisms (Common Wealth, 2003). There are also those who support both definitions and suggest a continuum of PPP relationships (Brinkerhoff, 2000, Bennet *et al.*, 1999, and Sohail *et al.*, 2003). It is therefore the interest of this thesis to attempt to define and locate the Tanzanian position within this PPP continuum or otherwise.

Pochano, 1999 in Fiszbein, 2000), Africa (Reinikka and Svesson, 2003, Verhallen, 2000) and Asia (World Bank, 1996, Hashem, 1995, Aminuzzaman, 1998). Indeed these are substantial learning grounds of PPPs experiences. Nevertheless, at the heart of PPPs, is how are they understood by different partners and what are their motives for collaboration, who contributes what, gains what, and to what extent is either lacking or taken for granted? This is what the thesis addresses.

Furthermore, it was raised with concern that some partners may be stronger than others, play greater roles, exercise more power and control of PPPs for personal interests (Humes, 1999; Reich, 2000; and Hartwich *et al*; 2003). This study intends also to take up the challenge of finding out how different stakeholders' objectives, contributions and gains are balanced for the better or worse of PPPs.

(c) It was again observed that PPP initiatives started to take shape in Tanzania in 1991 and since then various statements have been issued in support of PPPs (Wyss *et al.*, 2000, URT, 1998,URT 1999). Some documents have outlined government intentions for working with the private sector and even developing a strategic plan for implementation expected to end in 2004 (MoH, 2000). It is further understood that PPPs in public health service delivery do exist (MoH and NIMR 2000, Tibandebage *et al.*, 2001, Mackintosh and Tibandebage, 2002). The literature has also indicated that, where PPPs were successful, they were facilitated by national policies and regulatory frameworks (Gilson and

Thomas, 2003, Batley, 2004, World Bank, 2004). How possible is it that there are PPPs in public health service provision in the absence of robust and specific policy or regulatory frameworks to guide the same in Tanzania after more than 13 years now, and who gains what out of it, requires an answer. That answer could be found in the strength of informal relationships and trust (Fiszbein in Collins, 2000; Buse and Walt, 2000). This is also what the thesis has examined.

These research gaps are filled through operationalisation of variables indicated in the analytical framework shown in Figure 3. The framework starts with the assessment of PPPs from the nature of PPPs and the motives of each key stakeholder. These determine the PPP models adopted and contributions of each partner in the PPP basket and the effects as consequences (see the arrows).

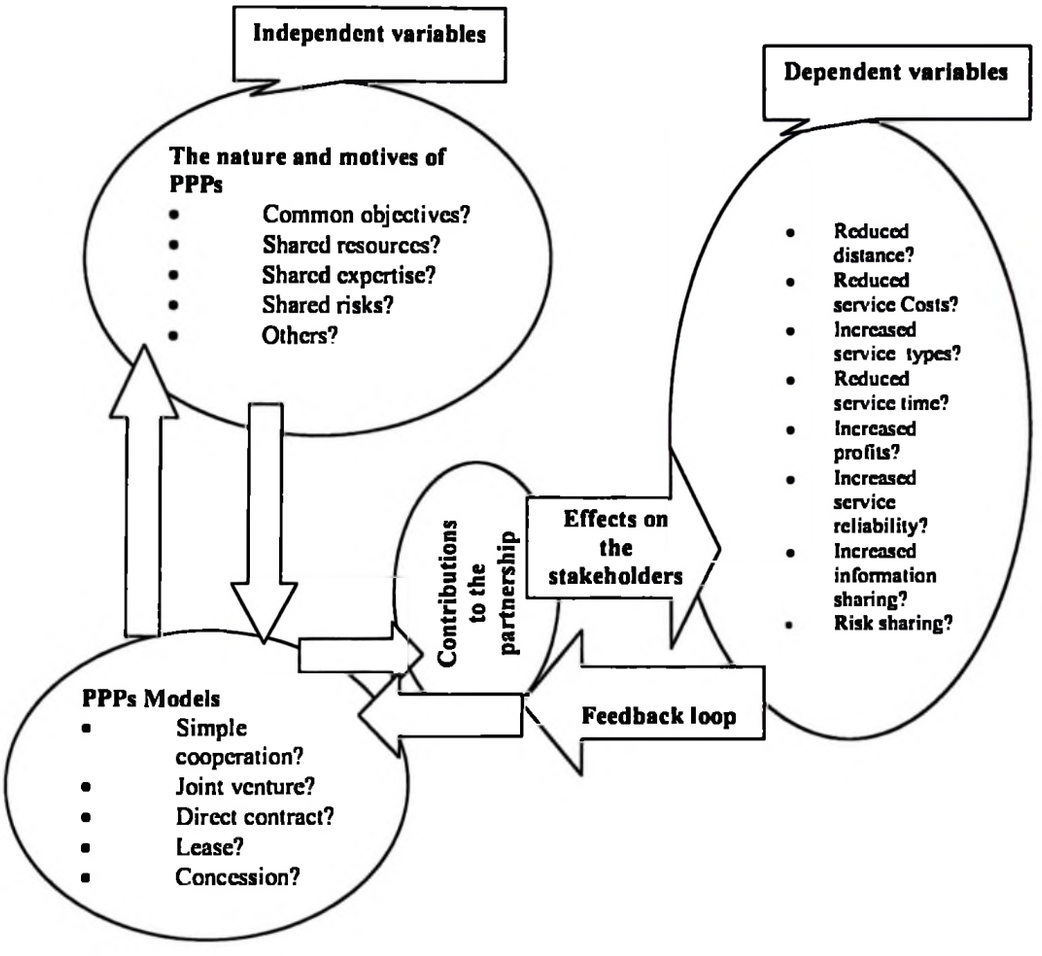

Figure 3: The analytical framework of the thesis.

Source: Designed PPP models and stakeholder theory (Sohail *et al.*, 2003)

The effects of the process are captured by eight variables on the right hand side of the diagram. The effects of the partnerships could be positive or negative. This constitutes feedback to the contributions, models and the nature and motives. In order for the partnership to continue to benefit each stakeholder, the process has to be rejuvenated through dialogue.

CHAPTER THREE

3.0 METHODOLOGY

3.1 The study area

The study on public private partnership was conducted in Dodoma Municipal Council (DMC) and Dodoma District Council (DDC) from March to October 2005. Dodoma was chosen for three reasons. Firstly, it is one of the leading regions with PPPs for health service provision in the country (MoH and NIMR, 2000). Secondly, by using cluster survival indicators, Dodoma Region is the last in the regional ranking (URT, 2003). Thirdly, since it is government strategy to reduce poverty through improving private public mix in rural areas (URT, 2005), conducting this study by comparing the urban and rural areas is useful for policy feedback particularly on efforts to reduce the urban- rural inequality in public health service provision.

3.2 Research design

The research design was a cross-sectional case study. The choice of this design was not arbitrary. It was guided by the nature of the research questions and the scope of the study. The study focused on three "What" types of questions and one "how" type of question, which had to be answered in the shortest period possible in both exploratory and evaluative style, and at the same time minimise the influence of continuous changes in the study areas (Yin, 1994, Simon and Burstein, 1985).

3.3 Sampling

3.3.1 Sampling for PPP Cases

3.3.1.1 Dodoma Municipal Council (DMC)

The PPP cases were sampled purposefully because the focus was on the health service providers, which were in collaboration with the council. Dodoma Municipal Council has 58-health service provision centres: Three hospitals (two owned by government and one owned by the private provider). Five health centres (three owned by government and two by private providers) and 49 dispensaries (21 owned by government and 20 by the private sector). From that list of health service providers, eleven (11) cases had PPP components in health service provision and hence made up the study sample.

In terms of administration, Dodoma Municipal Council has five divisions and 30 wards but all private service providers were clustered in the Dodoma urban division with the exception of only one case of Bihawana Dispensary in Zuzu Division owned by the Roman Catholic Church. In areas without private health service providers, the Council established dispensaries and in more remote areas, services were provided through outreach arrangements. It is important to note that most of Dodoma urban area has the characteristics of a rural setting. Out of 30 wards, 16 are categorised as rural, six are mixed and eight are urban (URT, 2003). This was a challenge during data analysis because the concept of the rural-urban dichotomy between the Municipal Council and District Council did not feature very well. There were 11 cases of PPPs in health service delivery, as shown in table 1.

Table 1: PPP Cases in Dodoma Municipal Council

S/N	PPP cases	Division	Ward	Ownership
1	Hombolo Hospital (Leprosarium)	Hombolo	Hombolo Bwawani	Religious (Diocese of Central Tanganyika- DCT)
2	Dr. Matovolwa Health Centre	Dodoma Urban	Chamwino	Private for profit provider
3	Aga Khan Dispensary	Dodoma Urban	Madukani	Religious (Hindu Community)
4	Mackay House Health Centre		Madukani	Religious (DCT)
5	St. Mary Immaculate	Dodoma Urban	Miyuji	Religious (Roman Catholic-RC)
6	Tumaini Dispensary	Dodoma Urban	Hazina	Private for profit provider
7	Vyeyula Dispensary	Mackay House Health Centre	Dodoma Urban	Religious (RC)
8	Bihawana Dispensary	Zuzu	Mbabala	Religious RC
9	Nzuguni Dispensary	Dodoma Urban	Nzuguni	Religious RC
10	Ntyuka Dispensary	Dodoma Urban	Kilimani	Community owned
11	Michese Dispensary	Dodoma Urban	Mkonze	Community owned

Source: Dodoma Municipal Council Comprehensive Health Plan (2003

The only PPP case where the community was involved was the construction of Ntyuka dispensary through the combined efforts of the DMC, Italian NGO (Centro–Mondialita-Reciprocco -CMR) and a local NGO (Agricultural and Livestock Production Development Association -ALPDA). The other one was Michese dispensary, although the role of the municipality and community was very limited because KONOIKE Construction Company built the dispensary without involving the community in terms of contributions of labour, materials or cash. However, these two cases were also included in the study.

There was no partnership in the supply of drugs and health service equipment. All drugs and equipment were procured from the Medical Stores Department (MSD) and distributed to different health centres and dispensaries by using council staff and transport. The major explanation was that all procurements were directed by guidelines from the Ministry of

Health for the purpose of quality control. Therefore, the study could not cover pharmacies and drug sellers.

3.3.1.2 Dodoma District Council (DDC)

Dodoma District Council has eight divisions, 48 wards and 128 villages. It is served by 81 health service facilities. There was no private for profit health service provider in the district because people depend on better and cheaper services from the church based providers. The inability of rural areas to attract the private sector is common in the country. The other anomaly was that all the cases belonged to the Roman Catholic Church with the exception of Mvumi (the so-called designated District Council Hospital), which was under the Anglican Church, Diocese of Central Tanganyika. There were five religious NGOs, which worked together with the council to provide public health services. Table 2 provides the summary.

Table 2: PPP Cases in Dodoma District Council

S/N	Cases	Division	Ward	Village	Ownership
1	Mvumi Hospital	Mvumi	Mvumi Mission	Not applicable	Religious (DCT)
2	Chikopelo Dispensary	Chipanga	Chipanga	Not Applicable	Religious (RC)
3	Mlowa Bwawani Dispensary	Makangwa	Mlowa Bwawani	Mlowa Bwawani	Religious (RC)
4	Bahi Sokoni Dispensary	Bahi	Bahi	Not Applicable	Religious (RC)
5	Itiso Dispensary	Itiso	Itiso	Not Applicable	Religious (RC)

Source: Dodoma District Council Comprehensive Health Plan (2003)

Based on these facts, there was no point in sampling PPP cases. All the five cases were included in the study. However, partnerships between Dodoma District Council and Mlowa Bwawani, Bahi Sokoni and Itiso were limited for a worthwhile detailed study. Hence, these cases are described very briefly in the findings as a matter of making a note.

3.3.2 Sampling for the key informants

Sampling for the key informants was purposeful (Bailey, 1994). The interest was on people with specific information on PPPs in health service provision. Key informants on policy and legal issues from the Ministry of Health (now Ministry of Health and Social Welfare- MoHSW) and the Prime Ministers' Office Regional Administration and Local Government (PMORALG) were involved in the study. The objective was to get the general picture of the relationship between PPP practice on the ground and government policies and future expectations. At the Council level, Directors, Heads of Departments and General Nurses were included in the sample. Others were Owners and Managers of private hospitals, dispensaries and General Staff. Ward Officers and Village Chairpersons were also included in three cases because the partnerships involved the community in terms of various contributions. Therefore, the total sample of key informants was 106. Table 3 shows the number of key informants in each of the PPP cases.

Table 3: The number of informants from Ministries, DMC, DDC, and Health Centres

Organisations	Key Informants				Total
	Directors	Manager/Owner	Heads	Staff	
MoH SW	1	0	4	0	5
PMO-RALG	1	0	1	0	2
DMC	1	0	4	6	11
DDC	1	0	4	2	7
Mackay House	1	1	2	3	7
Dr. Matovolwa Health Centre	0	1	2	2	5
Aga Khan Dispensary	0	1	2	2	5
Nzuguni Dispensary	0	1	2	1	4
St. Mary Immaculate	0	1	2	2	5
Veyula Dispensary	0	1	2	1	4
Tumaini Dispensary	0	1	1	1	3
Hombolo Hospital	1	1	3	1	6
Mvumi Hospital	0	1	3	2	6
Chikopelo Dispensary	0	1	2	0	3
Bihawana Dispensary	0	1	1	1	3
Total	**6**	**11**	**34**	**26**	**78**

As noted earlier on, since Mlowa Bwawani, Bahi Sokoni and Itiso dispensaries were not significant PPP cases, general information was obtained from the Priest In charge for health services in Dodoma Roman Catholic Cathedral.

For the Ntyuka and Michese dispensary projects, the sample had a different composition. Some were community leaders and others were funded by NGOs. Table 4 displays the key informants.

Table 4: The number of informants from community projects and funding NGOs

Organisation	Managers	Ward Executive Officer	Village Executive Officer	Workers	Total
Michese	0	1	1	0	2
Ntyuka	0	1	1	2	4
CMR	1	1	1	2	5
ALPDA	1	1	1	2	5
Total	**2**	**4**	**4**	**6**	**16**

It was planned that village welfare committees and community health workers would also form part of the sample. Unfortunately, these were not in a position to give any useful data. One representative from private for profit health service providers and one from faith- based health service providers were also part of the sample.

3.3.3 Sampling for service beneficiaries

It was necessary to get the opinions of individuals who participated in and benefited from particular services under partnerships rather than relying on the key informants alone. This category of sample was useful to generate survey data for quantitative analysis of the effects of health services on the community as a partner. Data obtained were complementary descriptive data (Kerlinger, 1964., Bailey, 1994., Yin, 1994). The sample was drawn systematically from the general population that visited service provision centres on different days.

The procedure was to pick every third patient in the queue waiting for services. In cases where such patients were not willing to participate in answering the questions, the next third person was picked until the desired sample size was obtained. In each of the 11 partnership cases (9 from the DMC and 2 from the DDC), 15 respondents were selected, making 165 health service beneficiaries. The choice of 15 respondents for each case was

based on purpose, sufficiency and economy. The purpose of the questionnaire was to get the opinion of the service recipients to complement data from key informants.

Since most respondents were from the same socioeconomic background and participated in almost the same types of health services, it was not anticipated that a larger sample size would make a significant impact on the conclusions, particularly when time and costs are considered (Yin, 1994). In the case of Mackay House, respondents were visited at their homes because they were HIV/AIDS sufferers and it was difficult to meet them elsewhere. The average age of repondents was 28 years with an average of 2.6 children each. Other sample characteristics are shown in tables 5 -6.

Table 5: The sample size of health service beneficiaries (N= 165)

Study Areas	Sample size	Percent
Dodoma Municipality	135	81.8
Dodoma District Council	30	18.2
Total	**165**	**100.0**

Data in Table show the distribution of the sample size skewed towards Dodoma Municipal area. This is a reflection of the disparity between rural and urban areas in terms of distribution of health services as well as partnerships.

Health service seekers were mostly from the same ward because each ward had a dispensary run either by the government through partnerships or purely by local authorities. Where the respondents came from a ward outside the place where the health facility was located, they were visitors of their relatives. At the research design stage, it was planned that the sample would also be categorised according to villages and streets. This was not practical, particularly in the urban areas because the demarcation line

between one street and another was not clear to all respondents. Since this categorisation was not critical in addressing the research questions, the idea was dropped. Table 6 summarises sample distribution by ward. .

Table 6: Sample distribution by Wards (N = 165)

Ward	Sample size	Percent
Hombolo Makulu	15	9.1
Nzuguni	15	9.1
Msalato	15	9.1
Chali	14	8.5
Chipanga	2	1.2
Hazina	15	9.1
Mbabala	15	9.1
Kizota	15	9.1
Madukani	15	9.1
Ihumwa	15	9.1
Mvumi	15	9.1
Miyuji	14	8.4
Total	**165**	**100.0**

Usually Mother and Child Health (MCH) services are gender biased. It is rare to find men attending clinics. Of all the 165 respondents, there were only 6 men (3.6%). Some of these men went for vaccination against tetanus, others for taking TB tablets and one for treatment of bilharziasis, which was a government programme to eliminate the disease in Chali ward.

3.4 Data collection methods

3.4.1 In-depth interviews

Formal in-depth interviews were useful because they helped to capture detailed data, clarify issues and cross-check the reliability of data through verbal and non-verbal expressions. As emphasised by Guba (1990), since there is no one reality of phenomena, close interaction between the researcher and the interviewee is useful in "discovering" meanings from the interviewees. This created an opportunity to validate opinions through

more questions, through listening, and observing body language until consensus was reached rather than rushing to take notes (Alwin, 1991; Denzin and Lincoln, 1994). In-depth interviews were used to collect data on the nature and motives of PPPs, models, contributions to the PPPs and effects on the stakeholders as owners and or managers. To facilitate the process of enquiry, an interview guide was constructed and used for each category of key informants. The structure and the details of the guides are attached as Appendix 3. Lists of items were used as checklists in order to capture specific variables and indicators that were difficult to capture in general interviews and as guidance in the interview process itself (Johnson, 2002). The checklists collected data on "the nature and motives for PPPs" and "PPP models". For more details of the structure and contents of the checklists, see Appendix 3.

3.4.2 Questionnaire

In order to tackle the "what are the effects of PPPs" on service beneficiaries, an opinion survey was conducted with the PPP cases (Yin, 1994). Semi-structured questions were administered to a sample of 165 health service beneficiaries. In order to maximise the response rate, avoid misunderstandings of questions by respondents and omissions, " a survey interview technique" was used as guided by Royce *et al.* (2002); Alwin, (1991); Cannel and Oksenberg (1981), that is the researcher had to sit with the respondents during the filling in of the questionnaire. This technique was a very useful motivator given that most respondents were either standard seven leavers or below and not exposed to answering questions through writing. Therefore, the researcher was able to repeat the questions for clarity and solicit clarification through further probing. For more details about the questionnaire in terms of structure and contents, see Appendix 3.

3.4.3 Documentary review

Several documents were reviewed. These were Municipal and District Profiles, Comprehensive Health Plans, Strategic Plans, Private Hospitals Act 2002, applications for health service provision licences, Supervision Reports. Others were, MTUHA (Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya Na 2.1), which is a guiding document for standard recording of medical care provision for patients, the Procurement Act, 2004: Local Government Act, 1982 and technical reports on PPPs in the health sector commissioned by the then Ministry of Health (now the Ministry of Health and Social welfare).

3.4.4 Focus group discussions

There were three PPP cases, which were involved in outreach programmes in RCH. These were Hombolo, Veyula and St. Mary Immaculate. It was important to get the opinions of the beneficiaries in this category because they were not represented in other groupings. The best method to collect data was focus group discussions, because the services were delivered in open and sunny gatherings, with very limited chairs to allow for interviews. Also, the objective was to capture opinions on health service-seeking behaviours at St. Mary Immaculate and government centres. Therefore focus group discussions were held with two groups (Seven members each) of mothers who attended clinic services at Ndachi village under St. Mary Immaculate-DMC partnership as a representative of the other two cases.

One group comprised women who only attended RCH services in the village and the other was for those who attended RCH services as well as other outpatient services at St. Mary Immaculate dispensary. The task of identifying the groups, the request for participation in

the study and arrangements for the discussion was done through consultation with and support from the village ruling party chairman where the health services were housed. Figure 4 shows an assembly of women and their children listening to RCH staff instructions on health issues before vaccination. Vaccination services and distribution of anti-worms medications were done through the combined efforts of one nun from St. Mary Immaculate dispensary and two MCH staff from Dodoma Municipal Council.

Before discussions, the chairman and RCH staff were asked not to be around in order to avoid possible influence of the results. The group members were briefed on the objective of the study and asked to be free to give their opinion, and that no name would be mentioned anywhere when a particular individual gave specific comments unless such an individual gave consent. The participants were asked by the researcher to allow him to write some notes during discussions. In addition to that, an audio tape recorder was used to keep record of the discussions. Some group members were comfortable to let their opinion be recorded while others were hesitant. However, the recording was successful.

The discussions started with general questions, leading to specific ones. Each group member was given an opportunity to agree, disagree or just maintain neutrality. At times, some members felt uneasy speaking in Kiswahili, but as the discussion progressed, the discussions became livelier. Initially, it was planned that men and women would be separated, but no man came for mother and child clinic services.

3.4.5 Community meeting

The use of meetings for data collection was useful in community-based projects where there was community assembly for communal work. Meetings were used to get data from

Ntyuka and Michese villages where there were constructions of community dispensaries. There were two types of meetings in Ntyuka village. One meeting was held with the Ntyuka village government and the second with the community. A public meeting was arranged jointly with the Ward Executive Officer and Village Executive Officer in Ntyuka village. Figure 4 shows the introduction of the researcher to the community meeting by the village chairperson.

Figure 4: Community meeting at Ntyuka village: Consent of the group participants

The meeting provided useful inputs in assessing the nature and motives of PPPs, the models, the role of the community as a stakeholder and expected benefits.

One meeting was held with the village government officials in Michese village. These officials were useful because they were well informed and were able to provide sufficient information about the dispensary project.

3.4.6 Observation

Observation schedule was used to record comments on the quality of the working premises, procured materials, fittings, and equipment, working tools, protective gear, medicines, laboratories and other accessories (See Appendix 3).

3.5 Data processing and analysis

3.5.1 Qualitative data

Qualitative data was processed by using "themes, patterns, clusters and relationships" techniques (Huberman and Miles, 1994). Data from interviews, focus group discussions, meetings, and rich texts were cleaned, summarised and organised according to PPP cases. In each case, major and minor themes were developed. Three major themes were identified. The first theme was the nature and motives for PPPs, secondly PPP models and thirdly the contribution of each stakeholder to the PPP basket. These were independent variables. Thirdly data were collected on the effects of PPPs on the stakeholders (dependent variables). Each major theme was further disaggregated into several minor themes as guided by the analytical framework (see Figure 3 in chapter 2).

The first major theme was categorised into five minor themes: These are common objectives, shared resources, expertise, risks and "others". The second one was sub-divided into simple cooperation, joint venture, direct contract, lease and concession. The third was on the contribution of PPPs which formed categories ranging from 32 to 39 (see Appendix 4). Qualitative data on the effects of PPPs on service providers were organised into service costs, profits, risk sharing, information, and capacity to deliver services.

The first theme (nature and motives of PPPs) and the second one (PPP models) were analysed by using Grounded Theory approach where the content analysis technique is the major analytical tool because the objective of the theme was to come up with a conceptual understanding of the PPPs in the study areas (Denzin and Lincoln, 1994, Manning and Cullum-Swan, 1994). Grounded theory approach focuses on language and interpretations based on actors' point of view. Content analysis is basically analysing verbal or written texts based by comparing with other sources of knowledge. Pattern marching is about relating findings from one case to another in a style that makes comparisons.

Data from the checklist and in-depth interviews were used to complement each other in a narrative style (Manning and Cullum-Swan, 1994). This was useful, not only for testing data validity (Kerlinger, 1964, Bailey, 1994), but also for unearthing the context in which positions were reached through check lists. From the data categories, a 'Pattern Matching" technique was used to analyse data (Yin, 1994).

The third theme "contribution of PPPs" and the fourth theme "effects of PPPs" on the key stakeholders other than service beneficiaries, both frequency and content analysis techniques were used. These tools created an opportunity to synthesise data and discuss the relationships between percentages in pie charts, documented data, focus group discussions, meetings and observation of the situation on the ground. Since the study was exploratory where the process model under stakeholder theory was used, content analysis, cross-case analysis, and pattern-matching techniques were used to support each other in reaching a general conclusion (Yin, 1994, Jones, 1995, Reeds, 1999).

3.5.2 Data from questionnaire

The objective of the questionnaire data was to obtain that to measure the statistical significance of the PPPs to the service beneficiaries. The variables covered were reduced distance, service types and numbers, service waiting time and reliability. To determine the influence of PPPs on distance to the health facility, service variety, service waiting time and reliability, Analysis of Variance (ANoVA) was used at 0.05 level of significance. To separate the effects of PPPs on the continuous variables, T test was used to compare pairs of PPP cases. For categorical variables, including background of the respondents, frequency analysis was used.

3.6 Pilot study

Before the commencement of the major research, a pilot study was conducted in Dodoma Municipal Council, Dr. Matovolwa Health Centre and Aga Khan Dispensary. This was important because PPP is an emerging new field in service delivery in Tanzania, and it was difficult to establish strong research methodology without a clear understanding of the general picture in the field. The pilot study helped to refocus the type of sample and sampling techniques, the structure, content of the questionnaire and interview guides.

3.7 Data quality and limitations of analysis

Quality control of data is not an easy task. It requires vigilance and taking back-stopping measures throughout the research process and more importantly during the question-setting stage. Although most researchers fear to acknowledge the weaknesses of their data, lest they are criticised for not being careful enough and even being called "journalists", it is important care should be taken and the ground cleared sothe data are trustworthy.

To start with, it must be acknowledged that interviewing people during working hours has its own limitations. There were frequent interruptions from colleagues and customers which reduced concentration and focus on the topic at hand. In order to minimise the negative effect on the quality of data, the researcher had to postpone the interview until the next visit. In some other instances, interviews changed into group discussions because some staff joined in the process and it was difficult to refuse their participation. This was a strength because many issues were covered in a relatively short time but also it was a limitation because there were possibilities for staff to be "too" selective on what to tell the researcher that would not be too critical. To reduce that risk, some interviews were held informally on different visits.

Even in cases where the interview was completed, other visits were made to clear up doubts that were observed in the data. There was also data comparison from different interviews (government and private), and from different departments in the same organisation. Reference to the available records was also made to ensure that there was reliability in the whole set of data, although such data was on the number of customers served and the basket fund and not on the description of PPP which was of most importance to the researcher.

On the part of the questionnaire survey, despite the pre-testing, it was not possible to continue without further fine tuning of the questions, including adding more questions that seemed relevant or even skipping others. It is also important to mention here that estimation of the annual income was reached after considerable discussion and trying to come up with various sources of income per week and month. Therefore, the figures recorded were just rough estimates in the eyes of the respondents. The number of

kilometres travelled was reached after some consultations with more informed people, verification from maps and at times recording mileage during field visits. Walking and waiting times before getting served were reached through general agreement. They are estimations that considered the location of the respondent and the ability to walk when ill. Data on travel costs was based on a one-day trip for one member of the family. Although it was said that some money was saved, most people walked and a few used their bicycles. All in all, despite the limitations, the findings should be taken by any reader as reflecting the true picture of the PPP experiences in Dodoma.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSIONS

4.1 An overview

The chapter presents, analyses, and discusses the research findings in a style that starts with a summary of the profile of the PPP cases, followed by answering the research questions posed in the background chapter as guided by the analytical framework. This approach is intended not only to make the reader get an insight into the cases studied, but also to be able to link the study findings with the PPP and stakeholder discourses.

4.2 The profile of the PPP cases

The PPP cases studies had different backgrounds, ownership and areas of collaboration. Appendix 4 summarises the profile of the case studies.

It is learned from Appendix 4 that, it was difficult in a number of cases to establish the actual year in which collaborations started. The reason is that, there were no records because collaborations started informally where specific individuals were involved who were no longer in office. Indeed some collaborations were as old as the institutions themselves. For example, Hombolo and Mvumi have had some form of collaboration with the government since the 1960s.

There were less important cases of collaboration that were not worth a detailed study but are also important to describe briefly just for the awareness of readers. These are Mlowa Bwawani, Itiso and Bahi Roman Catholic dispensaries in Dodoma district

council. According to the Dodoma Diocese Health Secretary, these dispensaries are the result of the efforts of Holy Ghost missionaries who started mission work in Kondoa district in 1907. Later, Passion Fathers spread the missionary work to other parts of Dodoma, including Mlowa Bwawani, Itiso and Bahi. In order to cater for health services for the church community, infirmary centres were started within the parish buildings.

As demand for services from the surrounding communities increased, these centres grew into dispensaries where patients were charged minimal costs in order to sustain the services. The heads of the dispensaries were parish priests being supported by nuns as secretaries-cum- practitioners. Usually services were delivered by nuns with minimum medical qualifications or who just learned through experience. Other supporting staff were usually medical attendants who had no formal medical education. Thcy learned from experience and by doing. Partnership with the Municipal Council has been in the form of "invitation for training" which is offered by the Ministry of Health to all health providers in the country.

The dispensaries benefited through training of their staff. Unlike other cases, there were no partnerships in reproductive and child health because there were government-owned dispensaries near these mission dispensaries. According to the church based health services coordinator in the municipality the partnership has not taken serious roots because there was no significant commitment by all the parties concerned. The church saw the dispensaries as micro projects for the parish priest "to earn some income" while the government officials looked at the church-based health providers as

private domains. These experiences are similar in Chikopelo dispensary.

4.3 Assessment of PPPs in health service delivery

The assessment of the PPP in health service delivery in Dodoma Municipal Council and Dodoma District Council follows the pattern suggested in the research objectives, questions and the analytical framework in chapter one. In order to avoid duplication and repetition, and also since there were only two PPP cases from Dodoma District Council, the findings from the two study areas are presented jointly. Where differences could be explained by the rural-urban dichotomy, an observation is made.

4.3.1. What is the nature and motives of PPPs in Dodoma?

4. 3.1.1 The observations

As a starting point, the understanding of the nature and motives of PPPs in Dodoma was approached by using four variables adopted from conventional PPPs and stakeholder theory, because strong PPPs should have common objectives, shared resources, expertise, risks and any other variable that could be identified by this study. For each of these variables, specific indicators were used as proxies (see Appendices 1 and 2). Since the information collected was in the form of "Yes", "No" or "Do not know", data that are more detailed were generated through probing of key informants whereby specific experiences were discussed and documented. This led to massive descriptive data, which posed challenges on the choice of data presentation and, analysis techniques, that is, how to organise responses according to the categories and numbers of interviewees as well as cases. However, as mentioned in the methodology chapter, in qualitative studies, and more so in exploratory researches, what matters

most is not what was said by whom, and by how many people, but what are the general themes and patterns which give new insights and generate knowledge (Guba, 1990, Kerlinger. 1994, Huberman and Miles, 1994, Yin, 1994). Following the same logic, since data were drawn from different respondents from different PPP cases, data reduction had to be done in order to fit particular themes (variables) and sub themes (indicators), which were the building blocks in the thesis. This was followed by the Pattern Matching technique in displaying the findings as shown in Table 7.

Table 7. Pattern matching and cross case analysis

S/N	PPP Cases with the Municipal/ District Council	Variables on the nature and motives of PPPs				
		Are there common objectives?	Are there shared resources?	Are there shared expertise?	Are there shared risks?	Others variables?
1	Mackay house health centre	Implied	Yes	Yes	Not identified	-
2	Dr. Matovolwa health centre	Implied	Yes	Yes	Not identified	-
3	Hombolo hospital	Implied	Yes	Yes	Not identified	-
4	St. Mary Immaculate dispensary	Implied	Yes	Yes	Not identified	-
5	Veyula dispensary	Implied	Yes	Yes	Not identified	-
6	Nzuguni dispensary	Implied	Yes	Yes	Not identified	-
7	Tumaini dispensary	Implied	Yes	Yes	Not identified	-
8	Aga Khan dispensary	Implied	Yes	Yes	Not identified	-
9	Bihawana dispensary	Implied	Yes	Yes	Not identified	-
10	Ntyuka community dispensary	Yes	Yes	Yes	Not identified	Shared planning and management?
11	Michese community dispensary	Implied	Yes	Yes	Not identified	Inter-stakeholder conflicts?
12	Mvumi hospital	Implied	Yes	Yes	Not identified	-
13	Chikopelo dispensary	Implied	Yes	Yes	Not identified	-

Data in Table 7 show that the question on the nature and motives of PPPs were set within the parameters of established or implied "common objectives", "shared resources", " shared expertise", " shared risks" and " "any others". The findings match a pattern

which is described as 'implied" Yes", No, "Not identified", "Shared planning and management of PPPs projects", and "inter-stakeholder conflicts".

It is not an easy task to give all the detailed data that led to the above patterns because of bulkiness and also more details can be obtained from Appendix 5. However, despite this limitation, a description of the variables is a worthwhile endeavour to make the findings more concrete. To do that, Mills (1906) in Denzin and Lincoln 1994) and also supported by Bailey (1994) and Nachimias and Nachimias (1996) have recommended the use of "Narrative Technique" derived from ethnology in data analysis in a style that is acceptable in social science research. By adapting the same ethno-methodological approach, each variable in Table 8 can be analyzed by referring to multiple data sources.

a) By referring to the aspect of whether the nature and motives were based on established common objectives, data from key informants varied from "Yes", "No" and "Do not know". The former finding was by implication rather than from a direct answer, that is, it was common knowledge that the objective of the collaboration was to improve health service delivery to the community. However, since there were no fora for arriving at that common understanding, some interviewees felt that there were no common objectives. Some did not have the answer because they were not involved in the negotiations for collaboration. This made the PPP objective somewhat intuitive and indeed a matter of common sense for whoever was involved. It was assumed that, since services are for the people and organisations serve people, combined efforts

should benefit the people. This limitation contributed to a situation whereby there were neither specific established objectives for collaboration nor targets and monitoring systems.

The Ntyuka village dispensary was somewhat of an exception to this position because of the involvement of donors who were more systematic in their collaborative relationships to the extent of planning and management of the dispensary project. Michese project was also different because the community had been demanding rights for collaboration with Konoike Company to build a dispensary. Being a private organisation for profit and not interested in collaboration which would mean less profits, it was only through pressure and threats to ban the company from taking building materials from the village that made it give in to community demands. Therefore, this scenario has tempted the researcher to coin this form of collaboration as inter-stakeholder conflict-driven PPPs.

Therefore, since there was no common understanding of what each partner should gain from the PPP, including religious or moral benefits, or profits. This made it difficult to assess stakeholder benefits and performance in the most robust manner. Hence, an appropriate alternative of assessment was innovated.

b) Sharing resources for better health service delivery was the fundamental reason why partnership was needed. Each stakeholder had resources to share although not on an equal basis. These ranged from cash and infrastructure to materials.

Michese community dispensary was a peculiar case. Konoike contractors built the dispensary using their own finances and expertise.

The community contribution was the building plot and permission to use community stones and sand. Later, the community had to come in to build a pit latrine and provide security. This was an initiative taken by the village government rather than planned in the process of project ideation. There were plans to continue with the project by adding more buildings through community-Dodoma Municipality- Ministry of Health collaboration. The community expected to receive furniture, fittings, staff and drugs from the Ministry of Health through the Municipal Council. However, since the council had not budgeted for the project in advance, despite persistent follow-up, such contributions were not forthcoming. Therefore, since the dispensary could not be opened, the village leadership, community, and the council were in serious conflict to the extent that the leadership lost trust in the eyes of the community. Villagers boycotted participation in providing security for the building, and in finishing building the pit latrines. Village leaders were also reluctant to put more pressure on the community contribution lest they become too unpopular. The building was in danger of dilapidation because ants were already destroying parts of the wooden materials.

c) As in the case of sharing resources, each partner had some kind of expertise to share with the others depending on technical competence, experience and the location of the service provision point. This was commonly in the form of

using government specialists to train private health service providers, and using private health service providers to administer vaccinations on behalf of the municipal staff. In the case of dispensary projects, the municipality provided technical advice on drawings and engineering. More details of sharing expertise are covered in section 4.3.3 which deals with contributions to the partnerships.

a) In the conventional PPP the major reason why governments should engage in PPPs is to share the risk of service delivery. Risks are associated with the inability of the government to deliver the services effectively due to lack of resources, and even in cases where the resources are available, there might be failure due to a number of other reasons, including lack of technical and human competence, poor motivation, and tendencies for resource diversion from the poor (Commonwealth, 2003, Yamamoto, 2004, USAID, 2006). In theory, before any partnership commences, such risks have to be identified in a systematic way. Data from all key informants interviewed does not show that such risks were identified because as it shall be observed in section 5.2.2, there was no strong formalised system of engaging in collaborations. Commenting on the risk issue, one owner and manager of a private health centre said;

> Cholera outbreak is a public issue and, therefore, it is the government's responsibility to control it and treat patients when affected. We find it our duty too to treat cholera patients as quickly as possible before even the government comes in... It is very expensive and risky for our staff. It should be covered through partnership agreement but I have to bear it myself... also if anything goes wrong with patients who receive reproductive and child health services here I do not know where to go or who to ask because it does not seem that government officials are interested. ...I do not think

> that the public officials know the meaning of risk because they do not even come to ask how we are coping (Translated from Swahili).

The last column in Table 8 refers to "other" variables that might constitute partnerships. The Ntyuka and Michese cases reveal situations where one could have multiple actors coming together to complement community efforts. This finding adds value to many of the definitions of PPPs worldwide in that, apart from the four variables, PPPs could also go to the extent of joint planning and management of a PPP project or work through conflicts.

4.3.1.2 The lessons

These results give an opportunity to say that the nature of and motives for collaborations in Dodoma are centred on the need to share scarce resources and expertise in order to improve public health service delivery in general. How to go about collaborations, what each stakeholder aimed to achieve and how to assess the same, was met with silence. It remained in the mind of an individual person who initiated the partnership. Whatever that individual understood as the meaning of and motive for collaboration, the rest of the staff could not share.

Therefore, it is safe to say that PPPs in Dodoma emerged as formal-semi formal or informal arrangements for sharing available resources (including expertise) between the government and private sector organisations for direct or implied benefits to the key stakeholders. This statement summarises both the nature of and motives for PPPs in Dodoma. It becomes formal when there are formalised arrangements for collaboration but it is informal when personal relationships between staff of the partner

organisations influence the initiation and management of the collaborations. Benefits include resources, technical knowledge and profits.

This finding is in some ways similar to the conceptualisation of PPP adopted by Fiszbein, in Collins, (2000), that, PPP is "any arrangement between the public and private sector where there is a pooling together of resources". Since the term "any" in this definition does not tie all PPPs to specific models of collaboration, it is important here because all forms of collaboration between the private and public sector in principle are PPPs. Therefore, the term "any" covers formal, semi-formal and informal collaborations as captured by the cases investigated. While the findings concur with Fiszbein's conceptualisation of PPP, using the phrase "pooling together of resources" as a necessary condition for collaborations to fit into a PPP framework is stronger here than the cases could justify.

The cases do not reflect that there were strong efforts by each stakeholder to pool resources. It is more of "sharing available resources". Furthermore, Fiszbein has used the phrase "commonly agreed social goal" Although the goal of all PPPs observed in the study was supposedly social (to improve the health status of the people), this perspective may be misleading because it hides the reality that each partner has and should have organisational goals to be achieved through the partnership. Therefore, the omission of "key stakeholders' benefits", particularly profits for the private sector as a definition of PPP, shows that the private sector cannot commit resources without the assurance of substantial profits and so an appropriate assessment of the performance of collaboration cannot be made.

Unfortunately, and in fact similarly, the PPP cases in Dodoma were assumed to be for a social goal and so this could explain why no room was given for sorting out stakeholder benefits in a more focused manner rather than general community health improvement. This is a bit ambiguous because what community means may be unclear. For example, eleven out of thirteen cases enquired into the PPPs were on RCH services which are basically for sexually reproductive women and under-five children rather than the entire community of women and men.

By using stakeholder theoretical concepts, the study was able to introduce the concept of "benefits" including profits, as part of PPP effects on the partners (which justify going for PPPs) in the process of sharing resources. This has enriched any PPP definition because it underscores the rationale for rational collaborations between two or more parties. In this proposed conceptualisation of PPPs, the benefits become direct, where they are stated or implied when the whole PPP affair is semi-formal or informal and benefits are best realised in the course of sharing resources.

Commonwealth (2003) emphasises appropriate sharing of resources, risks and rewards as the fundamental characteristics of PPP. USAID (2006) and Hemming (2006) hold the same views. These characteristics are barely supported by the study findings for the following reasons.

a) PPPs did not use conventional typologies which the definitions were intended to support.

b) There were inequalities in the partnership relationships. The local authorities had all the regulations and opportunities to influence the partnership compared with the private sector because the latter was suppressed for many decades. This limitation is also noted and shared by Pierre (1998); USAID (1997); and Walt (2000) in their reviews of PPPs in developing countries. In addition, all the PPP cases depended mostly on cash, materials, personnel, and training from the Ministry of Health, donors or local authorities. This is contrary to the requirements of classical PPPs whereby the expectation is to have substantial transfers of technical, operational, and financial risks to the private sector (USAID, 2006). Indeed as well argued by Prefontaine *et al.* (2006) as a rule, PPPs are for public service by using private funds. In other words, if the government can do it effectively using, its own resources, the justification for PPPs collapses.

Therefore, the experiences from all cases (Dodoma Municipality and District Council) tend to support Brinkerhoff's (2000) position that there is no one common definition of PPP acceptable to all countries, service types and contexts. To support this line of argument, Bennet *et al.* (1999) look at PPPs as a continuum, ranging from simple to complex collaborative arrangements. Therefore, to re-echo Sohail *et al.*, (2003) the study confirms that,

> The types of partnership that have emerged most often in developing countries contain many variations not found in conventional definitions.... Many partnerships in developing contexts occur to respond to gaps in municipal service provision.

This position is further elaborated in the next section by reviewing the PPP models adopted in Dodoma and how they work to achieve the intended objectives regardless of whether they were direct or implied.

4.3.2. What are the PPP models in DMC and DDC

From the literature review, it is understood that there are four main PPP models that are used worldwide to manage partnerships in public service delivery (see Fig.1). Each model depends on the needs and context. In order to assess how the Dodoma PPPS fare, the same continuum of models was applied. In this study, the various PPP models are treated as variables and the characteristics of such variables as indicators. By using the same thematic and pattern-matching techniques, the results are displayed in the table attached as appendix 4 and described in the following section.

The findings in the table attached as Appendix 4 are important. With the exception of Ntyuka and Michese community dispensary projects, the indicators for the PPP models found in Dodoma can be described as "general semi-formal agreements" to share available resources and expertise for a social goal. This makes these models come somewhere between simple collaboration to joint venture in the PPP continuum as shown in Fig. 1. However, the word "agreement" here does not necessarily mean that there was what one may call "a meeting of minds" among the stakeholders or even the existence of a formal PPP document meant for legal enforcement in case of a breach of the agreement. It was more or less a matter of "give and take" or "ask and you shall be given if willing or if what is asked for is available".

For example, CMSR decided to work directly with the community without using the formal municipal bureaucracy because not only had the community and the government already played their roles but also because any formal engagement with the municipal bureaucracy would have continued to delay the work. According to the CMSR official, the municipal leadership had yet to be informed officially of the collaboration with the municipality, and it was planned that they would be informed when submitting a quarterly project development report which was an administrative matter. Village government officials also said that the municipal management was aware of the collaboration (through the health officer) but nothing more, because there had been no any formal communication from the village government.

It is not possible to give all the stories of all cases that show that PPPs have taken an informal rather than formal route because this thesis does not have enough space. However, Narrative, and Content Techniques of data presentation and analysis (Bailey, 1994) and the few descriptions from different cases that were either transcribed or audio recorded during interviews can best summarise some of the many stories and incidences in the form of rich texts quite often suggested by Yin (1994). The following is the list of extracted texts from notes written during interviews, focus group discussions and meetings.

a) Informality of PPPs

> ...The partnership is informal. It is mostly based on personal working relationships and friendship... It becomes formal when we write a letter asking for trainers for our programmes (we pay them)...they are represented on our health board... we invite them to our meetings but they do not invite us... We give them a copy of performance reports but

no feedback...We do not give an account to them because we do not receive any money from them... Our programme is more influenced by top-down programmes including Care Tumaini and National Aids Control Programme (NACP). We report to Care Tumaini and they report to higher organs like USAID and the Ministry of Health. ... I do not think they are interested in us when there is no payment of allowances (Quoted from Programme Manager- translated from Swahili version).

b) Initiation of PPP by the private sector

... I wrote a letter asking for MCH services in my hospital because I could see mothers passing here going to the General Hospital or Makole Health Centre and I thought I should do something about it. Instead of replying to my letter, they brought a refrigerator, vaccines and nurses. I gave them one furnished room where they provide their services to date.

c) The role of personal initiatives in establishing PPPs

...Our collaboration started a long time ago before the reforms. It was personal and depended on individual initiatives. We are trying to make it formal but the process is very bureaucratic and frustrating (Quoted from the head of the hospital- translated from Swahili).

b) PPP a the last resort and problems of transparency

... From 2000 to 2004, the hospital faced critical financial constraints, which led to inability to pay electricity bills, to repair vehicles, buy medicines and pay salaries. During the same period we requested support from the municipality but it was only in 2003 after an appeal to the Minister of Health that the municipality started to collaborate with us. In 2003, the municipality promised to pay 3 million Tanzanian shillings for supporting the running of the hospital but that figure remained in their book of accounts. There was no way to demand it because it was upon the discretion of the government to issue it or not. In the 2004/2005 financial year, the municipality supplied various items without consultation. I do not even know the value. I wonder how to account for them (Quoted from one Hospital In-charge- translated from Swahili version).

c) Local authority initiates collaboration

...Before opening the dispensary, it was the municipality, which requested a room to run MCH services in order to reduce distance and queuing at the Makole Municipal Health Centre (Quoted from the Dispensary In Charge- translated from Swahili)

d) PPP may not be demand driven

... The relationship is mainly supervisory as a duty of the District Medical Officer (Quoted from the head of MCH services- translated from Swahili version).

e) PPP as resource and expertise sharing

... Collaboration starts when they apply for a permit to open a dispensary. We give them a registration form... we visit their premises and when we are satisfied... we allow them to operate... we send our nurses there to provide MCH services or if they can do it themselves we supply them with a refrigerator and vaccines (Quoted from the Head of Health Services Department- translated from Swahili version).

f) PPP could start from the community side

Our councillor and member of parliament visited us and through that meeting we decided to build our own dispensary... we collected money, stones and we were ready to provide manual labour for any work... we started well... However, we could not manage to do it alone...we went to the municipality to ask for financial support... It took more than 10 years before we could get something (Quoted from Councilor- translated from Swahili version)

i) PPP could be out of perceived opportunity and pressure

... we saw big lories from Konoike passing here carrying "kifusi" (a mixture of soil, sand and stones for road compaction)... we learned that it was obtained from our village... we pressed for compensation but they refused by saying they were allowed by the Capital Development Authority and Ministry of Natural Resources and Tourism. ... We kept fighting through the local authority... at last they came, built this dispensary, and left without an official hand over. We have requested it to be opened but we receive different contradictory responses from the District Commissioner and Municipal Director... People are very angry

> because the building is now deteriorating while we send guards every day to protect it from vandalism (Quoted from Village Chairman- translated from Swahili version)

j) Partnership may not be voluntary

> ... Having some sort of collaboration is not a choice but a must "you cannot get a license to operate a dispensary without MCH unit"... marriage of compromise.
>
> ... we MCH nurses work with other staff in this hospital like neighbours (Quoted from a dispensary manager and one nurse on different occasions- translated from Swahili).

k) PPPs could be informal

> ...What is done here evolved through piecemeal informal consultations or requests by individuals ... I wrote several letters but no response (Quoted from one in charge of a dispensary- translated from Swahili)

The above statements and many more that convey similar messages confirm that there are problems not only in understanding PPP and motives but also in setting the right PPP model. However, this was unusual because it is the expectation that the government is a bureaucratic organ working through policies, laws and regulations and hence serious business like PPPs should not have been undertaken with informality, ambiguity and laxity.

These findings made it interesting to look at the existing policies, laws, and guidelines that should have played a key role in formalising and regulating PPPs in Dodoma. By using Content Data Analysis Techniques to review descriptive documented data and also through comparing arguments through logic (House, 1977, Reese, 1980), the status of the regulatory framework is by and large unsatisfactory for successful PPPs.

a) DMC used the Strategic Plan for 2003 – 2007 as the main guidance for the operationalisation of PPPs in health service delivery in a style that reflects response to the MoHSW and PMO-RALG reform agenda for PPPs. However, this policy document does not have any section on how to strengthen PPPs. Indeed, the term PPP is mentioned in the Strategic Plan only once under "promotion of networking and partnerships" Page 19).

NGOs are scantly mentioned as "supporters" of municipality initiatives. DMC also uses Comprehensive Health Plan document 2004 to highlight the relationship between the municipality and the private sector. However, the document dumps NGOs and private for profit service providers under the blanket of "community involvement". Health service provision is just mentioned as item 5.8 in areas of interest for PPPs. It reads...construction and running of dispensaries, health centres and hospitals (Page 12).

More unfortunately, and indeed surprisingly, Dodoma District Council did not have documented strategies for PPP in health service delivery. Even the District Comprehensive Plan 2004-2005 did not contain a single word on partnership. There is only a sentence on Page 19 which says that the community is involved in planning, implementing and monitoring major health facilities in the district.

b) In terms of administration, PPPs are expected to be managed under the guidelines of Council Health Board and Committees. These organs were

established through guidelines issued by the MoH in 2001. However, it was only in July 2005 that the MoH formally inaugurated all health boards and committees in the country. It means that PPPs have been operating without any formally institutionalised organ for supervision. Collaborations were made depending on the wisdom and interest of the doctor in charge and the municipal director. Although the now established framework was meant to strongly improve the existing collaborations and facilitate the evolvement of others, it does not appear to be doing so due to a number of weaknesses in the set up of the boards and committees.

These weaknesses are partly due to the reason that such boards and committees were set up for the general management of health care services than for PPPs as such. Some possible limitations of the board are:

i. Members of the Municipal Health Board are elected. One from private for profit and one from NGOs against five from the public sector. The implications are: Firstly, when it comes to voting, the private sector representatives will never win a case because they are the minority. Secondly, since the board is accountable to the full council, sensitive issues, which will result in criticisms, will never reach higher authorities. Even the private sector representative is not motivated to do that because of fear of upsetting the government officials which may lead to back-biting.

ii. Item 2.4.5 of the document describes the private sector representative as "an important link with the municipality" (Page 6). The section lacks the forceful language of "partner" which waters down the nature of the collaborative relationships.

iii. The document puts an emphasis on participation in planning for health services for the local authority in general (page 6) and nothing on commitment to serious collaboration. Indeed the terms "cooperation" and "participation" are used instead of "partnership" which is more inclusive.

iv. For the Hospital Management Committee the same skewed representation of the private sector is noticed. More importantly the private sector representative has to be recommended by the Health Management Team whose members are heads of departments of health sections in the municipality (page 18). This section may deny a strong and critical private sector representative to be recommended.

v. At the operational level, there was no establishment of a forum for the private health service providers to launch a common strategy for partnership or even get feedback from their representatives on what was going on in the collaboration. Therefore, even where the representatives participated in municipal meetings, there was no formal feedback to the members. In this case, the supposed link between the private and the municipality was very weak and took the informal route depending on individual initiatives and relationships.

b) The Local Government (Urban Authorities Act) 1982 gives the municipality powers to work with the private sector. Section 54(2) of the Act states...the local authority shall provide their services in an efficient and cost-effective manner and foster cooperation with civic groups and other persons or authorities... improve health... (Section 54(5) c. This provision could form the basis for setting operational guidelines for partnerships, something that has not happened. The legal provisions that established the interactions with the private health service providers are provided by the Private Hospital (Regulations) Act 2002 but they are silent on establishing a partnership between the public and private sector in public health delivery. Only one section of the law seems to be somewhat relevant here. Part II c 7 (1) of the Act reads as follows:

> ... there is hereby established the board to be known as the Private Hospitals Board... be responsible to the minister for the registration, control and regulation of the business of private hospitals and of persons and organisations running private hospitals.

c) The Public Procurement Act 2001, as repealed in 2004, is the only legal guide used in outsourcing public services. It is widely used in PPPs involving construction works, cleaning, security and supplies. Part IV of the Act provides for procedures and methods of procurement and these could be used in PPPs which involve delivery of public health services particularly by using Part IV (b) 33 (1) of the Act where competitive tendering may not work. Unfortunately, no evidence of the use of these or other regulations existed.

Data from key informants from the MoHSW and PMO-RALG converge in that, although there were no national laws or guidelines for managing PPPs, the MoHSW should be responsible for policies while PMO-RALG should establish the PPP regulatory framework and local authorities should be implementers. However, much as this division of roles is important in facilitating better stakeholder management in PPPs, it may not work at the local authority level because collaborations are mostly in areas that require resources that are mainly from development partners through the MoHSW. This makes capacity building at the local level inevitable for successful PPPs in the country.

In terms of PPP optional models and the process of engagement, the PPP cases studied revealed that the local authority, private sector or the community could initiate PPPs. The process was more informal than formal depending on personalities and networks. Even in what should have been a rigorous regulatory framework for collaboration between Ntyuka community and development partners an unusual level of informality was in evidence.

Although these findings in Dodoma are similar to other PPPs worldwide because they signify the role of public private partnership in service delivery, by and large they are different from globally documented PPP experiences. For example, in Peru, PPP contracts make it clear that communities participate in defining health priorities, indicators for performance, and monitoring and provide performance assessment (Yamamoto, 2004).

In Ireland, there is a comprehensive risk assessment and quantification process before a PPP contract is written (Department of the Environment and Local Government, 2000). Indeed, all studies show that PPPs in health service delivery are contractual and rewards or sanctions are based on a predetermined agreement.

It is not possible to cite all the cases here because the list is overwhelmingly long. However, a few citations will do. These are: Allen, (2003), Sadran, (2004), Hofmeister and Burchert, (2004); and Burnert, (2006) for European experiences. North American and Australian studies include Ministry of Home Affairs, (1999); Agere, (2000); Prefontaine *et al.* (2000); and KMPG, (2002). In Latin America, Vicki, *et al.* (1998); Loevinsohn (2000), and Bhushan *et al.(* 2002). Asian countries particularly India, Pakistan, Philippines and Bangladesh have taken a big step in regulating PPPs (Ahmed, 2000; Farrington et al, 1993; Planning Commission, 2004; Saade *et al.,* 2001; Chakraborty *et al.,* 2000; Hall *et al.*, 2005; de La Cruz, 2006). African countries are far behind with the exception of South and North Africa which is in the lead, followed by a few instances, particularly in Senegal, Ghana, Morocco, Tunisia, Botswana, Zambia and Uganda (Marek *et al.* 1999; Sedjar, 2004; Caires and Lush, 2004).

One common factor that dominated the initiation of all these PPPs in the developing world is that they were donor driven in the form of projects rather than local initiatives. Such projects include HIV- AIDS, malaria tuberculosis, immunisation and food supplements where both private and not for organizations were engaged. Although the PPP cases in Dodoma were also donor driven, the influence was at arms length in the form of resource contributions through the MoHSW which are in turn passed on to the

local authorities.

At the national level, it was observed that the use of PPP as an alternative health service delivery mechanism is enshrined in various health sector reform policy papers and guidelines, which is quite common elsewhere, but unlike the most successful countries in PPPs, including UK, Canada, Australia, South Africa, Morocco, Tunisia and India whose governments have national PPP laws and other regulatory bodies to back up policy guides.

Tanzania has not yet come up with the machinery which would put a PPP regulatory framework in place. This limitation is equally noted by the most recent PPP study in Tanzania (Mapunda, 2005; MoH/PORALG, 2005; MoH, 2005). This regulatory shortcoming has contributed to the observed PPP variations in the thirteen cases studied, because each stakeholder had freedom to act as seen appropriate given certain circumstances, without the legal backup of decisions and actions.

It is also important to note that, much as strongly regulated PPPs are considered necessary in effective and sustainable PPPs, there are also arguments that informality as opposed to strong contractual relationships in PPPs is a definite advantage because it reduces transaction costs of the collaboration, opens up opportunities for frequent negotiations and creates a coalition of willing supporters of the collaboration (Andonova, 2005). Even without considering the cost element, this observation is in line with the caring dimension of stakeholder theory where advocates would argue that contracts should be the means and not the ends in serving stakeholders. Two famous

scholars put it thus;

> Stakeholder theory requires that organisations respond to stakeholder needs by making appropriate decisions rather than mere conforming to contractual obligations (Burton and Dunn, 1996).

Some PPP advocates, including Brown and Archana (2002) and Tvedt (2002), support the same position that stakeholder benefits matter more than the means in partnerships. This means that, if PPP enhances service delivery and empowerment of the people at the grassroots level, any collaboration should be taken as a success regardless of the means used to achieve the same.

Going back to the cost issue and flexibility for resource mobilisation, it is difficult to imagine what the cost would have been to the stakeholders in Dodoma in terms of fees to engage lawyers and time to prepare contracts or memoranda, let alone implementation of a regulatory framework. In regard to the opening up of opportunities for negotiations and seeking more collaboration, informality helped Ntyuka community dispensary to mobilise resources from various stakeholders. Ndachi villagers were served through outreach programmes; HIV/AIDs patients at Ihumwa village received multiple supplies while most of the people in Dodoma district received public health services from the mission dispensaries.

Other problems could also make solid contractual relationships unfruitful because of shortages of competent staff to manage such contracts particularly in ensuring effective accountability. Staff competence goes also with commitment. The fact that in both the local authorities and the private sector there were hardly any knowledgeable

staff in PPPs, coupled with low motivation and commitment to work (Mogedal and Steen, 1995, MoH/PORALG, 2005), a regulatory framework alone is unlikely to be a useful tool for improving public private collaborations.

Even in the absence of a regulatory framework for PPPs in Dodoma, the collaborations in reproductive and child health could have been better if simple guidelines for guiding collaborations had been available. The Royal Tropical Institute in Amsterdam issued an example of such guidelines (Manual) with support from the UNFPA. This guide could be useful in guiding local-level PPPs. The manual outlines the process of the private sector to collaborate in the provision of reproductive and child health, which includes development of the district health plan, and communication with private partners by using the health management team and joint meetings for defining areas, objectives and outcomes of collaborations in measurable terms. Others aspects are, the responsibilities of each partner, decision making, coordination structures, and accountability mechanisms (Reerink and Campbell, 2004).

The way collaborations started and worked in Dodoma seem to be close to this typology only that they were not systematically formalised. This had a bearing on the effects on the types and processes used to contribute resources for the achievement of community health.

4.3.3 Contributions to the partnerships

Data obtained through the checklist and in-depth interviews were organised according to the types of contribution made by each partner. The contribution ranged from 32 to

39 items. They include office accommodation, staff, staff salaries, vehicles, furniture and fittings, tools and equipment, cash ... up to 39 items, varying according to the case, which are displayed by using stakeholder analysis matrix (ODI, 2004). Data values and labels are attached as Appendices 5 and 6.

The details are attached as appendix...The Statistical Package for Social Sciences was used to provide percentages of contributions to the partnership package for health service delivery (Gordon and Gordon, 1994). It is important to state here that the percentages were in terms of numbers of items contributed and not the value of the items because such values could not be computed due to problems of data availability and reliability. Therefore, high or low percentages may not tell much beyond a general appreciation of the contributions unless one goes into the details of cases (Appendix 5). The list of contributions (Appendix 4) checklist data measurement and value labels (Appendix 6) to give the real picture on the ground. The emerging scenarios are summarised case by case below.

4.3.3.1 Contributions from Mackay House, Health Centre Dodoma Municipality, Village Government and Community

Mackay House (MH), Dodoma Municipality (DMC), Village Government (VLG) and Community worked through collaboration to provide home based health care for HIV/ AIDS patients. Various contributions from each part complemented each other ranging from training, drugs supply, supervision, and materials as listed in Appendix 4. The percentage contributions of each partner are indicated in Fig. 5.

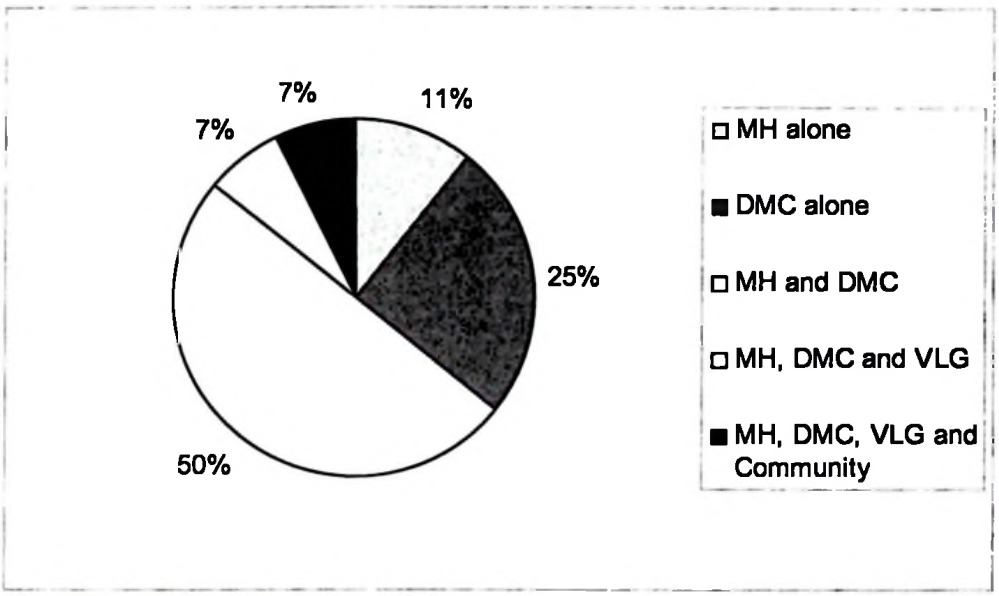

Figure 5: Stakeholders' contributions to the partnership

Fig.5 shows that DMC was the largest single contributor to the partnership (25%) followed by Mackay House (11%), which together made a significant package, in the whole home-based health care programme (50%). There were specific materials that were contributed as part of a safety net for the patients as listed in Table 8.

Table 8: List of items contributed by Mackay house health centre

S/N	Contributions	Value in Tshs
1	50 kgs of maize flour	5 500
2	12 kgs of beans	5 000
3	12 Kgs of groundnuts	6 000
4	Cash	4 000
5	Mosquito net (provided only once)	3 500
6	Second hand clothes and school uniforms for children	3 000
	Total value	**36 000**

The DMC also provided a nurse who was specialised in home-based care. She worked hand-in-hand with MHHCACP home-based health care providers,

including home visiting, counseling, treatment and referral to the general hospital. Other contributions are listed in the table below.

Table 9: Contributions from DMC

S/N	Contributions	Value in Tshs.
1	5 Kgs of sugar	3 500
2	12 Kgs of maize flour	2 500
3	Cash (for the caretaker of the patient at home)	1 020
	Total	**6 020**

The total support that was given to the clients was substantial. Indeed it was far beyond the income of an average household which ranged between 8000 -15,000 per month.

4.3.3.2: Contributions from DMC and Hombolo hospital

In this case, Hombolo hospital under the Anglican Church Diocese of Central Tanganyika had a bigger share in the collaboration (53%) while DMC had 30% as indicated in Fig. 6.

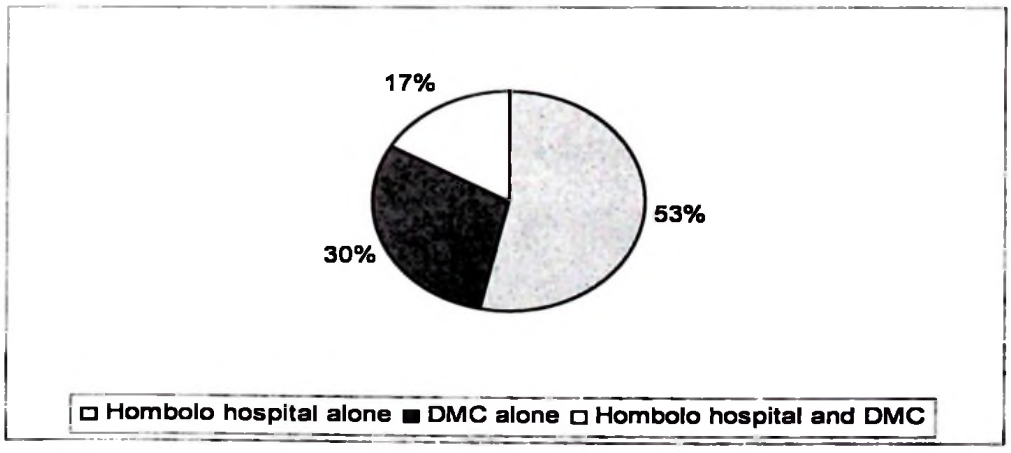

Figure 6: Percentage contributions to the partnership

Although one would expect that, since Hombolo hospital is regarded as a designated District Hospital, the PPP should have been strong in terms of a systematised system and mutual agreement in terms of who contributes what, of what value, when and how, the situation was to the contrary. It was full of misunderstandings, complaints, mistrust and suspicion. Some of the statements uttered by key informants from both sides is a reflection of the immaturity of the collaboration. These statements are reproduced here as a matter of evidence and thought provocation. Commenting on the goods supplied by the municipality (see Appendix 5), one key informant said;

> ...we do not understand why they brought all these goods for... we have never told them we need such items and of that quantity... we need money to repair water tanks and buy a new water pump". Referring to accountability for the goods received it was said... " I am not interested in accounting for goods that I did not request.

Responding on the same issue of "blind contributions" without consulting with key partners in decision-making, one official from the municipality said;

> ...they are a problem...they do not like to cooperate... sometimes we have to do things for them because we do not have an option

The books of accounts from the council showed that Hombolo was allocated Tshs. 15 262 816 for the 2004/2005 financial year. However, no access was made possible to the records for the value of the items delivered. Hombolo hospital management was neither informed of the total value of the items contributed nor the money allocated for that financial year.

4.3.3.3: Dr. Matovolwa Health Centre and DMC

Joint areas of contribution between Dr. Matovolwa health centre and DMC are leading in the whole PPP package (37%) followed by the DMC (33%) and lastly Dr. Matovolwa health centre (30%). Fig. 7 shows the percentages.

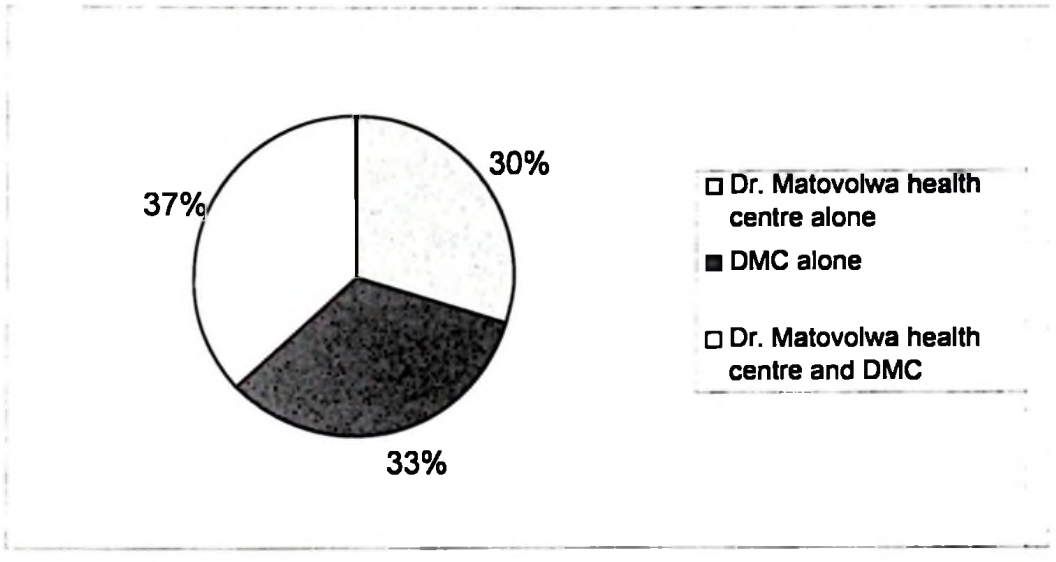

Figure 7: Percentage contributions to the collaboration

Although the municipality seems to make a greater contribution to the partnership, the owner was of the opinion that he made more contributions because, according to him, the collaboration used 98% of his facilities and resources.

4.3.3.4: St. Mary Immaculate Dispensary and DMC

Each stakeholder contributed differently to the partnership ranging from materials and labour to cash. St. Mary Immaculate contributed 38% which is equal to the contributions made jointly between the two (38%) as indicated in Fig. 8.

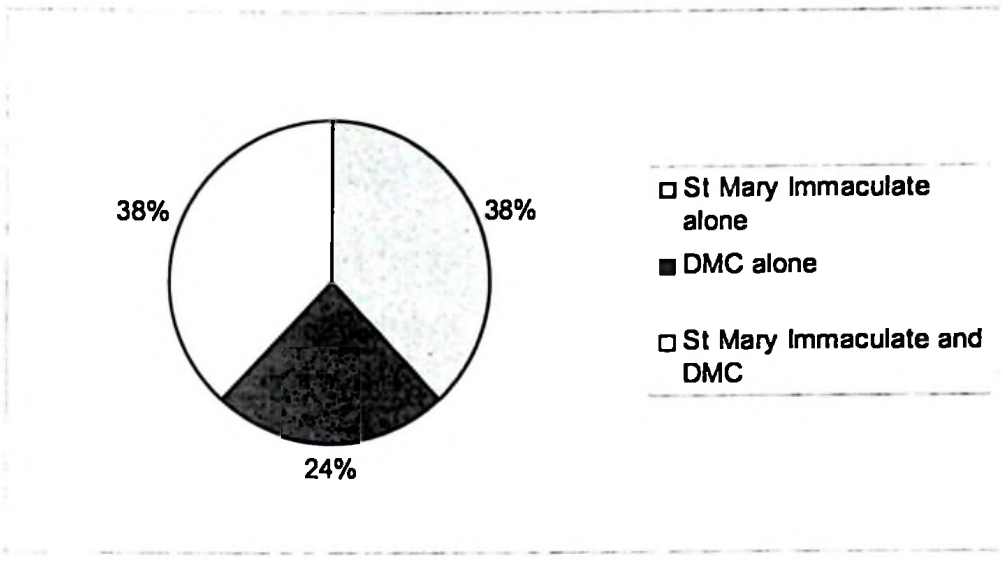

Figure 8. Contributions made to the collaboration

Collaboration between St. Mary Immaculate dispensary and DMC seems to be the most serious one. The most interesting feature is the way deficiencies were complemented through a joint understanding between the parties. For example, when there was a shortage of malaria drugs from the municipality, mothers were given the drugs by the dispensary at the rate of Tshs. 100 per dose against Tshs. 500 by other private service providers. Mothers were also given Ferrous Sulphate for Tshs. 50.

Ndachi village, which is located about 8 kilometres from St. Mary Immaculate, was able to get outreach MCH services three times per month through combined efforts. The municipality provided vaccines, nurses and an out-of- pocket allowance of Tshs. 5000 per trip per staff including the one from St. Mary Immaculate dispensary. St. Mary Immaculate contributed one member of staff, a land rover for transport and a driver. Mothers paid Tshs. 100 per service for fuel regardless of the number of children who attended at the clinic. On average, the amount collected per trip was not more

than Tshs. 3000 which barely covered for the fuel costs. Therefore, in the course of attending MCH services, clients were able to get other services at a reasonable cost, which was the prime objective of all the stakeholders.

4.3.3.5: Aga Khan Health Centre and Dodoma Municipality

Contributions from Aga Khan Health centre and DMC include office accommodation, fittings, training for up to 15 and 18 variables for Aga Khan and the DMC respectively. Some were jointly and others were independently contributed. Fig. 9 shows the percentage of contributions.

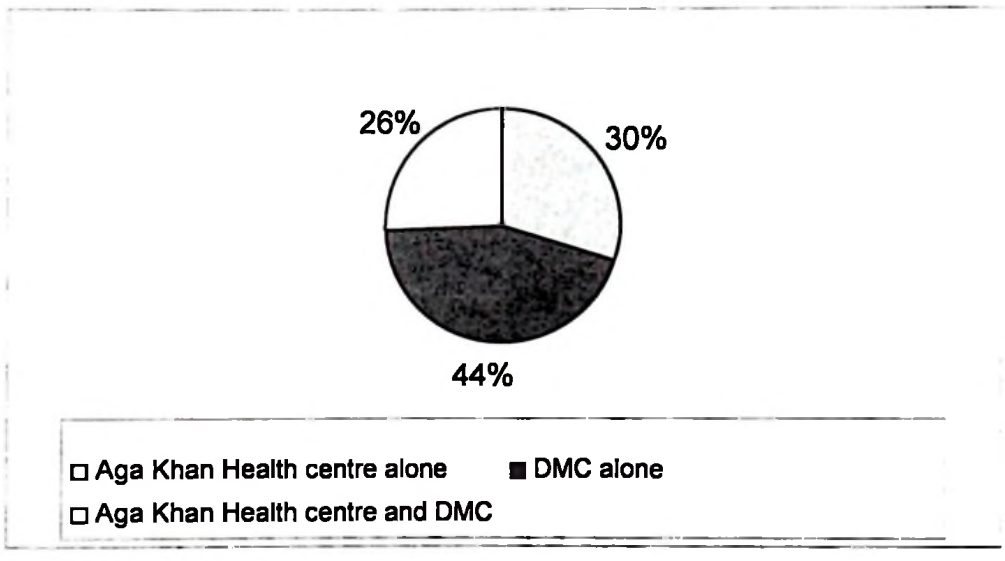

Figure 9. Contributions Aga Khan and DMC

Fig. 9 shows that the majority of the contributions that went to the collaborations were jointly shared (44%).

4.3.3.6: Tumaini dispensary and DMC

Tumaini dispensary contributed 18 items against 16 by the DMC. This dispensary had

one special case because it received a refrigerator from Care Tumaini through lobbying although later it was registered as the property of the municipality and hence the collaboration became Tumaini-DMC. As in the previous cases, the percentage contributions of each stakcholder are shown in Fig. 10

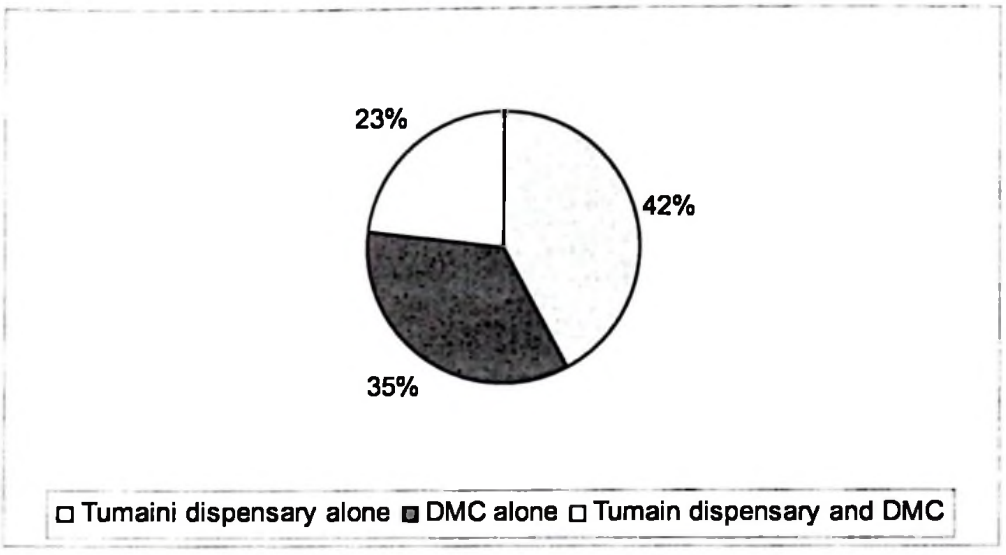

Figure10: Total contributions to the partnership

Tumaini dispensary alone contributed 42%, which was far beyond DMC and even Tumaini and DMC combined. This observation is an important pointer to the readiness of the private for profit service provider to engage in more fruitful future collaborations, particularly in the area of mental illness which the dispensary is specialised in.

4.3.3.7: Veyula dispensary and DMC

When the dispensary started to operate DMC supplied it with some facilities and vaccines for reproductive and child health services. These include a cooking stove, weighing scales, buckets and other items as listed in Appendix 4. Other contributions

were made as the partnership strengthened.

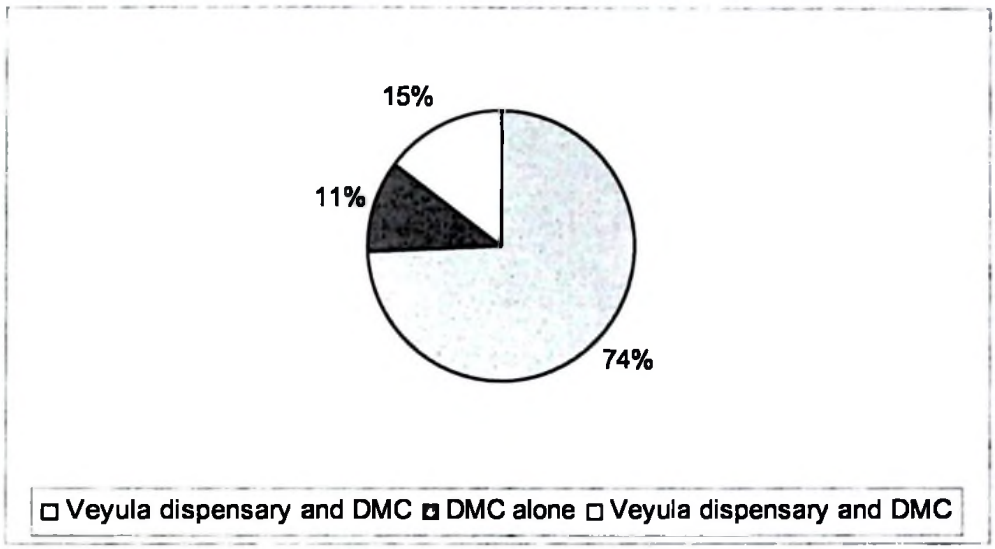

Figure 11. Contributions to the collaboration in service delivery

Fig. 11 shows that combined efforts between Veyula and DMC were very significant in supporting improvement in health service delivery (74%). Individual contributions were not significant compared with other cases observed earlier. Since this collaboration started using the same style used in other PPP cases, it is not known why most contributions were shared because the head of the dispensary was new and could not give any explanation.

4.3.3.8: Nzuguni dispensary and Dodoma municipal council

The way contributions to the partnerships were made between Nzuguni and DMC were not different from Veyula. It followed the same process of sharing resources. However, and indeed surprisingly, Nzuguni alone contributed far more than the two combined (78%) against only 7%.

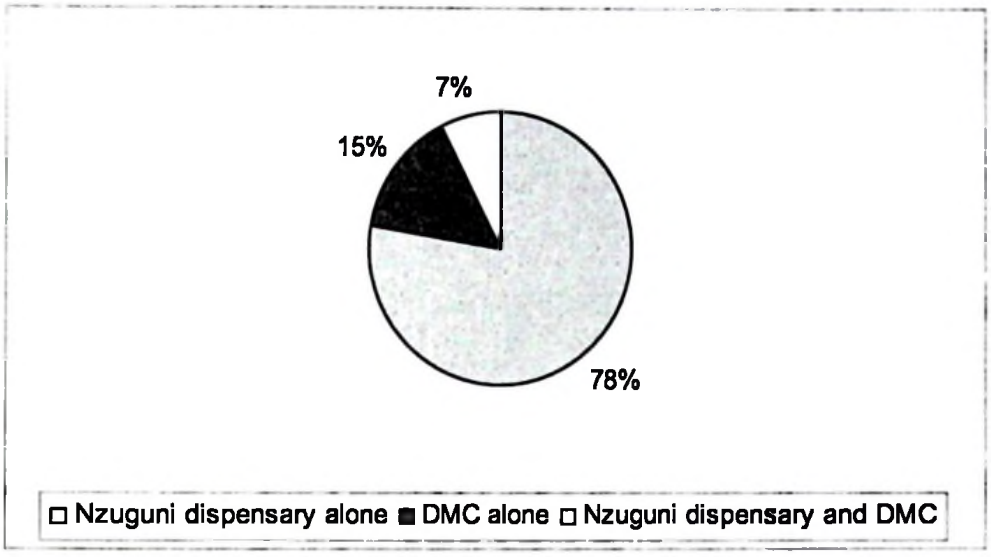

Figure 12: The contributions to the partnership

Fig. 12 reflects the power of networking personal initiatives and relationships in strengthening collaborations. Veyula (Fig 11) was more proactive in following up on the training, seminars and participation in national immunisation day, all of which were paid for by the municipality, hence contributing more. Nzuguni was more dependent on support from headquarters in India to complement whatever was received from the municipality.

4.3.3.9: Bihawana dispensary and Dodoma Municipal Council

The Bihawana and DMC case also shows skewed representation in the contributions to the collaborations in health services. Out of twenty-seven (27) variables identified, six (6) came from the DMC.

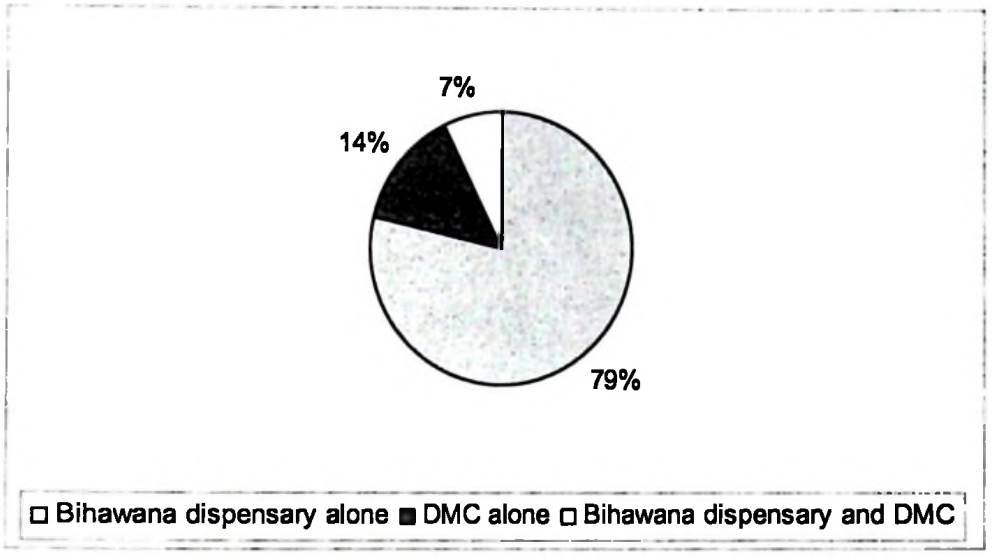

Figure 13: Contributions to the collaboration by Bihawana and DMC

In terms of percentages, Bihawana dispensary contributed 79%, followed by those jointly contributed (14%), and lastly DMC who contributed only 7%. The 14% was mainly for staff involvement during national immunisation day, provision of anti - worms drugs and stationery.

4.3.3.10: Collaboration between Ntyuka Community, DMC, CMSR, ALPDA and Canadian Embassy

This was the most complex collaboration process aimed at the construction of a community dispensary because it involved multiple partners. The most significant single contribution came from the community (22%) while DMC alone contributed only 8%. The percentage contributions of all partners are shown in Fig. 14.

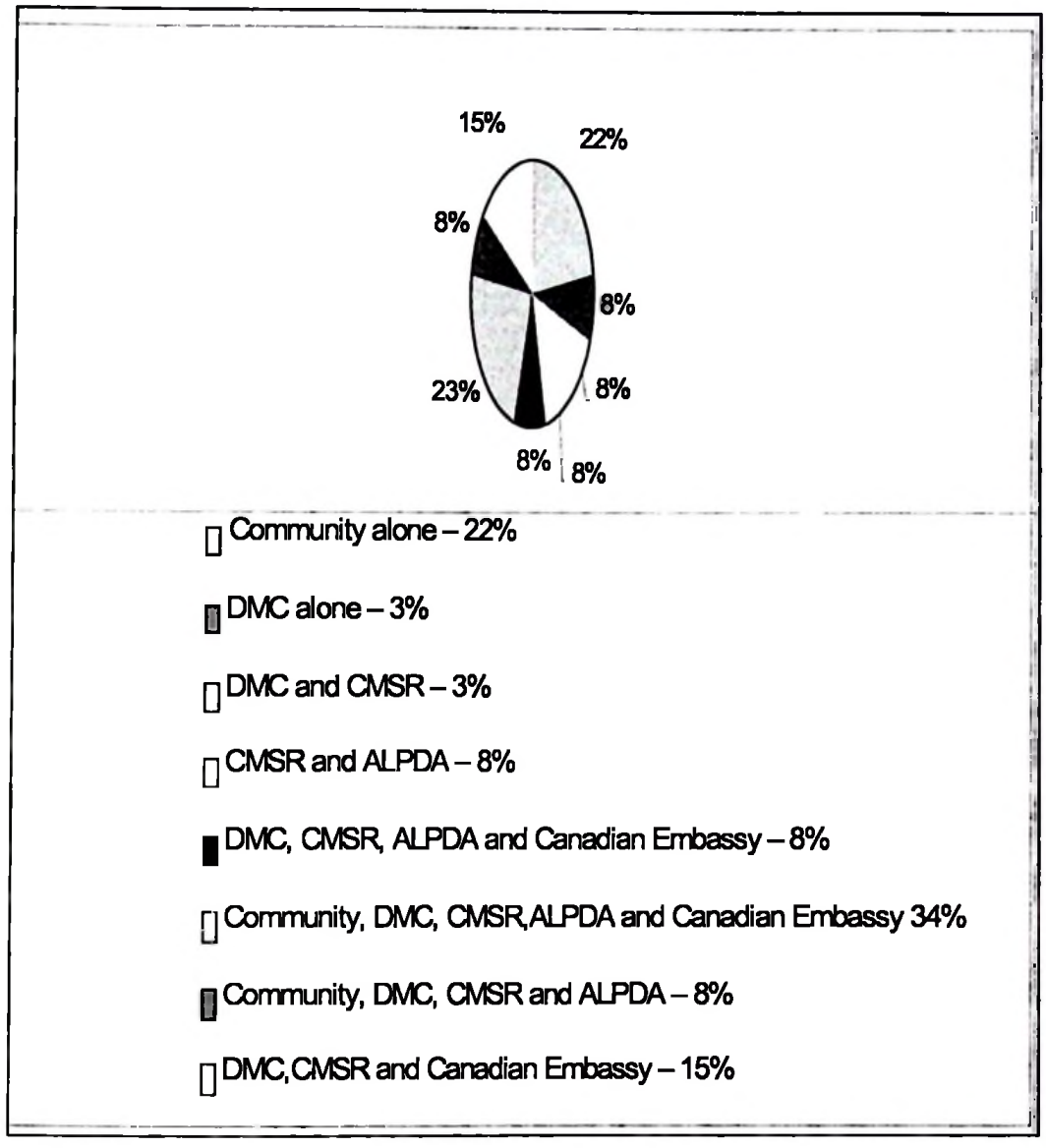

Figure 14: The percentage role of each stakeholder in the partnership

Since this case was significantly different from the rest involving various stages of stakeholder involvement, it is worth discussing some key contributions in much more detail. The community provided labour for collection of sand, stones, and (construction) in the initial phase of the dispensary building. The village was also the source of sand and stones. The municipal technician was responsible for the drawings, site planning and preparing the building structures. One lorry from the municipal

council was used to ferry materials to the building site. The municipality also contributed Tshs. 2.4 million that was used to buy materials and pay some skilled workers in the construction work. This level of collaboration helped to build four rooms and a veranda up to roofing stage.

Partnership with CMSR started in April 2005. The village executive officer and the councillor were proud that the partnership was the result of their own efforts on the one hand, and guidance from one of the municipal health officers on the other.

> ... We noted that our building was rotting; the roofing sheets donated by honourable Samuel Maleccla (the one who laid the foundation stone) were also rotting. Money from the municipality was not enough. Our people were contributing money and labour to construct a shallow dam for harvesting rainwater... there is hunger... we decided to look for other sources of support.

He said that it started through informal discussions with one of the municipal health officers (classified as a friend) who advised them to visit CMSR for some ideas, because he knew CMSR supported community initiatives. CMSR officials were met with and after several consultations, site visits by CMSR and proposal writing, finally their request was honoured. Although the village asked for Tshs. 2 million the expert who visited the site and advice from the CMSR engineer suggested 7.5 million, which was almost four times the amount requested. The money was used by CMSR for building materials and payment of other associated costs.

According to the chairperson, ALPDA noted that the dispensary building had been at a standstill for a long time and tried to intervene. The management approached the

village leaders for advice. It was agreed that a technical proposal be written with support from ALPDA so that assistance could be sought from donors. Finally, a proposal for renovation of the building was sent to the Canadian Embassy in 2004. The Embassy agreed to support the community initiative, but with the condition that the municipality makes a commitment to contribute to the partnership. The Canadian Embassy contributed Tshs. 8 000 000 for construction of a staff house and toilet. The role of ALPDA became supervisory and accounting for that money to the embassy. Other forms of contribution are listed in Appendix 4.

4.3.3.11: Michese community dispensary project

Michese dispensary project received twelve (12) types of contribution. Although Konoike company contributed six (6) of them while the remaining six (6) items were contributed by the community (3), DMC (1), and Village government (2), Konoike made the most significant impact. Fig. 15 displays the percentages.

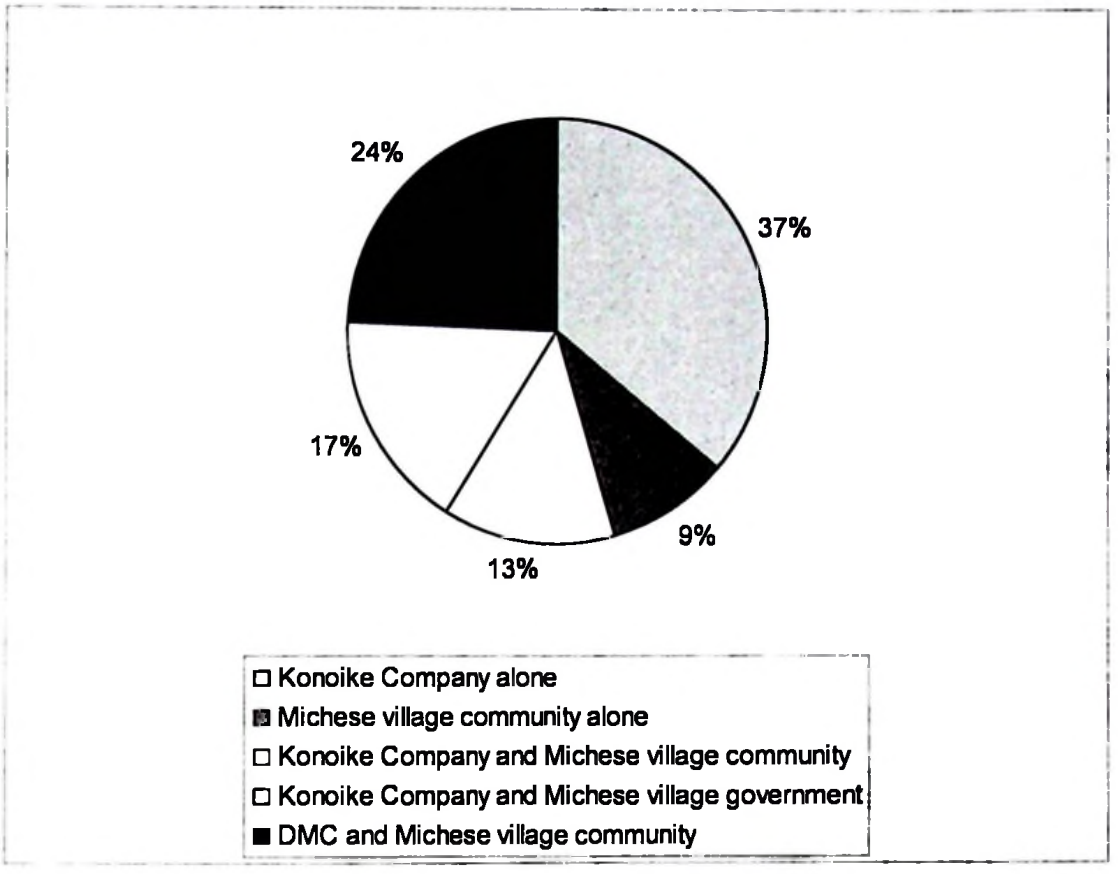

Figure 15: Stakeholders' areas of contributions

The thirty seven (37) percent made up almost the entire cost of the dispensary project. The combined efforts of the DMC and Community (24) percent were in the form of building site, architectural drawings, construction of pit latrine and security. The role of the village government was to provide follow-up and informal support as well as ensuring the availability of the building site and labour (9) percent.

4.3.3.12: Mvumi hospital and DDC

Mvumi hospital and DDC had thirty (30) items, which constituted the contributions to the partnership. Out of these, twenty- one (21) were from the Mvumi hospital alone while sixteen (16) came from DDC.

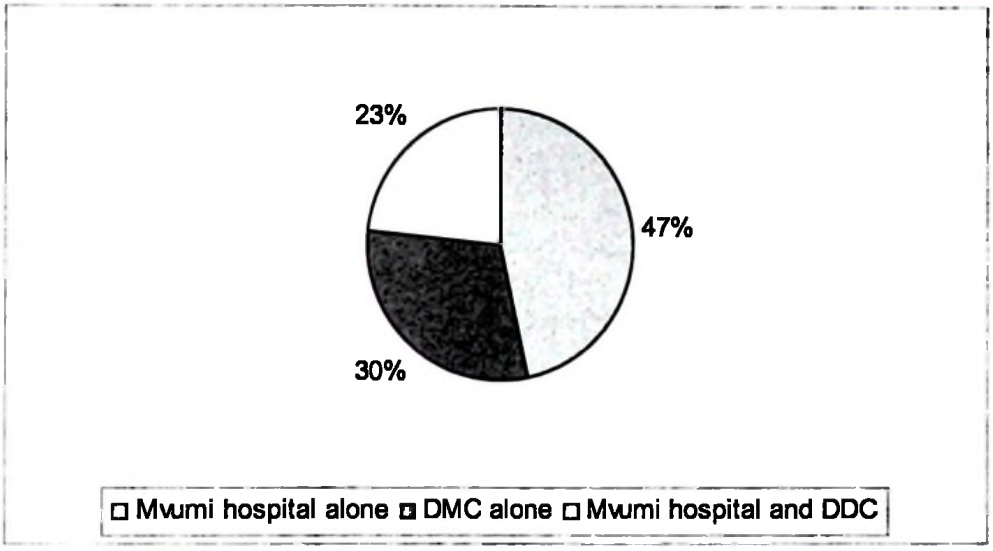

Figure 16: Contributions to the partnership package

Therefore, Mvumi led by 47%, which is far greater than the combined efforts of the two partners 30 %. However, as a reminder, as in the case DMC, contributions from the DDC were not from internal sources as such but rather they were from the MoHSW and donors because:

Firstly, the money for MCH services came from donors such as Danish Development Aid (DANIDA) through the Expanded Immunisation Programme (EPI) that is a national programme through the ministry of health. Therefore, the council was a mere conveyor belt. In terms of accountability for the money, Mvumi had to account to both the District Council and the MoHSW.

Secondly, the relationship with the Dodoma district council is supervisory as a duty of any District Medical Officer (DMO) because there was no other framework.

Thirdly, the MoHSW and not the District Council seconded most of specialised

medical staff working in the medical wards and training centres.

4.3.3.13: Chikopelo dispensary

Chikopelo dispensary- DDC partnership had 27 key areas where contributions were made. Out of these, 74% came from Chikopelo dispensary, 23% were from DDC and only 3% were jointly contributed. These were joint vaccinations and emergency services, particularly when there was cholera outbreak.

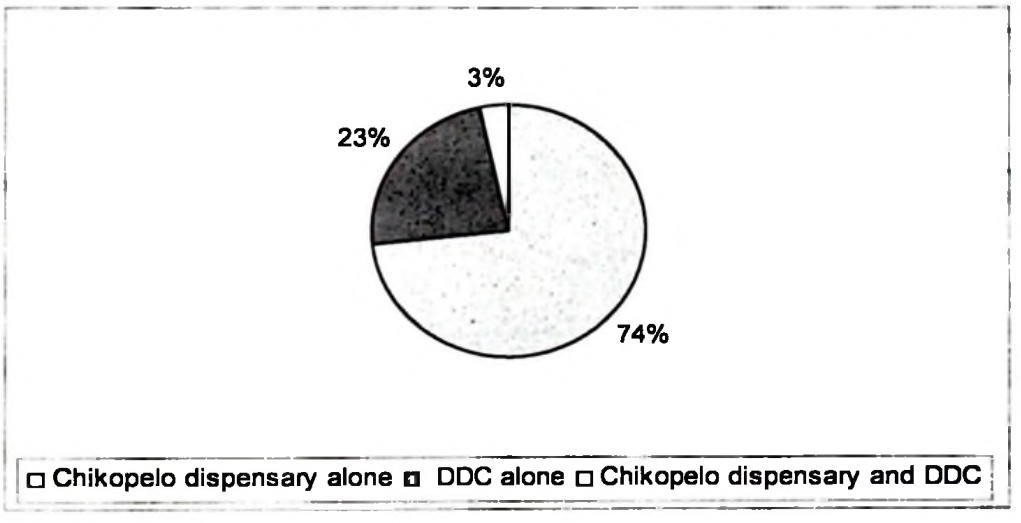

Figure 17. Areas of contributions to the collaboration

Chikopelo played a leading and very significant role, particularly through provision of transport during emergencies, free accommodation for DDC staff on national vaccination day, payment of transport costs for sending MTUHA report to the Council, free consultation services and referrals.

Unlike in other areas of PPPs including construction, solid waste collection, and revenue collection and cleaning, there are limited cases of PPPs in health service

delivery that have revealed key stakeholder contributions to the collaborations in a detailed manner. It is not known why this has been the pattern worldwide. One possible explanation could be that since collaborations were geared towards community health improvement based on some indicators, interest was in the outcome rather than the resources that went into the basket. In a few cases where contributions were captured, they were mentioned in passing without systematic and detailed analysis. India seems to have the best case where contributions to the PPP are clear.

The government with representation from the District Nodal Officer of the Mandhya Pradesh State AIDS Control Society and the Chief Medical and Health Officer agreed to collaborate with the Jeevan Jyot Health Service Society to expand Voluntary Counselling and Treatment (VCT). The contribution from Jeevan was testing and treatment of patients and pregnant women visiting clinics. Real Medicine Foundation (NGO) supplied funds, monitored and trained counsellors while the government provided the legal framework (De Cock, 2006).

Under stakeholder theory, the private sector, the government and the community can all gain, though not on the same scale if each contributes to a common goal through cooperative endeavours built on trust rather than pursuing opportunistic and selfish behaviours (Jones, 1995, Reed, 1999, Humes, 1999). The findings cannot prove or disapprove whether there were selfish motives in the collaborations. What is clear is that there were some complaints that some stakeholders were not acting in the interests of the partnerships as expected mainly due to some behaviours that were not considered trustworthy. For example, Michese village government officials felt that the

municipality could not be trusted because of empty promises to supply the required resources to facilitate the opening of the village dispensary.

On the other hand, since the municipality was short of resources and depended on supplies from the donors through the MoHSW it was difficult to meet expectations. This led to several incidences of conflicts with some stakeholders. Some of the manifestations were observed between Hombolo and the municipality on the issue of lack of transparency in budgeting and procurement of materials. Others were slow and non-response to requests for resources for the collaboration (Veyula and Dr. Matovolwa), and non-involvement in training (Aga Khan) which lowered morale and created dissatisfaction. This had a negative effect on accountability not only for the use of resources but also active participation in the collaboration, the contribution of resources and their use.

Although one may claim that having selfish interests is a potential explanation for these anomalies in the sense that some individuals could benefit through resource diversion, it could just be lack of managerial competence to manage partnerships. As in the Hombolo case where the budget allocated from the municipality was not revealed , lack of resources and mistrust between the government and the community has also been reported in Uganda and Zambia (Verhallen, 2001).

The cases in Dodoma are just at the baseline of partnerships. There is a need to open up better opportunities by moving ahead along the PPP continuum. For example, the UK, which is the mentor of PPPs worldwide, secures private capital to improve public health through a strategy called Private Finance Initiative (PFI). Allen (2003) has

documented an interesting case where the private sector built a health project through collaborations with private construction firms, consultants, and banks.

The government contributes land and provides an enabling legal framework, banks provide loans, consultants provide the technical aspects of the project (feasibility study and supervision) while the construction firms are responsible for putting up the structures. The rewards are shared as agreed by the terms and conditions of the project. In Tanzania, the main obstacle is not only lack of a strong private sector to invest in such projects but also strong government machinery and an enlightened community to take care of issues of service costs and enforcement of accountability for each key stakeholder.

However, in Tanzania, since the 4th term government appears to be committed to tackling institutional failures in the country, a starting point could be to take stock of the potential of both the public and private sector in terms of resources (financial, technical, human) to engage in effective PPPs. The data could form the basis for decision making in areas where more rigorously formalised but flexible PPPs could start. Such areas could be in mortuary management, medical supplies, and construction of advanced referral hospitals.

The study has found two surprising cases in PPP where individual community members have made "forced contributions" to the partnership due to pressure from fellow community members and local authority officials. In Michese and Ntyuka villages, some households were "robbed" of their rights to own and use their inherited traditional land in order to build the dispensaries and related buildings without

compensation. Although the community has an upper hand in decision making over individual members, these are sad stories which unearth the ugly side of community participation in partnership-based social projects. The cases indicate the problem of land planning for PPP projects as well as its misuse or lack of enough knowledge on the powers of village governments and the community over land, as stipulated in the Land Act, 1999. The two incidences could be the tip of the iceberg because there are many health projects going on in the country and the extent of the problem of individuals losing land without compensation, and the effects on the household would be an interesting area of enquiry.

At the global level, it is sensible to assume that, since most PPPs are contractual and hence legally enforceable, individual land ownership rights where PPP projects are established are taken care of by the agreements. This might be the case because there is no evidence of violation of individual land rights in the available literature. However, lack of such knowledge does not necessarily mean that no such land ownership abuses exist, particularly in rural areas where most people may not be aware of such rights, how to pursue them or even have the means to do so.

4.3.4. The effects of PPPs on the stakeholders

An assessment of the effects of PPP on health service delivery under stakeholder theory could mostly be done by comparing a set of gains or benefits indicators before and after PPPs (Kingsley and O'Neil, 2004). The results could be positive or negative. However, since the private sector was not transparent enough to give detailed data on the benefits from the PPP, particularly exact figures for the costs and profits,

inferences had to be derived from other variables or data (Nishtar, 2004). Common variables to assess the effects, which were adapted from the literature, are access (distance), service types, capacity to deliver services and reliability, which are of interest in governance and value for money audit (Fukunyama, 1995, Fiszbein and Lowden, 1999).

Effects in terms of risk sharing are frequently mentioned as a critical factor but it is usually done in rigorous PPP models (Home Affairs Office, 1999, Hemming, 2006, USAID, 2006). In this study, it was not possible to assess risk in any scientific manner because, as noted earlier, PPPs had very loose collaborative arrangements without any risk identification. Nevertheless, since under PPPs what counts most is what goes to the community (Yamamoto, 2004, Kingsley and O'Neil, 2004, Correaia, 2005), more variables were included in order to add better value to the study. These are travelling and waiting times for service, monetary savings from transport, and extra number of health services received. Based on this background, it is important now to look at the emerging effects of PPPs by starting with the service recipients.

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4.3.4.1 The effects on PPP on the health service beneficiaries

Questionnaires were used to obtain data from one hundred and sixty five service recipients. The following series of tables display the general characteristics of the respondents.

Table 10 Number of respondents by sex (N = 165)

Sex	Sample size	Percent
Female	159	96.4
Male	6	3.6
Total		**100.0**
Marital status		
Single	32	19.4
Married	128	77.6
Divorced	4	2.4
Widow	1	0.6
Total	**165**	**100.0**

It is noted that 96.4% of the respondents were female of whom (77.6%) were married. This was the case because the services delivered under PPP were mainly for reproductive and child health where fewer men are involved. The level of education was categorised into less than standard 7, standard 7, secondary school, college and no formal education. 72.7% had only primary school education as indicated in Table 11.

Table 11: Level of education of service beneficiaries (N = 165)

Variable	Sample size	Percent
Less than standard 7	12	7.3
Standard 7	120	72.7
Secondary school	12	7.3
College	1	0.6
No formal education	20	12.1
Total		**100.0**
Sources of income		
Crop cultivation	60	36.4
Livestock	2	1.2
Formal employment	2	1.2
Informal business	70	42.5
Cultivation and Livestock	12	7.3
Cultivation and formal employment	1	0.6
Dependent on husband	8	4.8
Cultivation, livestock and informal business	1	0.6
Cultivation and informal business	9	5.4
Total	**165**	**100.0**

Apart from wanting to know annual incomes for households, it was also important to know the sources because that will also determine ability to contribute to PPPs sustainably. It was difficult to come up with weekly, monthly and annual income figures. However, the average annual income was about Tsh 256 873.

In assessing the effects of PPPs on the service beneficiaries, only eleven cases out of thirteen were relevant because the two cases (Ntyuka and Michese) were on the construction of dispensaries which had not yet been opened.

a) The first effect of PPP was on the distance travelled to the service provision point. The respondents were asked to compare the distance travelled to get services from the government and the private centres where services were offered through PPPs. In order to reduce over-and-under estimations due to

lack of knowledge by the respondents, actual kilometres were calculated from the municipal and town maps. In addition, more informed people in the areas were asked to give distance estimates from different villages and streets to the health centre, hospital or dispensary, whichever was applicable. At times, mileage was recorded when visiting service provision points by using a hired car. Data in Table 12 show the means and standard deviations.

Table 12: Average reduced distance to the health centre (N = 165)

No	Health provider	Mean distance travelled (Kilometres)	SD	Mean reduced distance (Kilometres)	SD
1	Hombolo	1.80	0.70	0.43	0.34
2	Nzuguni	10.40	4.22	19.80	5.42
3	Veyula	2.20	1.37	0.46	1.03
4	Chikopelo	8.26	1.20	7.36	0.85
5	Tumaini	7.20	2.10	7.00	2.53
6	Bihawana	14.00	7.63	9.46	7.30
7	Dr. Matovolwa	9.70	4.10	6.13	2.87
8	Aga Khan	3.73	2.75	1.53	0.83
9	Mackay house-Ihumwa	42.00	0.00	0.00	42.00
10	Mvumi	15.53	1.20	11.06	1.53
11	St Mary Immaculate	25.33	7.04	13.00	2.07
	Average	**12.74**	**11.90**	**10.56**	**11.52**

The estimates in Table 12 are for return journeys. This does not consider shortcuts, which were sometimes used, particularly when they could walk or use bicycles. However, even with such shortcuts, the results did not seem to influence substantially the results because, on average, the saving was not more than 1 kilometre. The results show that PPP was able to reduce the distance travelled to the health service by an average of 19.80 to 0.43 Kilometres in Nzuguni and Hombolo respectively.

Although beneficiaries from Mackay House Health Centre programme seem to have been travelling a distance of about 42 kilometres (to and fro), this was only implied. They would have traveled that distance if the government in the town centre delivered services. Therefore, since the services were home based and for the first time through PPP, means reduced distance was 0.00 and that is why the standard deviation was the same 42 kilometres. This one case has significantly influenced the total mean.

Furthermore, the ANoVA (F Test) was used to determine the influence of PPP on the distance travelled by the service beneficiaries. It was observed that there were very significant differences ($p<0.05$) in the reduced distances to the health centre because of PPP. There were only a few cases where comparisons were not significant. These were between Hombolo and Veyula ($p=0.977$), and Hombolo and Aga Khan, ($P= 0.338$). This was because most beneficiaries came from the surrounding area.

b) Service cost reduction (money) is one of the key reasons for a PPP option. Since the services under PPP were free, and people were not forced to buy other services from the private providers, and also it was not possible to get genuine figures for the costs of other services sought, the most common cost element that could be fairly assessed was the transport component. Reduction in distance has one far-reaching implication. Since most of the beneficiaries were ordinary poor people, the shorter distance also meant that even those who could not afford to pay for car transport could hire bicycles or walk and spend

the money for other necessities including laboratory tests or drugs. Data in Table 13 show money saved from transport costs.

Table 13: Service costs recovered from transport (N = 165).

No	Health provider	Mean (Tshs)	SD
1	Hombolo	0.00	0.00
2	Nzuguni	600.00	0.00
3	Veyula	106.70	194.44
4	Chikopelo	1,093.33	477.30
5	Tumaini	753.33	172.65
6	Bihawana	1, 613.33	1,015.49
7	Dr. Matovolwa	686.66	195.91
8	Aga Khan	386.66	229.49
9	Mackay House- Ihumwa	1,400.00	0.00
10	Mvumi	860.00	145.41
11	St Mary Immaculate	373.33	103.27
	Average	**598.36**	**46.58**

Data in Table 13 show that PPP enabled individuals to save up to a maximum of Tshs 1 613.33 per trip if the services were to be obtained from a public centre. This is a significant amount, particularly when calculated annually, depending on the number of visits to the dispensary not only for MCH but also other health services. Hombolo was an exception because the beneficiaries were living within the vicinity while others could go to the nearby Hombolo Bwawani Health centre, which was fairly well served, by the municipality.

The t test shows significant differences $p<0.005$ when the means of all PPP cases are compared. However, Veyula and St. Mary Immaculate cases were insignificant ($p= 0.422$ and 0.005) respectively. The explanation for Veyula is that most beneficiaries rarely go to the general hospital and for St. Mary Immaculate; there were mothers in Ndachi village who had never gone for biomedical services. They depended on traditional medicine people and birth attendants.

c) Time reduction in traveling and waiting for services was another variable. This is important because it is now common knowledge that some of the reasons for low preference for public health centres over private ones is the time wasted before getting services (Tibandebage, *et al.*, 2001, Mackintosh and Tibandebage, 2002). This has serious implications not only on the patient but also on economic activities. The more time spent on getting the service, the more health deteriorates. It also means less time to work and earn a living particularly when there is a high frequency of seeking health services. Data in Table 14 shows mean time saved, where services were offered through PPPs.

Table 14: Reduced number of walking hours (N = 165)

No	Health provider	Mean	SD
1	Hombolo	0.29	0.21
2	Nzuguni	5.20	1.74
3	Veyula	0.53	1.27
4	Chikopelo	4.73	1.09
5	Tumaini	2.00	0.70
6	Bihawana	3.20	2.81
7	Dr. Matovolwa	1.30	0.77
8	Aga Khan	0.78	0.55
9	Mackay House- Ihumwa	9.80	0.56
10	Mvumi	3.50	0.68
11	St Mary Immaculate	4.20	0.36
	Average	**3.23**	**2.90**

Data in Table 14 show that the mean number of hours saved were highest in Mackay House case and lowest in Hombolo. These results are normal because it is also noted in Table 15 that, mean distances travelled were the longest and shortest respectively.

Multiple comparisons (t test) at 0.05 levels of significance show that there are very significant differences in the amount of time saved across the cases, with the exception of Veyula (P=0.977) and Aga Khan (P= 0.338). The main explanation is that the service seekers were going to the nearest service provider because some went to Msalato government dispensary (near Veyula) or the general hospital (near Aga Khan).

PPPs have potential for reducing the number of service seekers in one centre by spreading them to other nearby centres. The implication is that there will be less people to attend to and hence less waiting time for patients. Respondents were asked to compare time spent in a public service centre against a private

one. Data in Table 15 shows the mean numbers of hours saved because of getting services through PPP.

Table 15: Reduced number of waiting hours for services (N = 165)

No	Health provider	Mean	SD
1	Hombolo	0.43	0.49
2	Nzuguni	2.06	1.38
3	Veyula	0.17	0.30
4	Chikopelo	2.31	1.12
5	Tumaini	1.18	0.57
6	Bihawana	3.06	2.16
7	Dr. Matovolwa	1.20	0.75
8	Aga Khan	2.00	0.92
9	Mackay house- Ihumwa	0.00	0.00
10	Mvumi	0.00	0.00
11	St Mary Immaculate	2.13	1.12
	Average	**1.32**	**1.41**

It is interesting to note from the table that the highest mean is 3.06 hours (Bihawana) while the least is 0.00 hours (Mvumi and Mackay House). For Behawana the reason is that many villages are far away from the main road and transport is a serious problem. Therefore a patient cannot go to the general hospital or Mackay House and reach their before the queue is very long. This also means more waiting time before getting served. The patients who get services through the Mackay House-Ihumwa-community based programme have zero time to wait because each patient is attended to at home and such services are not offered by the government hospital. The Mvumi Hospital is an exception because under normal circumstances patients do not go to the government hospital because all health facilities are there. Therefore, there are no differences in the waiting time. The t test also shows very significant differences in the means ($P<0.05$) between waiting time for services in one

health centre and another. However, four cases were exceptional. These were between Hombolo and Veyula, Tumaini, Mackay House and Mvumi, due to various reasons. Hombolo is close to Hombolo Bwawani health centre, which reduces the number of patients quite considerably. Some patients who were attending Veyula could also go to Msalato dispensary, hence reducing the queue and waiting time significantly. Tumaini also has fewer patients because of the Police station dispensary. Since Mackay House provides home based, services the waiting time was insignificant. Mvumi hospital has big capacity in terms of nurses from its nursing school which is an advantage although as the government was increasing pay packages, the officials were worried about high attrition rates in the future.

d) Like any other person who goes shopping, one would prefer to go where she or he can get all the goods. Similarly, if more services could be obtained in the private sector under PPP than before, then one can sensibly say that PPP was useful. To capture the type and number of services gained as a result of PPP, respondents were given a long list of services to choose from the period when they attended services in public centres and the current service centre. Data in Table 17 show the extra mean number of health services received from PPP arrangements.

Table 16: Extra mean number of health services received because of PPP (N= 165)

No	Health provider	Mean	SD
1	Hombolo	4.06	2.21
2	Nzuguni	2.00	2.13
3	Veyula	0.93	2.15
4	Chikopelo	3.06	2.84
5	Tumaini	2.73	2.12
6	Bihawana	2.46	2.09
7	Dr. Matovolwa	3.93	3.20
8	Aga Khan	3.20	2.20
9	Mackay House- Ihumwa	7.35	2.13
10	Mvumi	0.00	0.00
11	St Mary Immaculate	1.20	1.20
	Average	**2.78**	**2.80**

Data in Table 16 show that HIV/AIDS patients who were receiving health services through Mackay House Programme were the most beneficiaries because of the social welfare component as was noted in the contributions to PPP in section 4.3.3. On average, all health service providers were able to provide more health services than before PPP, except Mvumi Hospital, which is used as a designated District Hospital where all types of services have been provided for more than four decades as a church initiative. These services include counselling, laboratory tests, referrals, and medication.

In addition, F Test also shows very significant increases in the number of health services ($p< 0.05$) when the previous service provider is compared with the one under PPP in Nzuguni, Veyula, Bihawana, Mackay House, Mvumi and St. Mary Immaculate. Chikopelo was not significant because, due to lack of laboratory services, other services like treatment and medication were limited. Tumaini was not significant because there were close alternative sources of

services including the Police station and general hospital, where a better variety of services could be obtained. Bihawana was more of an infirmary centre than a dispensary because of lack of qualified staff, laboratory services and drugs.

e) One of the reasons why patients go to private service providers is reliability in service provision (UNICEF (1997). It is very disappointing to go to the service provider and after spending a good number of hours one is told come back tomorrow or the service is not available.

To test reliability of services delivered under PPPs, a question was asked if there was an incidence whereby the patients came for MCH health services but failed to get them.

Table 17: Reliability of service delivery under PPP (N= 165)

Variable	Frequency	Percent
Not Reliable	8	4.8
Reliable	157	95.2
Total	**165**	**100**

Data in Table 17 show that 95.2% of the patients never missed out services. These results are very encouraging. However, high ranking on reliability does not necessarily mean that there were no incidences where services were not delivered as scheduled. On one of the days the researcher was conducting the study, MCH services were delivered at neither Hombolo hospital nor Zepise village. Mothers with children on their backs waited for hours only to be told that there were no vaccines because the Mlowa Bwawani Health Centre did not

receive their share for Hombolo (Fig. 18).

Figure 18: Some mothers preparing to leave Hombolo hospital without service

Fig. 18 shows some of the mothers planning to leave Hombolo hospital in anger and frustration. However, the tests on the effectiveness of PPP seem to suggest that the Hombolo case was an exception because overall preference of the private sector was high even if PPP services are not considered. Data in Table 19 show that more than 65% of respondents attended the services either always or frequently.

Table 18: Frequency of attending health services in the private sector (N= 165)

Attendance for reproductive and child health services	Frequency	Percent
Always	38	23.0
Frequently	70	42.4
Somehow frequently	18	10.9
Rarely	8	4.8
Not at all	31	18.8
Attendance for other health problems		
Always	28	17.0
Frequently	58	35.1
Somehow frequently	32	19.4
Rarely	28	17.0
Not at all	19	11.5

PPP has not only attracted a significant number of mothers seeking MCH services but also other services. Data shows that when mothers had other health problems they preferred to go to the private rather than government health service provision centres.

4.3. 4. 2 The effects of PPPs to the health service providers

The first expected impact of PPP on the service providers is capacity to deliver better services. The task here was to find out whether each stakeholder was able to improve their own capacity to deliver services after engaging in collaborations. The units of assessment were changes in the technical knowledge of staff, tools, equipment and other supplies, geographical spread of the services and number of customers served.

It is hard to imagine a situation where there is partnership, which does not improve the capacity of the partners involved. One of the major successes of this study was to document detailed information on partners' capacity to deliver health services to the community. It is not necessary to repeat here, what is sufficiently covered in section 4.2.3 on contributions to the partnership. However, as a matter of brief recapitulation,

all private providers gained knowledge through training, sharing of tools and equipment, stationery and cash subsidies which were all useful for capacity improvement. Some outreach programmes were also facilitated through PPPs and hence improved the geographical spread of the services.

However, to measure the extent to which the capacity to deliver affected service delivery, the best way is to look at the number of beneficiaries from the service over the years. Data collected by the municipality and the district council respectively through MTUHA system for four years shows fluctuating trends in each PPP case reported. The following section presents the patterns case by case, starting with the Aga Khan Dispensary.

(a) Aga Khan Dispensary

Aga Khan Dispensary being at the town centre with the MCH unit run by municipal staff, has reported the highest number of service beneficiaries compared with all the other cases. The number increased greatly between 2001 and 2002. However, and indeed surprisingly, it declined almost at the same rate in 2003 and remained low in 2004. It was found that Measles was the least delivered service because of frequent shortages of vaccines.

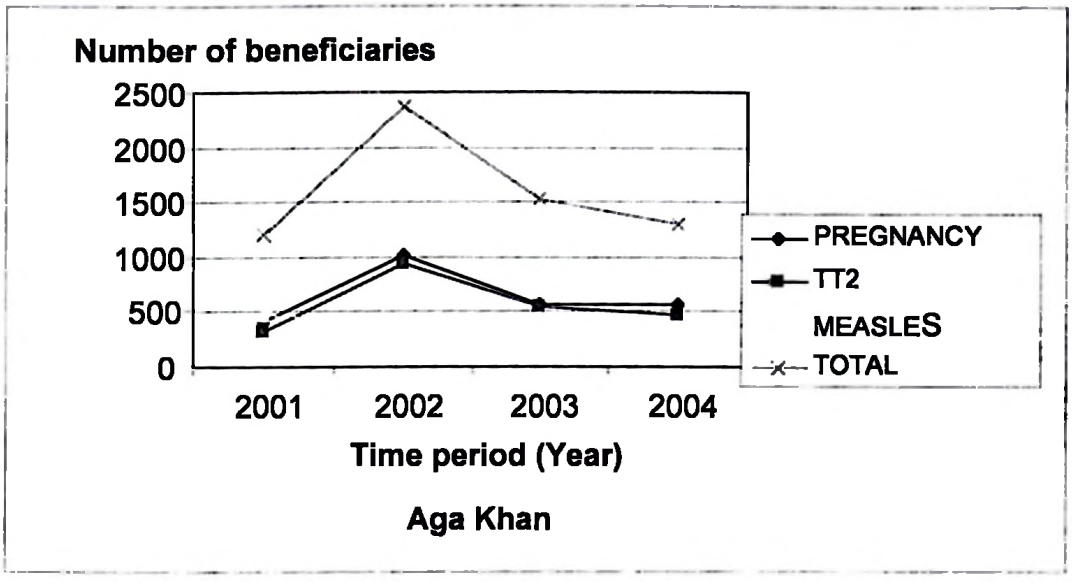

Figure 19: The number of Aga Khan Service beneficiaries (2000-2004)

Although these data were officially recorded and submitted to the municipality quarterly, their reliability is still highly questionable because the staff responsible for collecting data was not committed to the job, as one senior official from the dispensary complained that:

> ...they brought nurses here who were not competent enough... it was like dumping the unwanted ones. I trained them... when they learned that they were now good they shifted to other clinics... I warned them... these days I am told that the municipality conduct courses for nurses but these ones are always left out. I think there is a misunderstanding somewhere (Translated from Kiswahili).

On a different occasion, one nurse complained that she had stayed for 5 years without training despite many enquiries while her colleagues in government clinics attended several courses every year.

... One time there was training for MTUHA but we were not invited. ... They brought me MTUHA forms to fill in. I said I would fill them in when I want. Sometimes I do and sometimes not... I think they do not like us because we are better remunerated (Translated from Kiswahili).

With this kind of working environment of dissatisfaction and complaints, there are limited comments one can make about the data.

(b) Hombolo Hospital

Hombolo Hospital has shown more unsatisfactory patterns. It appears that service delivery was better before 2001, went down in 2002 and shot up again in 2003. They curve down again in 2004. Fig.21 displays the patterns.

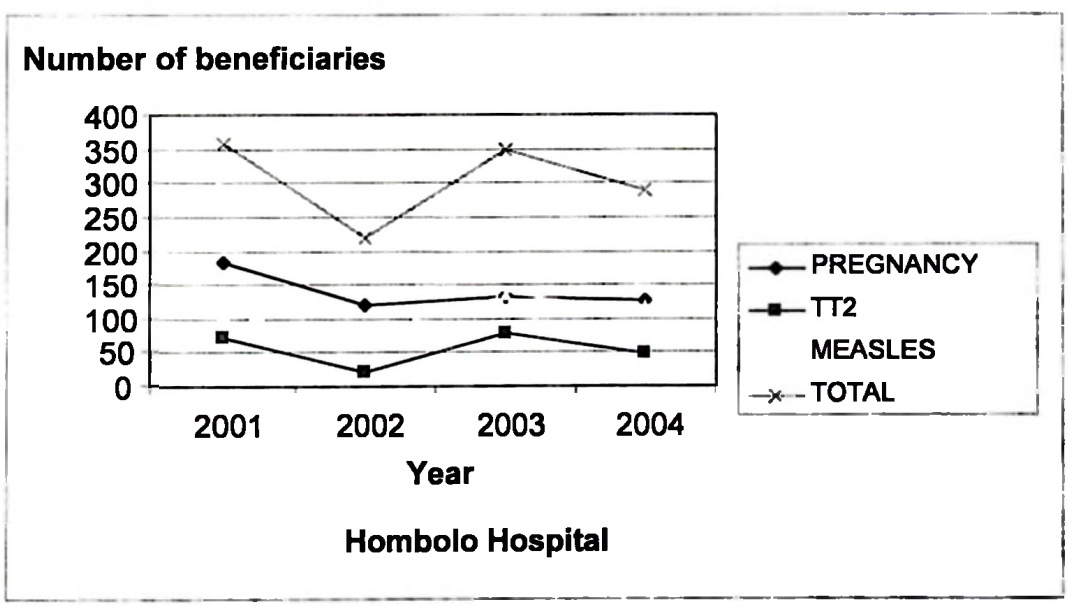

Figure 20: The number of Hombolo service beneficiaries (2000-2004)

The patterns shown in Fig.21are not surprising, for the following reasons: Firstly, in 2002, data available were only for two quarters and in 2004 quarter 4 was not reported. Secondly, there were outreach services offered at Zepise

village, which were not reported, and the data could not be found. Thirdly, service delivery was not reliable because the hospital had no refrigeration facility. It relies on support from Mlowa Bwawani, which is a nearby government Health Centre.

(d) Bihawana dispensary

Bihawana has also reported fluctuating patterns in service delivery. Although inconsistent supplies of vaccines for measles have affected the numbers, there are also reasons to do with record keeping. For example in 2002, the records show data for only 2 quarters because the in-charge for data recording and keeping was away during that time.

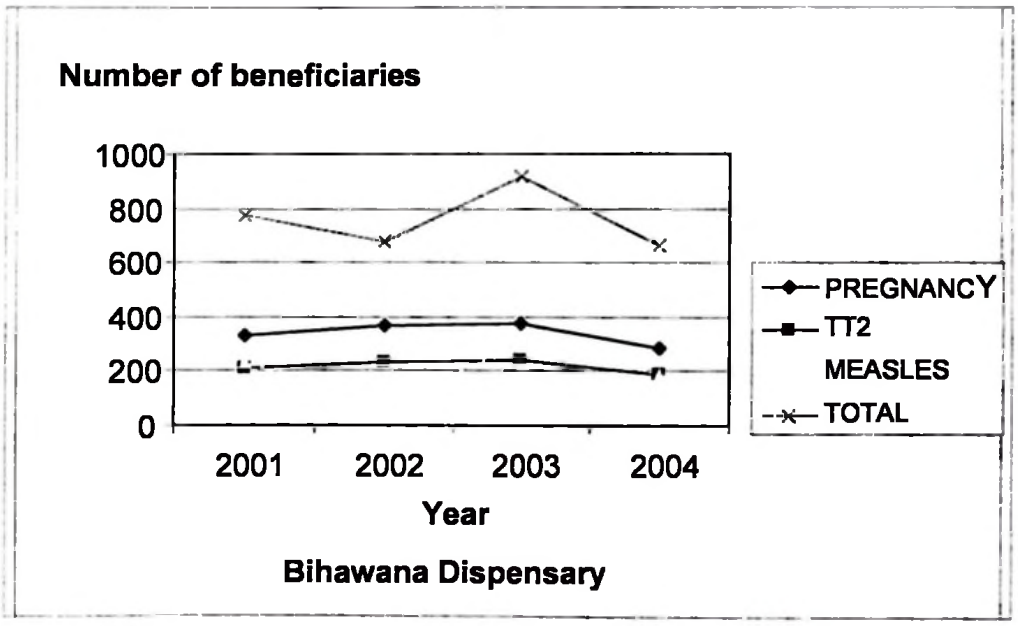

Figure 21: The number of Bihawana service beneficiaries (2000-2004)

The total performance for pregnancy, TT2 and measles has been declining since 2003. Apart from the explanations given above, other reasons cut across all cases as will appear at the end of this section.

(e) St. Mary Immaculate

According to interviews held with municipal officials and the dispensary in-charge and nurses, St. Mary Immaculate has been doing quite well in terms of record keeping and submission to the municipality. However, the results have shown rather declining patterns with slight signs of increase in 2004. This is not normal because the dispensary covers a wide catchment area, including Ndachi village where outreach services are offered. It appears that these figures might be under-represented although no official acknowledged that. The possible explanation is that apart from shortages of vaccines there were also serious shortages of clinic cards for pregnant women. Although efforts were made by the dispensary to photocopy some and distribute them to mothers, some beneficiaries said that they were inadequate, easily damaged and were not used consistently. Sometimes exercise books (daftari) were used instead.

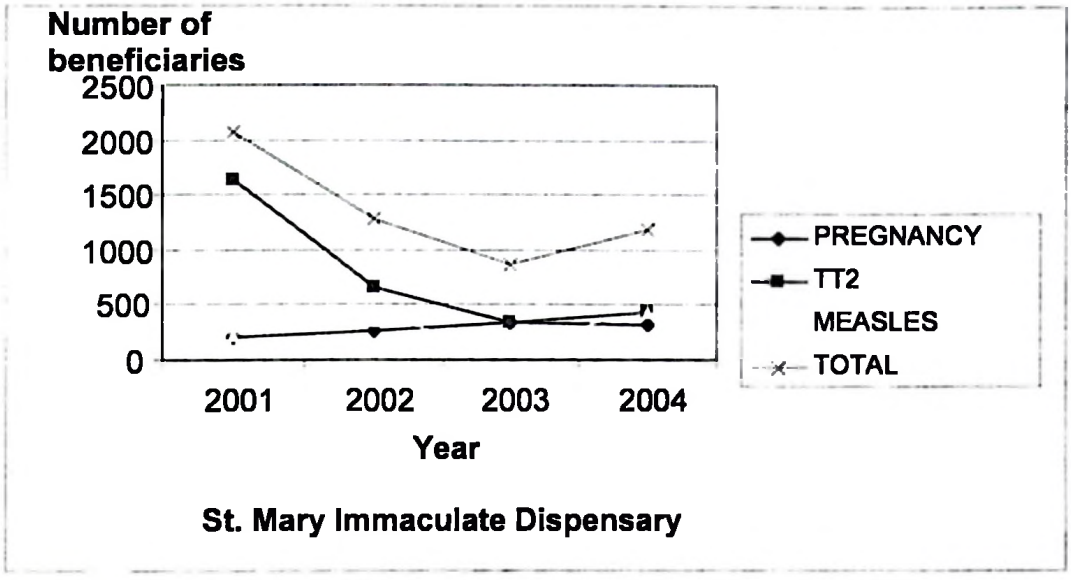

Figure 22: The number of St. Mary Immaculate service beneficiaries (2000-2004)

Therefore, with these data limitations it also important to caution that much as it is important to note the trends the are strong reasons to believe that service delivery must have been better than shown here.

(f) Veyula Dispensary

Veyula Dispensary started fairly well in 2001 with the exception of measles, which has been a common problem throughout the cases. The 2004 records show general declining trends in all types of services. One of the reasons is that data for one quarter were not available.

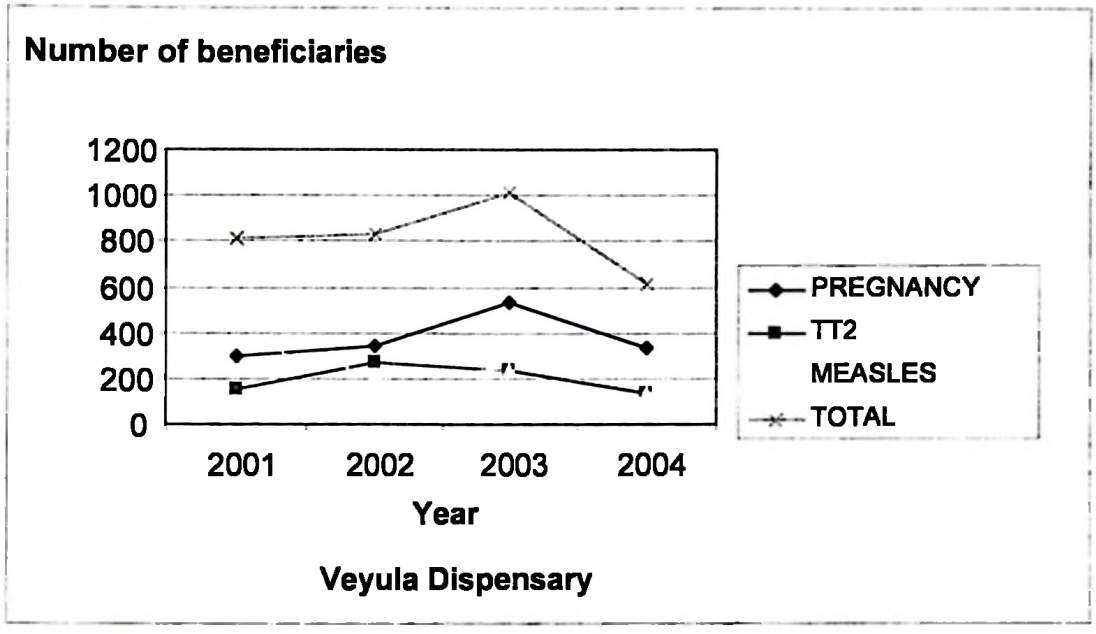

Figure 23: The number of Veyula service beneficiaries (2000-2004)

(g) Nzuguni Dispensary

Nzuguni has reported general low levels of service delivery with only some improvements in TT2 and pregnancy in 2002. The results are in figure 25.

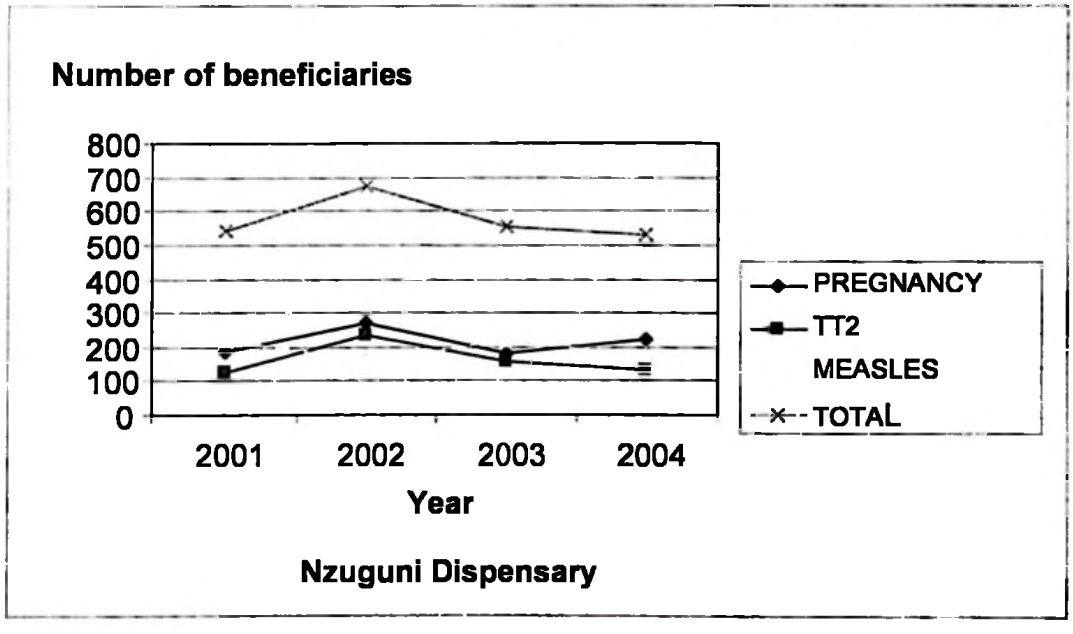

Figure 24: The number of Nzuguni service beneficiaries (2000-2004)

Efforts to get an explanation for the trends from the record keepers have found that there were good reasons for the fluctuations.

Firstly, in 2001 data were for quarters 2 and 4 only

Secondly, in 2002 and 2004 data were for 3 quarters only. However, it was not possible to explain why data for 2003 was so low.

One explanation given by one official is that some mothers could be getting the services in the nearby Isaga Dispensary, which is run by the municipality.

(h) Dr. Matovolwa Health Centre

Dr. Matovolwa Health Centre seems to have done very well except in 2004 although it was very low in 2001. In 2001, data for quarter 1 was not available.

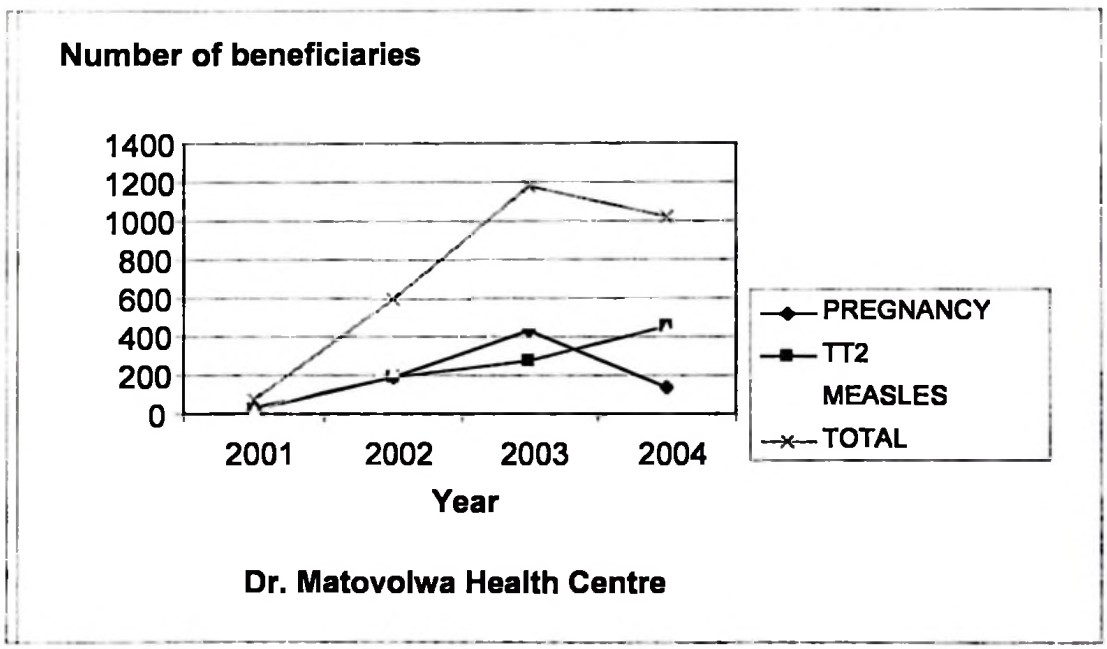

Figure 25: The number of Dr. Matovolwa service beneficiaries (2000-2004)

(i) Tumaini Dispensary

Tumaini Dispensary was rather peculiar because it reported the lowest levels of all cases but showed peaks in 2002 and lowest levels in 2003. However, there were improvements in 2004 which was contrary to other cases.

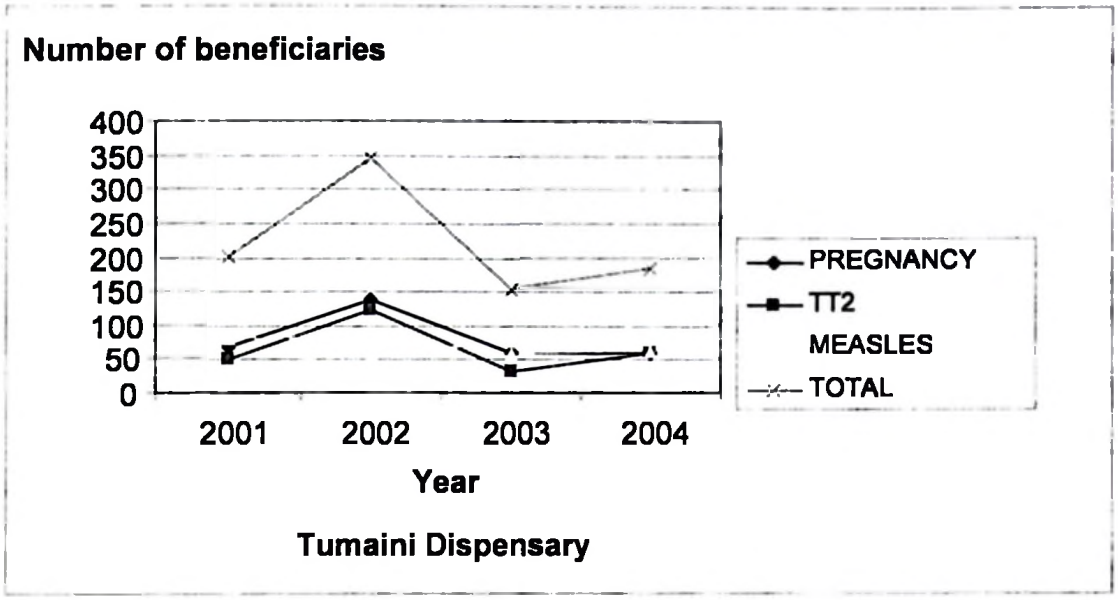

Figure 26: The number of Tumaini service beneficiaries (2000-2004)

Although it was possible that some mothers could have received the same services from the nearby Police Station dispensary, one official felt that the data might have been cooked and hence not reliable.

(j) Mvumi Hospital

Mvumi Hospital in Dodoma District has shown unpredictable patterns when all three types of service are compared.

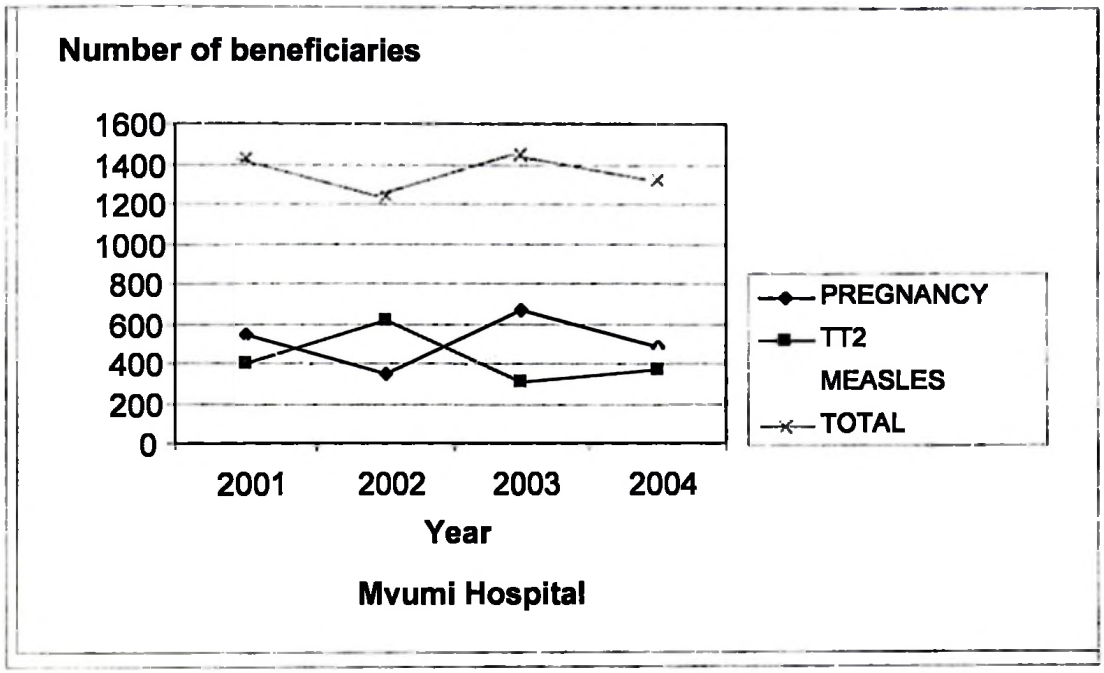

Figure 27: The number of Mvumi service beneficiaries (2000-2004)

Contrary to the other cases, vaccinations for measles have been increasing since 2002. This was influenced by the fact that Mvumi Hospital is being treated as a designated district hospital and had a better opportunity to get enough vaccines. However, it was not possible to get reasons as to why the same opportunity did not improve services for TT2 and pregnancy. For example, TT2 increased in 2003 while pregnancy monitoring declined. The general pattern shows the highest peaks in 2003, but declining in 2004.

(k) Chikopelo Dispensary

Although Chikopelo Dispensary served a large geographical area, the reported figures are the second lowest after Tumaini Dispensary. The general picture shows the highest number of beneficiaries in 2002. Since then the trend has been downward, except for measles, which picked up in 2004.

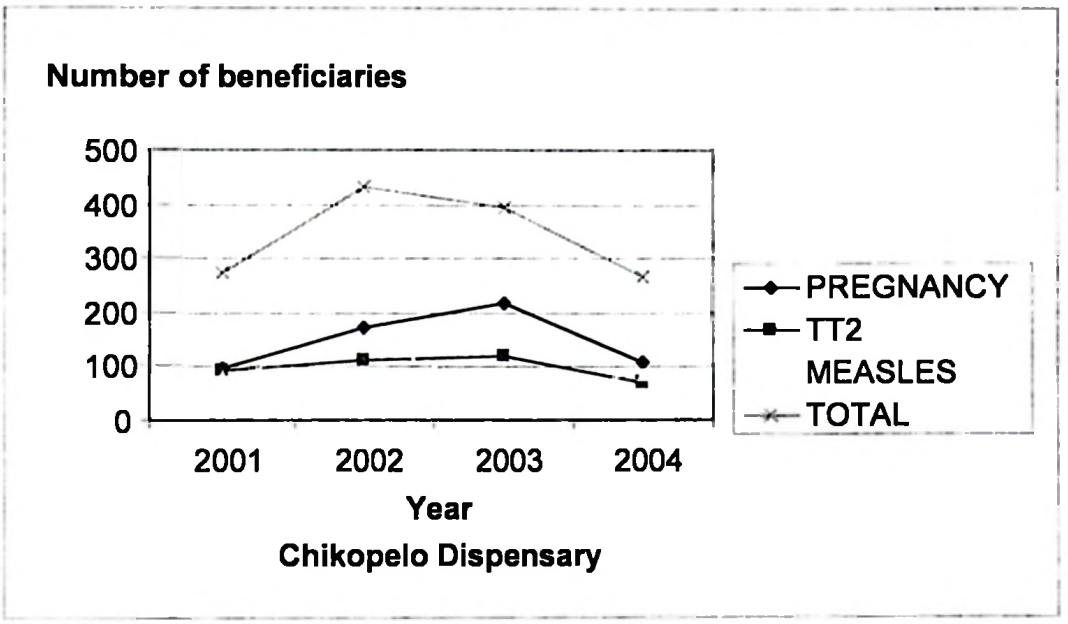

Figure 28: The number of Chikopelo service beneficiaries (2000-2004)

The above scenarios can also combine to give a grand picture of the patterns of service delivery in all PPP cases. Fig. 29 shows the patterns.

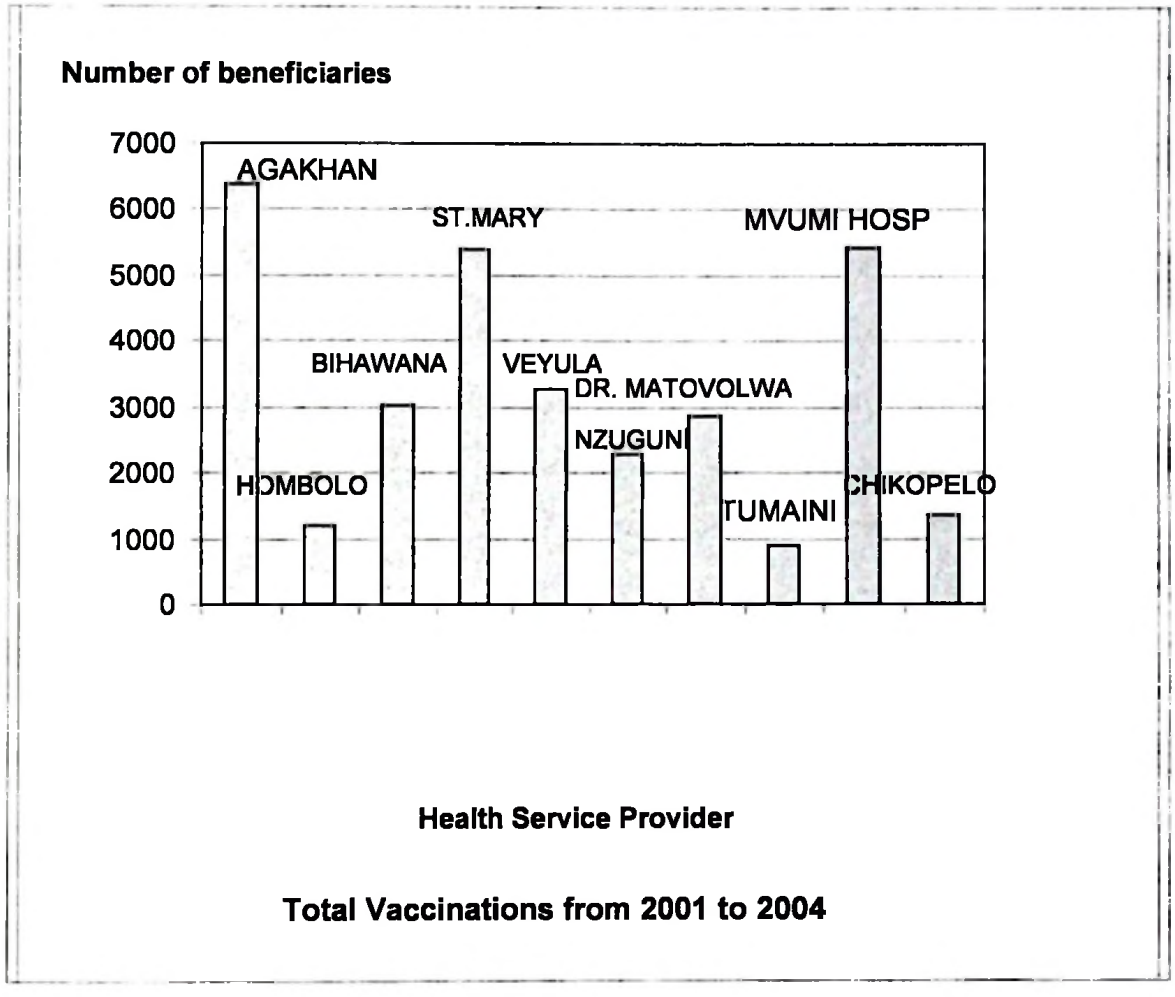

Figure 29: Total Vaccinations from 2001-2004

Source: Compiled from Quarterly MTUHA Reports

Fig. 29 shows that, if the question of data reliability is ignored, Aga Khan Dispensary stands out from the rest, followed by Mvumi Hospital and St. Mary Immaculate. Other efforts to find out the possible reasons for the fluctuations are as follows.

Firstly, is the seasonality. All service providers and beneficiaries had a common agreement that during the farming season attendance for MCH services was lower.

Mothers had to attend to their farms. The better the season also meant more time to spend on the farms and less in the dispensaries. This was the most significant explanation of annual fluctuations. Secondly, it was found that data for TT1 were not recorded because immunity is developed after TT2. Therefore, there was strong possibility that some mothers went for TT1 and failed to attend for TT2 due to farming. Thirdly, Since TT can be obtained from any dispensary, some mothers changed service centres and hence it was difficult to trace them for record purposes. Lastly, the major explanation for low levels of vaccination against measles was shortage of vaccines. These results could be better explained if, from the beginning, there were formalised PPP objectives, targets, monitoring systems and accountability mechanisms. In the absence of all these, it is hard to make further comment on the number of service recipients.

The second component in assessing the effects of PPP is cost reduction on the part of service providers. This was not possible for two reasons. Firstly, it was difficult to estimate the real market value of knowledge gained through training, service rooms, furniture and fittings, informal consultations frequently done with local authority nurses, supervision, stationery and provision of information.

Secondly, with the exception of Mvumi Hospital and Hombolo Hospital which were receiving cash and or materials other health service providers were not ready to admit that service costs were reduced because they did not charge for services under PPPs. Indeed the opposite was claimed by the key informants to be the case, including paying electricity bills, preparing and sending MTUHA reports, and office and

furniture maintenance. A few examples can be cited as cases of cost reduction.

a) PPPs reduced training costs for staff in all private providers

b) All stationery for medical purposes was supplied freely

c) In Hombolo, the municipality supplemented the costs of electricity and salaries

d) All the monetary costs for Michese project were covered by the private sector

e) More than 50% of monetary contributions for the construction of Ntyuka dispensary came through private sector channels and the remaining from the municipality and community

f) From the private service providers' point of view, the average cost of hiring an empty service room and the furniture was estimated at Tshs 30,000 per month, which was paid for directly by the private sector.

g) The average cost of electricity for the service room per month paid by the private service provider was Tshs 5,000.

h) It was also estimated that the average maintenance cost of the service room was 100,000 per year. This includes painting, repairs, and replacement of furniture and fittings.

It was not possible to get average costs for supervision, record keeping and submission to the municipality. Therefore, from with the examples one can confidently say that generally PPP reduced costs of service delivery if they were to be provided by the private sector or the local authority alone.

The third variable on effects was profits accrued by the private sector. This question was a grey area and the most difficult one to deal with for two major reasons.

Firstly, no private health service providers were ready to admit that there were improved profits. Unfortunately, it was not possible to get access to the books of accounts.

Secondly, even if such books were accessible, it was impractical to link the profit with PPP services because such services were not meant for profit. Complaining that PPP was not profitable, one owner/manager said:

> *...There was a time when we had joint diagnose and treatment of STIs. The municipality provided reagents while I conducted laboratory test at subsidised rates. The patient paid an average of Tshs. 300 instead of Tshs. 500, which is the market rate.*

Although the manager was right, there is also the hidden argument that the higher the number of customers the higher the marginal profits.

However, this position was not supported by not-for-profit service providers because they were offering cheaper services, ranging from Tshs. 200 to 300. Therefore, TShs 300 might have been the break-even point.

In the absence of raw data on profits made, the alternative approach is to look at the circumstances surrounding service delivery. Assuming that all business persons are rational and motivated by profit, and profits would increase with increased number of customers, a deductive method can be used to predict the profit scenario (Yin, 1994).

The establishment of an MCH unit increased the number of customers. It is wise to assume that some customers who go for MCH services will ask for other services which have to be paid for. Therefore, the identification of the number of services offered outside MCH can give a general picture of profits.

Questionnaire survey has shown that a significant number of mothers who attended MCH services also received other services for a charge.

Table 19: Types of service for profit

S/N	Types of service	Frequency	Percentage
1	Laboratory tests	118	71.8
2	Medical examination	96	58.2
3	Medical prescriptions	94	57.0
4	Bought drugs	93	56.4
5	Referrals	79	47.9

Source: Survey data October 2005

Their family members also went to the private service providers and paid for other services. It was also interesting to find out that, even the family members who did not need services under PPPs were also seeking other health services from private health service providers. Data in Table 21 show the frequency of attendance.

Table 20: Frequency of attendance of family members at the private hospitals

Attendance by other family members	Frequency	Percent
Always	27	16.5
Frequently	47	28.5
Fairly frequently	31	18.8
Rarely	29	17.6
Not at all	31	18.8
Total	**165**	**100.0**

Data in Table 20 show that more than 60% of the family members of the respondents attended the same service providers for a variety of health problems, which required medical examination and treatment. Therefore, there is no doubt that profits were made out of consultation fees, laboratory tests and selling of drugs.

Information sharing is also important in PPPs, with information being shared through seminars and in a few instances during meetings. The rest of the information received by the private sector was in the form of guidelines and instructions as directed by the Ministry of Health and Social Welfare. The role of the private providers in the informational aspect was record keeping and submission to the local authority as prescribed by MTUHA guidelines. Although this information could have been a strong basis for collaboration, it was one-way traffic. There was no feedback. Complaining about the lack of feedback, one official from the private sector said;

> ... *We have been sending them reports for years but we do not know what they do with them and how we help* (Quoted from the manager of a private hospital- translated from Kiswahili)

There was no information sharing through research, consultancy or publications. Furthermore, risk transfer is an impact of PPP. In section 4.3.1, it was observed that no stakeholder identified own risks before engaging in PPP. No joint discussion took place on risk issues either. Therefore, the only comment that can be made from this finding is that, since most services under PPP were MCH and still delivered and controlled by the local authorities, government risk transfer to the private sector is very limited.

The assessment of the effects of PPP in the literature has been mostly one sided. The tendency has been to look at the influence of certain health service programmes on targeted beneficiaries. These include reduced disease severity (Saade *et al.*, 2001, Haran et al., 1994), quality of health care (Haran *et al.*, 1994, Chakraborty *et al.*, 2000) and reduced levels of malnutrition (Marek *et al.*, 1999). Others are improved community knowledge on good health practices (Koul *et al.*, 1991, Ferraz – Tabor, 1993) and availability and sufficiency of medicine, and equal access (Warioba, 1999), and the overall costs reduction in costs through sub-contracting certain aspects of the health programme (Mills, 1998). The assessment of the effects of PPPs on the stakeholders has been to take stock of each partner benefits, including profits or otherwise which directly or indirectly arose from the collaborations. This study has focused on different sets of effects on both service beneficiaries and providers.

On the part of health service beneficiaries, the research results have shown significant positive effects of PPPs on the distance travelled, money saved from travel costs, service types, travelling and waiting times for services, and reliability. As a general rule, the literature suggests that improvement in health service delivery as an effect of

PPPs is not news. Similarly the Dodoma cases have not proved otherwise.

The main news found here in Dodoma is that, while in other countries such effects were through a regulated PPP framework, in Dodoma they were through mutual support and working relationships not subject to legal enforcement. In addition, these results are informative and largely complement the existing literature on PPPs and stakeholder theory because they have captured and measured important PPP assessment variables (categories and numbers), which are hardly observed in similar studies elsewhere.

Most studies are more descriptive and, where effect is rigorously assessed, fewer variables are considered as a matter of appreciation and support of certain conclusions about the value of collaborations. For example an Indian contract between the local authority and a local NGO (Anganwadi Centres) through Integrated Child Development Scheme managed to improve the provision of supplementary nutrition, immunisation, health check-ups, and referral services. Both the NGO and auxiliary nurse midwives were selected through a competitive process, which involved local community members (Planning Commission, 2004).

However, it is not known how such health service improvements were measured. Furthermore, in an effort to control tuberculosis, the government of India, through the district tuberculosis society used private medical practitioners, NGOs, paramedics, private hospitals and nursing homes on a 3 year renewable contract. Services were paid for as agreed by the contract. The good thing is that the process was through competitive bidding and negotiations and payments were in the form of grant aid.

According to the contract, where performance was unsatisfactory, the penalty was termination without notice. Improved capacity led to the reduction of TB cases by 85%, which is very successful. These are very useful lessons not only for Dodoma but also for the whole country.

To mention a few instances, using Indian experiences, Chikopelo dispensary could be used to facilitate the control of bilharziasis, which is a common problem in the village because of reliance on water from a nearby dam. Veyula dispensary was also interested, if given the opportunity in observing patients taking tuberculosis drugs (Direct Observation Strategy) while Hombolo was asking for collaboration to continue treating leprosy. Increased capacity in terms of number of service providers and resources also means increased consumer choice.

Similarly, in the United Kingdom, increased treatment capacity, reduced waiting times and more choice for patients were realised by using public funds to buy elective surgery services in private clinics, and by doing away with direct provision by government hospitals (Burnert, 2006). However, while in Dodoma the study has specified and measured the time saved and the percentages of patients who were in favour of the services through PPP, the cases in UK are not well articulated for academic purposes although it remains logical that, in any country, increasing the number of service providers increases the choice for patients.

In Zambia, the effects of PPPs in controlling malaria were assessed in terms of cost reduction in the supply of anti malaria drugs (Coartem). Lower costs influenced the prices for patients, who therefore had better access to the drugs. It was found that

collaboration with Norvatis (private company) reduced treatment costs from USD 12 to USD 2.40 per dose (Dlamini et al., 2004). Here access has been treated as opening up more opportunities through cost reduction of the drug. In a way the Dodoma case has moved a step further by looking at the facilitation of patients' access to the service centres in terms of reduced distance and cost of transport. This is useful complementary knowledge.

It is common in researches on effects of certain interventions to come up with negative aspects to balance the positive outcomes. Shortcomings in any project are normal but what is more important and indeed difficult to measure are the effects of such weaknesses on specific study variables in this study. For example, lack of transparency and effective accountability (Hombolo, Aga Khan), duplication of efforts (Mackay House project in Ihumwa village), and ineffective communication that was common for all cases affected the variables assessed. However, since the targeted beneficiaries were very positive about the programmes and even service providers were happy with continued collaboration, to dwell on the weaknesses of PPPs in Dodoma in more detail becomes less important.

In assessing the effects of PPPs on the service providers by using capacity, cost, and profits, significant steps were taken to explore capacity improvement in terms of number of service beneficiaries, geographical coverage and capacity building through training, as well as various supplies. This strategy is quite common elsewhere (Jacir de Lobo, in Fiszbein, 2000, Saade, et al., 2001). The main difference is that, unlike the former, the latter has been on programmes that were rigorously enforced through contracts. The assessment of programme costs and profits or benefits to the private

providers has been lacking in the literature, except where costs or benefits were determined by comparing two alternatives. Firstly, whether the overall project cost is implemented by government alone or secondly, whether it is outsourced (Mills, 1998). Therefore, what the actual costs are of engaging in PPP vis-a-vis the benefits (profits) have been lacking. This area was of interest in this research and hence pursued, though with some limitations as observed earlier on, which may also tell why such studies are not common in the literature. Despite such limitations, by looking at the data on contributions to PPPs and supplementary information from interviews it was possible to get a rough picture of what the costs to the private service provider could be, including training, stationery, service room, electricity, and salaries for the projects that were already in operation. Also the lists of contributions to the partnerships unearthed benefits (profits) although failure to quantify these in terms of monetary values is acknowledged.

The use of circumstantial evidence to predict profit-making possibilities through the provision of services outside reproductive and child health services (laboratory tests for mothers and children, disease treatment) is a methodological innovation that may be used elsewhere to predict the chances that profits were made or not, where hard evidence may not be forthcoming. The other is to detect the spill-over influence of targeted beneficiaries (mothers and children) on other members of their households and relatives in seeking paid health care services from private providers belonging to PPP categories.

Therefore although no private service provider acknowledged that costs were reduced and or profits were made from the collaborations, the emerging evidence tends to

support the view that PPPs do reduce costs of service delivery, not only for programmes under PPPs but also for the services meant for profit making. This conclusion, coupled with the satisfaction expressed by the service beneficiaries, is a counter argument that PPPs could work against the intended service beneficiaries when there is no strong regulatory framework for PPPs (Humes, 1999; Reich, 2000; Rosenbaum, 2006). However, when it comes to community-based projects, the Michcsc casc supports the argument that in the absence of strong government and the community, a powerful private sector may use the available opportunity for collaboration to pursue its own objectives at the expense of the local people. The community dispensary built by Konoike Company as compensation to the community might be just a token compared with what it benefited from the road construction contract. However, the local authorities (municipal and rural) had no data to support any argument that the government could have done better without collaborations.

All in all, despite some complaints that the private sector was not systematic and reliable in submitting MTUHA data sets, and that the faith-based service providers were hindrances to condom use and contraceptives, the use of the private sector was a significant relief to the local authorities in terms of accountability to the citizens.

Information sharing was another area that was thought could be beneficial to all stakeholders, particularly through joint research, consultancy and training. Although there might be good experiences in other countries, no evidence was found in the reviewed literature. Mvumi hospital had joint training with district staff based on technical expertise and experience of many years.

In the rest of the cases, information sharing was through formalised training of some staff, conveyance of instructions and guidance from the MoHSW, and informal exchanges during general supervision of both private and municipal staff. The MTUHA system could have been a useful way of sharing information in a forward and backward manner, which was not the case. This is an opportunity which should be utilised in a more meaningful way.

From a methodological point of view, it was necessary to study PPP cases from private for profit and faith-based service providers in anticipation that the nature of and motives for PPPs, models, contributions and effects could be different because by nature they are different. With the exception of Hombolo and Mvumi hospitals that had preferential treatment as designated district hospitals, there was no reputable evidence to suggest that there was anything serious in these categories of health services providers in participating in partnerships.

A small difference, which of course might matter regarding service beneficiaries' preferences, is that there was more of a human face among Christian faith-based providers in facilitating PPPs. This includes the use of own resources, time and provision of free drugs to the poor which was uncommon, not only in the private for profit providers but also the non-Christian provider.

Similarly, the choice of Dodoma Municipal Council and Dodoma District Council was for comparison purposes. That is, PPPs in urban centres could be more successful than in rural areas due to factors such as better access to information, networks and a better-educated population with more income.

The findings show that the difference between rural and urban areas was the concentration of more PPPs in the latter than the former. This is not surprising because it reflects the usual rural-urban dichotomy. However, other factors like income level, education, distance to health centre, waiting time, and transport costs were not significantly different between urban and rural areas. One major explanation is that a large proportion of the area of the municipality is categorised as rural or mixed (semi-urban). Therefore an attempt to propose that people in Dodoma urban area were getting better PPP services than in rural areas is faulty, unless it is qualified in terms of average numbers of PPPs. Indeed people who received services in Mvumi hospital (rural) were better off compared with those in Dodoma urban, because the former had a status comparable to a referral hospital.

The main disadvantage of the Dodoma rural areas is that there were only two health providers under PPP. The rest were public dispensaries and health centres or mission infirmaries (mostly short of staff and other essentials). The gap between rural and urban in Tanzania is quite different from India where rural health services have been improved by putting more emphasis and resources there(Bjorkman, 2007)

Therefore, efforts to reduce rural-urban disparities have to consider that there could also be people living in urban areas who face health service access problems similar to rural areas.

4.4 Summary

As a reminder of the whole research project, it was noted in chapter one that Tanzania has no regulatory framework for PPPs. This has led to limited understanding of the nature, motives, models, contributions and effects on PPPs to the key stakeholders. It was envisaged that by investigating PPPs in Dodoma, it would be possible to come up with a better understanding of local level PPPs and how that could inform the process of establishing regulatory framework and management of PPPs in Tanzania. In addition, it was also anticipated that such experiences could add value to the ongoing global discourses in the conceptualisation and management of PPPs.

Therefore, as a summary of the findings, it is observed that.

a) The nature and motives of PPPs in the study in Dodoma were influenced by the initiator of the PPP and the needs of key stakeholders. PPPs were formal, semi-formal and informal arrangements for sharing available resources between the government and private sector organisations for direct or implied benefits to the key stakeholders. PPPs were formal when there were formalised arrangements for collaboration and informal when personal relationships between staff of the partner organisations influenced the initiation and management of the partnerships. This is contrary to the conventional models whereby PPPs are arrived at through systematic needs assessment of resources, risks and rewards that have to be shared by the key stakeholders.

b) From the literature review, it is understood that there are four main PPP models that are used worldwide to manage partnerships in public service

delivery. Each model depends on the needs and context. In order to assess how the Dodoma cases are faring in PPPs, the same continuum of models was applied. In this study, the various PPP models were treated as variables and the characteristics of such variables as indicators. It was found that PPP models in Dodoma can be described as "general semi-formal agreements" to share available resources and expertise for a social goal. This makes these models fit in between simple collaboration and joint venture in the PPP continuum shown in figure 1. However, the word "agreement" here does not necessarily mean that there was what one may call a "meeting of minds" among the stakeholders or even the existence of formal PPP documents meant for legal enforcement in case of breach of agreements. It was more or less a matter of "give and take" or "ask and it shall be given if willing, or what is asked for is available" for partnership interests.

c) Stakeholders' contribution to PPPs ranged from 32 to 39 items. They include office accommodation, personnel, salaries, vehicles, furniture and fittings, tools and equipment, and cash. It is important to note that, since there was no formalised system of assessing the needs of each stakeholder, each contribution came piece-meal, depending on the situation, availability of what is asked for, and willingness of the partner to contribute to the health project.

d) Despite limitations a regulatory framework and accountability in the management of PPP projects, the effects of PPPs were very positive for each stakeholder involved. On the part of service beneficiaries, PPPs meant better

access not only to health services under PPP arrangements but much more access to other health services provided by the private sector. The private stakeholder benefited from PPPs through improved capacity building to provide health services and hence more potential for profits. Resources and information sharing, and increased service delivery capacity for the citizen were the main achievements of PPPs on the part of the government.

With these findings, some conclusive statements can be made which will dictate the need to take some specific actions in order to improve PPPs in the health sector in Tanzania. Some specific conclusions and recommendations are presented in chapter five.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1Conclusion

a) In regard to the nature and motives of PPPs. firstly, it is well documented that PPPs are usually established through a process whereby the local authority would bring key stakeholders together and assess the feasibility for collaboration in terms of common objectives, resources, expertise, rewards and risks sharing. The experiences in Dodoma were different. The needs and initiations of partnerships came from different stakeholders in search of sharing meagre resources in the name of health service improvement. Answers like how to go about collaborations, what each stakeholder aimed to achieve and how to assess performance were either not forthcoming or illusive. Indeed, what PPP was all about remained in the minds of individual persons who initiated particular collaborations in health service delivery. Such individuals came from the government or the private sector.

b) Although it was expected that, even with the absence of a specific regulatory framework for PPPs at the national level, local authorities could have their own home-grown frameworks for regulating partnerships, this was not the case. This was largely influenced by the fact that collaborations were mostly on national public health programmes driven by the donor community through the MoHSW that had a greater say in the PPP projects. Indeed the local authorities were more implementers of wishes for collaborations from the top which was shown by the reactive responses of requests for collaboration from local

partners or "solicitation" of places for the provision of reproductive and child health services. As a result, collaborations lacked strong ownership and management at the local level.

c) Although the combination of the Urban Authorities Act 1982, the Public Procurement Act 2004 and the Private Hospital (Regulations) Act 2002 could be used to provide a relatively better regulatory framework for PPPs, and hence guide the nature and motives for collaborations, there were no conscious efforts to do so. The agreements were mostly informal and verbal without a formalised documentary system usually used in contractual relationships. Therefore, there were no strong reasons to believe that there was a consensus in such PPP agreements. The implication has been lack of PPP documents for reference or taking action where deviations from set working relationships took place. Indeed, partnerships evolved through a style resembling teachings in the Holy Bible where we are told that "ask and you shall be given". Indeed in PPPs it goes further "ask and you may or may not be given and you might not necessarily get or receive feedback".

d) Although it was national policy for local authorities to forge partnerships with the private sector through resource supplies, there were also locally initiated partnerships by different stakeholders (local authority, private, for profit, religious based health provider, NGO). They were in the form of requests to get or share resources, which in the process lacked transparency, and were sometimes subjective in the way contributions were made.

e) The experiences of thirteen PPP cases in Dodoma show that the models in use fit in somewhere between simple collaborations and joint venture in the PPP continuum presented in Fig. 1.

f) Stakeholders' contributions varied depending on the nature of the partnership itself. They included labour, expertise, supervision, resources and cash. However, it was noted with surprise that some community members are forced to make additional contributions to PPP projects by releasing their traditional land for construction works without compensation.

g) Despite limitations in the institutional framework and accountability in the management of PPP projects, the positive effects of PPPs on the key stakeholders were significant.

h) Based on the diversity of PPP cases found, and the nature and motives for their establishment, the study has added to the literature on public private sector collaborations an alternative definition by putting emphasis on the concepts of resource sharing, informality and stakeholder benefits.

i) Both the PPP and stakeholder discourses worldwide support the argument that PPP cannot be successful without having a strong government, a strong private sector and vibrant civil society. Evidence from the thirteen PPP cases show that the local authorities, the private sector, the civil society and communities were

not strong enough to initiate and sustain successful PPPs in a conventional manner. However, despite the limitations, and strong dissatisfaction of each stakeholder on the way the partnership started and operates, in a finger-pointing style (see descriptive finings), the benefits were visible and all were ready to continue and improve the collaborations. Therefore, by referring to the analytical framework adopted in this study, it appears that PPPs can be successful without following any particular formalised conventional model, although having one will certainly improve the situation.

5.2 Recommendations

There are many recommendations that can be made from the study. Some are to do with high-level government organs; others are best handled at the local level, while still others require partnerships. Since the study involved different stakeholders, it may be useful to categorise the recommendations to specific stakeholders as follows.

5.2.1 The local authorities as stakeholders in PPPs

a) Since data support that PPP is the right policy option, it is important for the local authorities to work closely with the ministries responsible (Prime Minister's Office, Regional Administration and Local Government and the Ministry of Health and Social Welfare) in order to establish specific laws and regulations that can be used as guidance in initiating and managing various forms of PPP in the health sector. The laws and regulations will reduce many problems which arise due to lack of awareness, clarity, responsibility and accountability in PPP arrangements. The laws and regulations could establish

one responsible unit for guiding PPPs in all health projects in the local authorities in the country.

b) Local authorities should establish PPP units that will be responsible for identifying suitable areas for partnerships, conducting feasibility studies, facilitating monitoring and evaluating their establishment. Such units will coordinate PPP initiatives wth support from the national level unit.

c) Having an appropriate PPP policy and regulatory framework is one thing, but making it effective is another. Strong PPP require that each partner has certain sustained strengths, including financial, technical and human resources, to fulfil the agreed obligations and be ready to account for whatever happens. The research findings show that local authorities run partnerships by depending on resources from the central government and donors through top- down health programmes. It is important that local authorities develop strategies for reducing the dependence syndrome by setting aside some funds from own revenue for supporting even a simple form of partnership with the private sector.

d) While the current rather centralised PPP programmes go on, it is high time for the local authorities to renegotiate with development partners so that contractual relationships determine support packages, so that instead of channelling PPP resources through the top-down programmes of the MoHSW, they could go directly to the local authorities to facilitate robust types of PPP

where the contribution of each stakeholder would be determined in a systematic manner.

e) Simple PPPs like the ones in the study areas are good but not optimal. Pushing for better models along the PPP continuum beyond joint venture is a desirable strategy for the future because there would be better utilisation of both public and private sector efforts to improve health and health care.

5.3.2 The private for profit stakeholder

a) It was observed that, although the private for profit sector was eager to work with local authorities in health service provision through partnerships, the major problem was lack of trust. Both the community and local authorities did not trust the private sector operators because of their tendency to maximise profits at the cost of providing good quality services. Lack of trust is partly attributed for lack of transparency in transaction costs. It is recommended that private sector partners should make their books of accounts more open during negotiation for partnerships.

b) It was found that although private for profit stakeholders had legally established health centres and dispensaries, at the centre of the matter they were sole proprietor businesses. That is, the founder was also the owner-manager- practitioner. This creates doubts as to the sustainability of the business and the PPP itself. It is important that these businesses are registered as partnerships in which different interested professionals and other investors

could have shares. This will not only improve the resource base for the private sector but also safeguard the future of partnership projects.

5.2.3 Religious service providers

a) We have noticed that most PPPs were between the local authority and religious- based health service providers. They have been doing a good job by putting service to the community first before profit. They are highly commended for that. However, like in government dispensaries, health centres and hospitals, there were critical shortages of skilled staff. It is recommended that, while continuous training through PPPs is necessary, pay packages should be reviewed in order to attract and retain qualified and motivated staff.

b) Since health service transactions in these institutions are also not sufficiently transparent, in order to improve trust; more openness with collaborating partners is not only important but also necessary.

5.2.4 The community

a) It was found that in all PPP cases where the community was involved, success depends on leadership and community participation. Therefore, it is recommended that, during the election period, ability to sense an opportunity for a community project and mobilise key stakeholders for a common goal should be one of the critical competencies of a potential candidate. Moreover, capacity building, training on leadership, community mobilisation and networking are necessary for leaders at the ward and village level.

b) In a PPP project where construction work is required, questions of land and land ownership are paramount. In all the cases, it was found that dispensaries were built without serious thought and planning regarding land issues. As a result, some community members were illegally deprived of their land ownership rights at the expense of community dispensaries without compensation. It is recommended that village governments should have strategic land ownership and utilisation plans. In cases where individuals have to part with their traditional land ownership rights, compensation is well planned through formal negotiations and agreements.

However, although PPP seems to be the right policy option for improved health service delivery to the people, there is still a grey area which requires better understanding for improvement that is the strengths and limitations of both the public and private sector in engaging into medium and large scale partnerships in health service delivery in the country. Therefore, in the future, since the present study has used both positivist and post-positivist methodologies in bridging the gap between qualitative and quantitative variables, it is hoped that similar approaches could be adopted and adapted to enrich the knowledge of research methodology, PPPs, and stakeholder discourses.

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APPENDICES

Appendix 1:

List of independent and dependent variables

List of independent variables		List of dependent variables	
1	Shared expertise	1	Access
2	Shared resources	2	Service types
3	Shared risks	3	Service time
4	Common objectives	4	Service reliability
5	Simple cooperation	5	Service costs
6	Joint venture	6	Service profits
7	Direct contract	7	Service information
8	Lease	8	Capacity to deliver
9	Concession	9	Risk sharing

Appendix 2:
Variables indicators and measurements

Variables	Indicators	Measurement
Expertise	Technical competence of staff	Evidence of expertise shared through partnership
Resources	1. Salaries and or allowance 2. Modern laboratory 3. Staff 4. Office room 5. Tool kits 6. Office furniture 7. 7. Others	1. Estimated Tanzanian Shillings to the total cost of PPP 2. Stakeholder judgment of the partner's contribution
Risks	1. Profit loss 2. Technical failure 3. Financial failure 4. Operational failure	1. Stakeholder perception of such failures 2. Incidences of risk transfers
Common objectives	1. The existence of agreed common objectives for the partnerships	Awareness of each stakeholders' knowledge of the common objectives of the PPPs
Simple cooperation	No strong regulated PPPs	Lack of clarity on how PPP started, no documented evidence on agreements, evidence of solicited need for collaboration in areas of common interest
Joint venture	1. There are balanced roles 2. There are balanced interests 3. There are balanced risks 4. There are balanced accountability 5. There are balanced decision making 6. There are balanced benefits	1. Perceived equity in sharing activities amongst stakeholders 2. Perceived equity in interests to save public health 3. Perceived equity in sharing perceived hazards 4. Perceived equity in conforming to joint agreements 5. Perceived equity in arriving at decisions 6. Perceived equity in stakeholder benefits from PPPs
Direct contract	Service contract	1. Availability of contractual documents 2. Availability of service details 3. Availability of modes of payment 4. Availability of contract duration 5. Specified clause for private asset ownership 6. Specified clause for accountability to the public
Lease	Lease agreement	1. Types and number of infrastructure/service leased 2. Types and number of facilities leased 3. Number of years of lease 4. Responsibility for the private to charge service recipients 5. Responsibility for the private to bear financial risks 6. Responsibility for the government to retain accountability
Concession	Concessionaire	1. Types and number of infrastructure/ service under concession 2. Types and number of facilities under concession

Access	Distance	Estimated number of kilometers traveled to get service before and after PPPs
Service types	1. Preventive (family planning, immunisation, community campaigns on hygiene and HIV Aids) 2. Curative (Disease diagnosis, treatment, laboratory services, referrals, drugs	1. Types of services before and after PPPs 2. Number of services before and after PPPs
Service time	Waiting time for service	Estimated number of hours waited before getting service
Reliability	Consistence in service availability	Percentage number of days the health service was missed per year
Cost	1. Salaries and allowance 2. Modern laboratory 3. Staff 4. Office 5. Furniture 6. Tool kits 7. Provided transport 8. Rehabilitation 9. Others	Estimated monetary value in Tanzanian shillings per the duration of the PPP or per year
Capacity	1. Technical competence 2. Types of services 3. Number of clients served 4. Geographical spread	1. Evidence of staff who received technical knowledge through PPPs 2. Number and types of tools and equipment acquired through PPP 3. Number and types of services provided 4. Number of clients served before and after PPP 5. Number of health service provision points in "new" geographical locations
Profits	Money generated after deducting all costs	Estimated or actual Tanzanian shillings
Information	1. Joint data collection 2. Join newsletter 3. Joint research 4. Joint training 5. Joint consultancy 6. Joint publication 7. Joint conferences/workshops 8. Joint community sensitisation	1. Availability of data jointly collected per the duration of PPP 2. Use of jointly collected data per the duration of PPP 3. Number of joint training programmes per the duration of PPP 4. Number of joint researches per the duration of PPP 5. Number of community programmes run jointly

Source: Constructed from the analytical framework in Figure 2 and 3

Appendix 3

Data collection instruments

Instrument I – For use by the researcher

1.0 Interview Guide/Checklist for Key Informants

Background information

- Name of stakeholder – Public/Purely private/NGO/CBO
- Location
- Position of interviewee – Owner/Manager/Technician/Academic&Professional qualification/Experience

About the organisation

- Year of establishment
- Reasons for establishment
- Objectives
- Major source of funding
- Public services provided

About the nature and motives of PPPs

Background information on the establishment of PPP

Variables that define the nature and motives of PPPs

	Indicators	Yes	No	Do not know	Explanations/Examples
1	Common objectives for PPPs understood?				
2	Shared expertise				
	1. Technical competence?				
	2. Experience?				
3	Shared risks				
	Profit loss				
	Technical failure				
	Financial failure				
	Operational failure				
4	Shared resources? (List down)				
5	Other characteristics?				

CHECK LIST

About PPP models adopted

Joint venture?

Check list

	Indicators	Yes/No	Explanations/Examples
1	Equity in sharing activities		
2	Equity in saving public?		
3	Equity in sharing risks?		
4	Equity in honouring agreements?		
5	Equity in decision making?		
6	Equity in sharing benefits?		

Direct contract?

Check list

	Indicators	Yes/No	Explanations/Examples
1	Contractual documents available?		
2	Service details available?		
3	Modes of service payment available?		
4	Contract duration stated?		
5	Clause for private asset ownership?		
6	Specified accountability mechanisms?		

Lease?

Check list

	Indicators	Yes/No	Explanations/Examples
1	*rvice/infrastructure leased?*		
2	Evidence of facilities leased?		
3	Stated number of years of lease?		
4	Responsibility for the private to charge?		
5	Responsibility for private to bear financial risks?		
6	Responsibility for government to bear accountability?		

Concession?

	Indicators	Yes/No	Explanations/Examples
1	Evidence of service/infrastructure conceded?		
2	Evidence of facilities conceded		
3	Stated number of years of concession		
4	Responsibility for the private to charge?		
5	Responsibility for private to bear financial risks?		
6	Responsibility for government to bear accountability?		
7	Requirement for additional capital investment?		

What each stakeholder contributes to the partnership?

Check list

	Indicators	Yes	No	Explanations/Examples
1	Money			
2	Labour			
3	Staff			
4	Drugs			
5	Equipment			
6	Transport			
7	Office			
8	Furniture			
9	Information			
10	Tool kits			
11	Others (List all)			

- Which stakeholder makes the most significant contribution and why?
- What is the estimated monetary value?
- Which stakeholder makes the least contribution? And why?

Effects of PPP to stakeholders

Reduced operational costs?

Check list

	Indicators	Tick	Explanations/Examples
1	Staff salaries		
2	Staff allowances		
3	Laboratory services		
4	Equipment		
5	Building		
6	Office room		
7	Office fittings		
8	Tool kits		
9	Transport		
10	Storage		
11	Others		

Improved capacity to deliver?

Check list

	Indicator	Tick	Explanations/Examples
1	Increased number of staff with technical qualifications		
2	Increased number of tools and equipment		
3	Increased number of drugs		
4	Increased types of services		
5	Increased number of clients saved		
6	Increased service delivery locations		
7	Increased funding		
8	Others		

Improved information for decision making?

Check list

	Indicator	Tick	Explanations/Examples
1	Joint data collection available		
2	Joint collected data used		
3	Joint training programmes		
4	Researches conducted jointly		
5	Consultancy service provided		
6	Participation in meetings		
7	Joint publication available		
8	Participation in workshops		
9	Joint mass mobilization		

Improved reliability of service delivered?
Check list

	Indicators	Tick	Explanations/Examples
1	Consistency in service availability		

Improved profits?

Check list

	Indicators	Tick	Explanations/Examples
1	Profit from consultation		
2	Profit from lab services		
3	Profit from selling drugs		
4	Profit from bedding		
5	Others		

About overall PPP performance

- The extent to which PPP is a success
- The most beneficiary and why
- The least beneficiary and why

About the future of PPP

- Panacea for improved public health service delivery?
- Weaknesses/limitations/challenges/areas for improvement

Instrument II – For use by the researcher

2.0 Questions guide for focus groups discussions

a) General group data

1. Male/Female
2. Average age
3. Married/Single/Divorced/Widow
4. Average no of children.
5. General level of education
6. Main source of income. 1. Agriculture 2. Livestock 3. Formal employment 4. Informal employment 5. Other (mention)
7. Average income per month
8. Average no of years services were received
9. Average distance to the health service post

b) Public health services received before PPP was introduced

Checklist

S/N	Indicators	Tick	Explanations/Examples
1	Family planning		
2	Health check		
3	Vitamin A		
5	Deliveries		
6	Immunisation		
7	Laboratory		
8	Diagnosis and treatment of diseases		
9	Referrals		
10	HIV AIDS Counseling and testing		
11	HIV AIDS Counseling and testing, drugs, treatment and care of HIV AIDS illness		
12	Community health education		
13	Other (write down here)		

c) Service provider before PPPs

1. Public
2. Private for Profit
3. NGOs
4. CBOs
5. None

d) Public health services received under PPP

Checklist

S/N	Indicators	Tick	Explanations/Examples
1	Family planning		
2	Health check		
3	Vitamin A		
5	Deliveries		
6	Immunisation		
7	Laboratory		
8	Diagnosis and treatment of diseases		
9	Referrals		
10	HIV AIDS Counseling and testing		
11	HIV AIDS Counseling and testing, drugs, treatment and care of HIV AIDS illness		
12	Community health education		
13	Other (write down here)		

e) Contributions to PPP

1. Materials for construction of health post/other use
2. Labour
3. Money
4. Others? List

f) Public health service delivery improvements as a result of PPP

1. Reduced service distance? (No of Kms)
2. Increased service types? (mention types)
3. Reduced service time? (hours)
4. Improved reliability? (reduced frequency of service missed, quality, affordability)
5. Increased profits?
6. Others? Mention

g) Personal experiences on services received

- Positives
- Negatives
- Perceived causes
- How the situation could be improved

Instrument 3 – The researcher supports the respondents by clarifying questions

3.0 Questionnaire for public health service beneficiaries

a) General information

1. Male/Female
2. Age ----------
3. Marital status. 1.Married 2. Single 3. Divorced. 4 Widow
4. No of children. ----------
5. Average level of education ----------
6. Main source of income. 1. Agriculture 2. Livestock 3. Formal employment 4. Informal employment 5. Other--------- (mention)
7. Average income per month----------)
8. Name of the nearest health service post----------
9. Average distance to the nearest health service post----------kms

b) Contributions to PPPs

Have you made any contributions to the health service post for construction or other reason? 1. Yes 2. No.

If the answer is Yes, what did you contribute?

1. Materials for construction of health post ----------Shs
2. Labour (Monetary value)----------Shs
3. Money ----------Shs
4. Others ----------Shs

c) Public health services received before PPP
Tick health services received in the nearest service post (Tick)

Checklist

S/N	Indicators	Tick	Explanations/Examples
1	Family planning		
2	Health check		
3	Vitamin A		
5	Deliveries		
6	Immunisation		
7	Laboratory		
8	Diagnosis and treatment of diseases		
9	Referrals		
10	HIV AIDS Counseling and testing		
11	HIV AIDS Counseling and testing, drugs, treatment and care of HIV AIDS illness		
12	Community health education		
13	Other (List down here)		

d) Service provider before PPPs (Tick)

1. Public
2. Private for Profit
3. NGOs
4. CBOs

e) Checklist for public health services received in the nearest service centre after PPP (Tick)

Checklist

S/N	Indicators	Tick	Explanations/Examples
1	Family planning		
2	Health check		
3	Vitamin A		
5	Deliveries		
6	Immunisation		
7	Laboratory		
8	Diagnosis and treatment of diseases		
9	Referrals		
10	HIV AIDS Counseling and testing		
11	HIV AIDS Counseling and testing, drugs, treatment and care of HIV AIDS illness		
12	Community health education		
13	Others (List down here)		

f) Duration of services received under PPP

For how long have you been receiving the above services in the post mentioned?

----------years

g) Frequency of attending services

When you need health services how often do you go to the health post named above?

a. Always b. Almost every time c. Often d. Rarely e. Do not go at all.

h) Seeking health services from other providers

If you go elsewhere for health services, what are the reasons?

1.----------

2.----------

3.----------

i)Public health service improvement through PPPs

To what extent do you think that the health post has improved ?

1. Distance to the health post is reduced by:

---------kms

2. You can now get more different types of health services. How many------

3. It has reduced waiting time before you get service by ---------hrs

4.When you go for health service you always get it.

a. Always b. Almost every time c. Often d. Rarely e. Not at all

If the answer is Yes. why?

j) Problems, causes and strategies for improvement

Problems	**Causes**	**Strategies for improvement**
1		
2		
3		
4		
5		

Instrument IV- For use by the researcher

4.0 Observation schedule in service provision centers under PPPs

1. Name of Public health service delivery centre----------
2. Date of observation----------

Checklist

	Indicators	Tick	Remarks
1	Building appearance		
2	Service room and fittings		
3	Laboratory		
4	Bedding (if any)		
5	Refrigerator		
6	Tool kits		
7	Equipment		
8	Drugs		
9	Patients queuing time		
10	Others (List down here)		

Instrument V - For use by the researcher
Interview guide for MoH SW and PO-RALG officials

1. Guidelines (policies, laws, instruments issued or used to guide local authorities to initiate and manage PPPs in health service delivery
2. Any evidence of legally regulated PPPs
3. Means used to ensure that partners adhere to agreements
4. Achievements made
5. Limitations
6. Future regulatory strategies to improve PPPs

Appendix 4: The profile of PPP cases

S/N	Name	Year PPP started	Ownership	Areas of partnership				
1	Mackay House Health Centre	2003	Anglican Diocese of Central Tanganyika	Reproductive and child health	HIV/AIDS	Sexually transmitted infection	Training	Construction
2	Hombolo Hospital	Not clear	Anglican Diocese of Central Tanganyika	Yes	No	No	Yes	No
3	Dr. Matovolwa Health Centre	1994	Dr. Matovolwa	Yes	Yes	No	Yes	No
4	St. Mary Immaculate Dispensary	1992	Mary Immaculate Sisters	Yes	No	No	Yes	No
5	Aga Khan Dispensary	Not clear	Aga Khan Foundation	Yes	Yes	Yes	Yes	No
6	Tumaini Dispensary	2000	Dr. Aligawesa and family	Yes	Yes	No	Yes	No
7	Veyula Dispensary	1985	Ivrea Sisters	Yes	No	No	Yes	No
8	Nzuguni Dispensary	Not clear	Mary Immaculate Sisters	Yes	No	No	Yes	No
9	Bihawana Dispensary	Not clear	Miserecodia Sisters	Yes	No	No	Yes	No
10	Michese Dispensary	2004	Community	No	No	No	No	Yes
11	Ntyuka Dispensary	2004	Community	No	No	No	No	Yes
12	Mvumi Hospital	Not clear	Anglican Diocese of Central Tanganyika	Yes	Yes	Yes	Yes	No
13	Chikopelo Dispensary	Not clear	Roman Catholic Diocese of Dodoma	Yes	No	No	No	No

Appendix 5 : Stakeholders' contributions to the PPPs

CASE 1: Mackay House, DMC, Village Government and Community

List of contributions to the partnership		MHHCAP	DMC	Village government	Community
1	Provides staff and pays salaries	Yes	Yes	Yes (community members)	No salaries
2	Provides working office	Yes (But not only meant for the project)	Yes (Uses the dispensary)	No	No
3	Provides refrigerator	No	No	No	No
4	Pays electricity bills	No	Yes (For the dispensary)	No	No
5	Use own furniture and fittings	Yes (Not specific for the programme alone	Yes (The dispensary office	Yes	No
6	Joint training (shared expertise)	No	No	No	No
7	Supervises staff	Yes	Doubtful (No formal mechanis m)	Doubtful (Only in terms of auditing supplies)	No
8	Pays for security services	Not specific for the programme	Not specific for the programm e	No	No
9	Provides informal support	Yes (when requested)	Yes (when requested)	Yes (when asked)	Yes
10	Sphygmomanometer	No	Yes	No	No
11	Stethoscope	No	Yes	No	No
12	Screen	No	Yes	No	No
13	Examination coach	No	Yes	No	No
14	Weighing scale	Yes	Yes (In the dispensary)	No	No
15	Family planning kit	No	No	No	No
16	Fetal scope	No	Yes	No	No
17	Joint emergency services	Yes (when requested)	Yes (when requested)	No	No
18	Laboratory services	Yes (HIV AIDS testing)	Yes (Such as malaria and stool)	No	No
19	Medication	Yes	Yes	No	No
20	Free consultation services	Yes (Counselling)	Yes	No	No
21	Referral services	Yes	Yes	No	No
22	Provides office maintenance	Yes (For the general office)	Yes (Dispensa ry)	No	No
23	Provides special	Yes (Occasional)	Yes	No	No

	duty allowances		(Occasional)		
24	Joint meetings	Yes (Not formal)	Yes (Not formal)	Yes (Community sensitisation)	Yes (Attend village meetings
25	Joint planning	No	No	No	No
26	Jointly fund staff training	Yes (Own staff and community staff)	Yes (All staff- private and public)	No	No
27	Joint research (shared expertise)	No	No	No	No
28	Joint consultancy (shared expertise)	No	No	No	No
29	Joint publication (shared expertise)	No	No	No	No
30	Provides transport	Yes	No	No	No
31	Provides stationery (MTUHA)	Yes	Yes	No	No
32	Provides Health data (MTUHA)				
33	Provides food items	Yes	Yes	No	No
34	Provides cash	Yes	Yes	No	No
35	Clothes	Yes	Yes	No	No
36	Mosquito net	Yes	No	No	No

CASE 2: HOMBOLO HOSPITAL AND DMC

List of contributions to the partnership		Hombolo hospital	DMC
1	Provides staff and pay salaries	Yes	Yes (50% of total wage bill)
2	Provides working office	Yes	No
3	Provides refrigerator	No	No (Vaccines are stored by neighbouring public dispensary)
4	Pays electricity bills	Yes (30,000 per month)	Once (5 million Tanzanian Shillings)
5	Provides furniture and fittings	Yes	No (except items 37-41 in this table)
6	Joint training	Yes (Leprosy)	Yes (Leprosy)
7	Supervises staff	No	Yes (rarely)
8	Pays for security services	Yes	Somehow (provided 2 padlocks and torches)
9	Provides informal support	Yes (When required)	No
10	Sphygmomanometer	Yes	No
11	Stethoscope	Yes	No
12	Screen	Yes	No
13	Examination coach	Yes	No
14	Weighing scale	Yes	No
15	Family planning kit	No	No
16	Vaccine kit	No	Yes
17	Fetal scope	Yes	No
18	Joint emergency services	Yes (when asked)	Yes (For example during cholera outbreaks)
19	Laboratory services	Yes	No
20	Medication	Yes	No
21	Free consultation services	Yes	No

22	Referral services	Yes	No
23	Office maintenance	Yes	No
24	Provides allowances	No	Yes (for nurses - outreach services)
25	Joint meetings	No	No
26	Joint planning	No	No
27	Jointly funds staff training	Yes (own staff)	Yes (all staff – public and private)
28	Joint research	No	No
29	Joint consultancy	No	No
30	Joint publication	No	No
31	Provides transport	No	Yes (4 bicycles)
32	Provides stationery (MTUHA)	No	Yes (including pens, files, calculator)
33	Provides health data(MTUHA)	Yes	No
34	Bedding materials	No	Yes
35	Mosquito net	No	Yes
36	Wheel chairs	No	Yes
37	Stretcher	No	Yes
38	Buckets	No	Yes

CASE 3: DR. MATOVOLWA HEALTH CENTRE AND DMC

	List of contributions to the partnership	Dr. Matovolwa Health Centre	Dodoma Municipal Council
1	Provides staff and pays salaries	Yes (When asked)	Yes (MCH nurses)
2	Provides working office	Yes	No
3	Provides refrigerator	No	Yes
4	Pays electricity bills	Yes	No
5	Use own furniture and fittings	Yes	No
6	Joint training	No	No
7	Supervises staff	Yes	Yes (Occasionally)
8	Pays for security services	Yes	No
9	Provides informal support	Yes (when in need)	No
10	Sphygmomanometer	Yes (Informal -when requested)	Yes
11	Stethoscope	Yes (Informal -when requested)	Yes
12	Screen	Yes	No
13	Examination coach	Yes	No
14	Weighing scale	Yes (Informal- when requested)	Yes
15	Family planning kit	No	Yes (Through MCH wing)
16	Fetal scope	Yes (informal- when requested)	Yes
17	Joint emergency services	Yes (when requested)	Yes
18	Laboratory services	Yes	No
19	Medication	Yes	No
20	Vaccine kit	No	Yes
21	Free consultation services	No	Yes
22	Referral services	Yes	Yes
23	Provides office maintenance	Yes	No
24	Provides special duty allowance	No	Yes (when use private nurses)
25	Joint meetings	Yes (when visited)	Yes (rarely invited)
26	Joint planning	No	No
27	Funds staff training	Yes (Own staff)	Yes (all staff – public and private
28	Joint research	No	No
29	Joint consultancy	No	No
30	Joint publication	No	No
31	Provides transport	No	No
32	Provides stationery (MTUHA)	No	Yes
33	Provides health data (MTUHA)	Yes	No

CASE 4: ST. MARY IMMACULATE AND DMC

	List of contributions to the partnership	St. Mary Immaculate	Dodoma Municipal Council
1	Provides staff and pays salaries	Yes (1 nurse, driver)	Yes (2 MCH nurses)
2	Provides working office	Yes (2 rooms)	No
3	Provides refrigerator	No	Yes
4	Provides vaccine kit	No	Yes
5	Pays electricity bills	Yes	No
6	Use own furniture and fittings	Yes	No
7	Joint training	No	No
8	Supervises staff	Yes	Yes
9	Pays for security services	Yes	No
10	Provides informal support	Yes (when asked)	No
11	Sphygmomanometer	Yes (when asked)	Yes
12	Stethoscope	Yes(when asked0	Yes

13	Screen	Yes	No
14	Examination coach	Yes	No
15	Weighing scale	Yes (when asked0	Yes
16	Family planning kit	No	No
17	Fetal scope	Yes (when asked)	Yes
18	Joint emergency services	No	Yes (requests support)
19	Laboratory services	Yes	No
20	Medication	Yes (ant malaria, vitamins)	Yes (ant malaria, palliatives)
21	Free consultation services	Yes	Yes
22	Referral services	Yes	Yes
23	Provides office maintenance	Yes	No
24	Provides allowances	No	Yes (for outreach services)
25	Joint meetings	No	Occasionally
26	Joint planning	No	No
27	Jointly funds staff training	Yes (Own staff)	Yes (All – public and private)
28	Joint research	No	No
29	Joint consultancy	No	No
30	Joint publication	No	No
31	Provides transport	Yes (Land rover for outreach)	No
32	Provides stationery (MTUHA	Yes (supplement clinic cards through photocopying)	Yes (MTUHA stationery)
33	Provides health data (MTUHA)	Yes	No
34	Stove	No	Yes
35	Bucket	No	Yes

CASE 5: NTYUKA, DMC, CMSR, ALPDA AND CANADIAN EMBASSY

List of contributions to the partnership		Ntyuka Community	DMC	CMSR	ALPDA	Canadian Embassy
1	Provides staff and pays salaries	Yes	Yes	Yes	Yes	No
2	Provides working office	No	Yes	No	No	No
3	Provides refrigerator	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
4	Pays electricity bills	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
5	Use own furniture and fittings	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
6	Joint training (shared expertise)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
7	Supervises staff	No	No	Yes	Yes	No
8	Pays for security services	Yes	No	No	No	No
9	Provides informal support	When required	When required	When required	When required	When required
10	Sphygmomanometer	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
11	Stethoscope	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

12	Screen	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
13	Examination coach	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
14	Weighing scale	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
15	Family planning kit	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
16	Fetal scope	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
17	Joint emergency services	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
18	Laboratory services	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
19	Medication	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
20	Free consultation services	No	Yes	Yes	Yes	Yes
21	Referral services	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
22	Provides office maintenance	No	Village government office	No	No	No
23	Provides special duty allowances	No	Yes	Yes	No	No
24	Joint meetings	Yes (Public)	Yes (public)	Yes (public)	Yes (public)	Yes (public)
25	Joint planning	Limited	Limited	Yes	Yes	Limited
26	Jointly, funds staff training	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
27	Joint research (shared expertise)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
28	Joint consultancy (shared expertise)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
29	Joint publication (shared expertise)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
30	Provides transport	No	Yes	Yes	No	Yes
31	Provides stationery	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
32	Provides food items	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
33	Provides cash	No	Yes	Yes	No	Yes
34	Clothes	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
35	Mosquito net	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
36	Manual labour	Yes	No	No	No	No
37	Land	Yes	No	No	No	No

CASE 6: AGA KHAN AND DMC

	List of contributions to the partnership	Aga Khan health centre	Dodoma Municipal Council
1	Provides staff and pays salaries	No	Yes
2	Provides working office	Yes	No
3	Provides refrigerator	No	Yes
4	Pays electricity bills	Yes	No
5	Use own furniture and fittings	Yes	No
6	Joint training	No	Yes
7	Supervises staff	Yes	Yes
8	Pays for security services	Yes	No
9	Provides informal support	Yes	Yes
10	Sphygmomanometer	No	Yes
11	Stethoscope	No	Yes
12	Screen	Yes	No
13	Examination coach	Yes	No
14	Weighing scale	No	Yes
15	Family planning kit	No	Yes
16	Vaccine kit	No	Yes
17	Fetal scope	No	Yes
18	Joint emergency services	No	No
19	Laboratory services	Yes	No
20	Medication	Yes	Yes (Vitamins, Anti worms)
21	Free consultation services	Yes	Yes
22	Referral services	Yes	Yes
23	Provides office maintenance	Yes	No
24	Provides duty allowances	No	Yes
25	Joint meetings	Rarely	Rarely
26	Joint planning	No	No
27	Jointly funds staff training	Yes (Own staff)	Yes (All – public and private)
28	Joint research	No	No
29	Joint consultancy	No	No
30	Joint publication	No	No
31	Provides transport	No	No
32	Provides stationery (MTUHA)	No	Yes
33	Provides health data (MTUHA)		
34	Joint funding of Aga Khan staff training	Yes	Yes

CASE 7: TUMAINI DISPENSARY AND DMC

	List of contributions to the partnership	Tumaini dispensary	Dodoma Municipal Council
1	Provides staff and pays salaries	No	No
2	Provides working office	Yes	No
3	Provides refrigerator	No	Yes
4	Pays electricity bills	Yes	No
5	Use own furniture and fittings	Yes	No
6	Joint training	No	Yes
7	Supervises staff	Yes	Yes
8	Pays for security services	Yes	No
9	Provides informal support	Yes	No
10	Sphygmomanometer	Yes	Yes
11	Stethoscope	Yes	Yes
12	Screen	Yes	No
13	Examination coach	Yes	No

14	Weighing scale	Yes	Yes
15	Family planning kit	No	Yes
16	Fetal scope	No	Yes
17	Joint emergency services	Yes	No
18	Laboratory services	Yes	No
19	Medication	Yes	Yes
20	Free consultation services	Yes	Yes
21	Referral services	Yes	Yes
22	Provides office maintenance	Yes	No
23	Provides special duty allowances	No	Yes
24	Joint meetings	No	Occasionally
25	Joint planning	No	No
26	Trains staff	No	Yes
27	Joint research	No	No
28	Joint consultancy	No	No
29	Joint publication	No	No
30	Provides transport	No	No
31	Provides stationery (MTUHA)	No	Yes
32	Provides health data	Yes	No

CASE 8: VEYULA DISPENSARY AND DMC

List of contributions to the partnership		**Veyula dispensary**	**Dodoma Municipal Council**
1	Provides staff and pays salaries	Yes	No
2	Provides working office	Yes	No
3	Provides refrigerator	No	Yes
4	Pays electricity bills	Yes	No
5	Use own furniture and fittings	Yes	No
6	Joint training	No	No
7	Supervises staff	No	Yes (Rarely)
8	Pays for security services	Yes	No
9	Provides informal support	Yes	No
10	Sphygmomanometer	Yes	No
11	Stethoscope	Yes	No
12	Screen	Yes	No
13	Examination coach	Yes	No
14	Weighing scale	Yes	No
15	Family planning kit	No	No
16	Fetal scope	Yes	No
17	Joint emergency services	Yes	Yes
18	Laboratory services	Yes	No
19	Medication	Yes	Yes (For TB)
20	Free consultation services	Yes	No
21	Referral services	Yes	No
22	Provides office maintenance	Yes	No
23	Provides special duty allowances	No	Yes
24	Joint meetings	No	No
25	Joint planning	No	No
26	Funds staff training	Yes	Yes
27	Joint research	No	No
28	Joint consultancy	No	No
29	Joint publication	No	No
30	Provides transport (MTUHA)	No	No
31	Provides stationery	Yes	Yes
32	Provides health data (MTUHA)	Yes	No
33	Supervises treatment of TB	Yes	No

34	Provides medication for the epileptic	Yes	No
35	Juice and sweets to others and children	Yes	No

CASE 9: NZUGUNI DISPENSARY AND DMC

List of contributions to the partnership	Nzuguni dispensary	Dodoma Municipal Council	
1	Provides staff and pays salaries	Yes	Yes
2	Provides working office	Yes	No
3	Provides refrigerator	No	Yes
4	Pays electricity bills	Yes	No
5	Use own furniture and fittings	Yes	No
6	Joint training	No	No
7	Supervises staff	No	No
8	Pays for security services	Yes	No
9	Provides informal support	Yes	No
10	Sphygmomanometer	Yes	No
11	Stethoscope	Yes	No
12	Screen	Yes	No
13	Examination coach	Yes	No
14	Weighing scale	No	Yes
15	Family planning kit	No	No
16	Fetal scope	Yes	No
17	Joint emergency services	Yes	No
18	Laboratory services	Yes	No
19	Medication	Yes	No
20	Free consultation services	Yes	Yes
21	Referral services	Yes	Yes
22	Provides office maintenance	Yes	No
23	Provides special duty allowances	No	No
24	Joint meetings	No	No
25	Joint planning	No	No
26	Funds staff training	No	Yes
27	Joint research	No	No
28	Joint consultancy	No	No
29	Joint publication	No	No
30	Provides transport	No	No
31	Provides stationery	No	Yes
32	Provides health data (MTUHA)	Yes	No
33	Free medical services to the poor	Yes	No

CASE 10: BIHAWANA DISPENSARY AND DMC

List of contributions to the partnership		Bihawana dispensary	Dodoma Municipal Council
1	Provides staff and pays salaries	Yes	No
2	Provides working office	Yes	No
3	Provides refrigerator	No	Yes
4	Pays electricity bills	Yes	No
5	Use own furniture and fittings	Yes	No
6	Joint training	No	No
7	Supervises staff	No	Rarely
8	Pays for security services	Yes	No
9	Provides informal support	Yes (when asked)	No
10	Sphygmomanometer	Yes	No

11	Stethoscope	Yes	No
12	Screen	Yes	No
13	Examination coach	Yes	No
14	Weighing scale	Yes	No
15	Family planning kit	No	No
16	Fetal scope	Yes	No
17	Joint emergency services	Yes	No
18	Laboratory services	No	No
19	Medication	Yes	Yes (Anti worms)
20	Free consultation services	Yes	No
21	Referral services	Yes	No
22	Provides office maintenance	Yes	No
23	Provides special duty allowances	No	Yes
24	Joint meetings	No	No
25	Joint planning	No	No
26	Funds staff training	No	Yes
27	Joint research	No	No
28	Joint consultancy	No	No
29	Joint publication	No	No
30	Provides transport	No	No
31	Provides stationery (MTUHA)	Yes (photocopy to complement clinic cards)	Yes
32	Provides health data (MTUHA)	Yes	No
33	Free medical services to the poor	Yes	No
34	Free accommodation	Yes (for DMC staff during vaccination day)	No
35	Pays for transport	Yes (send MTUHA report to the DMC)	No
36	Clinical tray	No	Yes

CASE 11: MVUMI HOSPITAL AND DMC

List of contributions to the partnership		**Mvumi Hospital**	**Dodoma district council**
1	Provides staff and pay salaries	Yes	Yes
2	Provides working office	Yes	No
3	Provides refrigerator	No	Yes
4	Pays electricity bills	Yes	No
5	Use own furniture and fittings	Yes	No
6	Joint training	Yes	Yes
7	Supervises staff	Yes	Yes
8	Pays for security services	Yes	No
9	Provides informal support	Yes	Yes
10	Sphygmomanometer	Yes	No
11	Stethoscope	Yes	No
12	Screen	Yes	No
13	Examination coach	Yes	No
14	Weighing scale	No	Yes
15	Family planning kit	No	Yes
16	Fetal scope	Yes	No
17	Joint emergency services	No	Yes
18	Laboratory services	Yes	No
19	Medication	Yes	Yes (Anti worms, malaria)
20	Free consultation services	No	Yes
21	Referral services	Yes	Yes

22	Provides office maintenance	Yes	No
23	Provides special duty allowances	Yes	Yes
24	Joint meetings	No	No
25	Joint planning	No	No
26	Funds staff training	No	Yes
27	Joint research	No	No
28	Joint consultancy	No	No
29	Joint publication	No	No
30	Provides transport	No	No
31	Provides stationery	No	Yes
32	Provides health data (MTUHA)	Yes	No
33	Provides cash	No	Yes (Basket fund)
34	Bed grant	No	Yes (30,000 for 180 beds)
35	Free house	Yes	No
36	Free water	Yes	No

CASE 12: KONOIKE, DMC, MICHESE VILLAGE GOVERNMENT AND COMMUNITY

List of contributions to the partnership		**Konoike Company**	**DMC**	**Michese Village government**	**Community**
1	Provides staff and pays salaries	Yes(those who built the dispensary)	No	No	No
2	Provides working office	Yes (the dispensary)	No	No	No
3	Provides refrigerator	No (not opened yet)	No	No	No
4	Pays electricity bills	No (not opened yet)	No	No	No
5	Use own furniture and fittings	No	No	No	No
6	Joint training (shared expertise)	No	No	No	No
7	Supervises staff	Yes (those who built the dispensary)	No	Yes (Security staff)	No
8	Pays for security services	No	No	No	No
9	Provides informal support	No	Yes (when requested)	Yes (when asked)	No
10	Sphygmomanometer	No	No	No	No
11	Stethoscope	No	No	No	No
12	Screen	No	No	No	No
13	Examination coach	No	No	No	No
14	Weighing scale	No	No	No	No
15	Family planning kit	No	No	No	No
16	Fetal scope	No	No	No	No
17	Joint emergency services	No	No	No	No
18	Laboratory services	No	No	No	No
19	Medication	No	No	No	No

20	Free consultation services	No	No	No	No
21	Referral services	No	No	No	No
22	Provides office maintenance	No	No	No	No
23	Provides special duty allowances	No	No	No	No
24	Joint meetings	No	No	No	No
25	Joint planning	No	No	No	No
26	Jointly fund staff training	No	No	No	No
27	Joint research (shared expertise)	No	No	No	No
28	Joint consultancy (shared expertise)	No	No	No	No
29	Joint publication (shared expertise)	No	No	No	No
30	Provides transport	Yes for construction	No	No	No
31	Provides stationery (MTUHA)	No	No	No	No
32	Provides Health data (MTUHA)	No	No	No	No
33	Provides food items	No	No	No	No
34	Provides cash	No	No	No	No
35	Clothes	No	No	No	No
36	Mosquito net	No	No	No	No
37	Provides land	No	Yes	Yes	Yes
38	Provides building materials	Yes (various)	No	No	Yes (sand and stones)
39	Provides expertise	Yes design and construction	Yes (design)	No	No

CASE 13: CHIKOPELO DISPENSARY AND DDC

List of contributions to the partnership		**Chikopelo dispensary**	**Dodoma District Council**
1	Provides staff and pays salaries	Yes	No
2	Provides working office	Yes	No
3	Provides refrigerator and vaccines	No	Yes
4	Pays electricity bills	Yes	No
5	Use own furniture and fittings	Yes	No
6	Joint training	No	No
9	Supervises staff	No	Yes (Rarely)
10	Pays for security services	Yes	No
11	Provides informal support	Yes (when asked)	No
12	Sphygmomanometer	Yes	No
13	Stethoscope	Yes	No
14	Screen	Yes	No
15	Examination coach	Yes	No
16	Weighing scale	Yes	No
17	Family planning kit	No	No
18	Fetal scope	Yes	No
19	Joint emergency services	Yes (outbreaks)	Yes (outbreaks)
20	Laboratory services	No	No
21	Medication	No	Yes (for Bilharziasis)

22	Free consultation services	Yes	No
23	Referral services	Yes	No
24	Provides office maintenance	Yes	No
25	Provides special duty allowances	No	Yes
26	Joint meetings	No	No
27	Joint planning	No	No
28	Funds staff training	No	Yes
29	Joint research	No	No
30	Joint consultancy	No	No
31	Joint publication	No	No
32	Provides transport	Yes (on hire when there is emergency)	No
33	Provides stationery (MTUHA)	No	Yes
34	Provides health data (MTUHA)	Yes	No
35	Free medical services to the poor	No	No
36	Free accommodation	Yes (for DMC staff during vaccination day)	No
37	Pays for transport	Yes (send MTUHA report to the DMC)	No
38	Clinical tray	Yes	No

Appendix 6

Detailed Case by case descriptions of PPPs in DMC and DDC

1. Mackay House Health Centre Aids Control Programme

- **Background**

Mackay House Health Centre Aids Control Programme (MHHCACP) was part of Mackay House Health Centre (MHHC) initiatives to provide public health in Dodoma region. It was initiated by the Anglican Church Diocese of Central Tanganyika (DCT) as a response to the need to promote voluntary counseling and testing for HIV Aids in the region. In 2003 the Angaza Centre was opened under support from Netherlands' based NGO (Inter-Church Cooperation Organisation –ICCO) as an annex to MHHC to provide services in Community Health Education (CHE), Voluntary Counseling and Testing (VCT), Home based Care (HBC) and treatment of HIV Aids associated symptoms. ICCO support contract was closed in March 2005 and now it is partially funded by African Medical Research Foundation (AMREF). Lack of enough support has led to cloture of most of the HBC and treatment services which were run by Angaza Centre.

In 2004 Mackay House Aids Control Programme was started under support from Care Tumaini which is a Tanzanian wing of Care International. MHHCACP was run closely with Angaza Aids Centre to provide services in areas of community health education, home based care, and voluntary counselling and testing. Other activities provided by MHHCACP were small projects for income generation for families affected with HIV Aids, food, clothes, school uniforms and cash.

- **The nature and motives of PPP**

Partnership between the MHHCACP and DMC had different dimensions which ranged from informal to semi formal and formal setups. This mixed institutional collaboration is difficult to describe because it depends on who is giving the story. However, it could be simply put that it was more of "recognising the presence of a stakeholder and hence do something to involve him" rather than any clearly coordinated partnership arrangement.
The following statements from various key officials consulted give the whole picture.

> ...The partnership is informal. It is mostly based on personal working relationships and friendship... It becomes formal when we write a letter asking for trainers for our programmes (we pay them)...they are represented in our health board... we invite them in our meetings but they do not invite us... we give them a copy of performance reports on weekly and monthly basis but no feedback...we do not account to them because we do not receive any moneys from them... our programme is more influenced by top down programmes including Care Tumaini and National Aids Control Programme (NACP). We report to Care Tumaini and they report to higher organs like USAID and the ministry of health. ... I think they are not interested in us if there is no payment of allowances.

The experience in this case is that there is no formal development of PPP concept that is used and has a common meaning to both MHHCACP and DMC. Indeed the vocabulary of PPP is hardly used outside official policy documents in the health sector reform circles. Instead, the word "ushirikiano" meaning cooperation is used. Even the concept of cooperation seems to be more of paying lip service than real commitment in action. One official commented with strong negative feelings thus;

> ... They just come to demand reports... our vehicle which we were given by our donor were involved in accident and hence we cannot move. We have closed some centres because of lack of resources. If they were willing they should have helped us... I heard donors want to channel money through the municipalities but there is bureaucracy and lots of politics... I cannot see any partnership. At most, they see us in the opposition side.

At the level of programme implementation, the village government officials perceive and experienced PPP in a different way. They saw both government and MHHCACP working together as stakeholders.

- **The experience from home based health care**

MHHCACP started home based care in 2004. By 2005 there were 26 centres using 30 volunteers and 5 supervisors. Each volunteer provided services to 5 homes. The supervisors were employees of MHHC. The volunteers were identified and trained by the MHHCACP at Mtumba centre. The role of volunteers was to identify people with long illness, counsel and refer them for HIV Aids testing in Angaza HIV Aids Control Centre. They also provided first aid services including palliatives. Each supervisor worked with 5 volunteers. It was the duty of the supervisor to ensure that the volunteers provided services as directed. They also visited clients to complement services provided by volunteers. While volunteers reported to the supervisors, the later reported to the manager who was directly accountable to Care Tumaini and the Bishop, DCT.

At programme delivery level, MHHCACP was working with DMC through clinical officers and nurses in municipal dispensaries (where available). This was a form of partnership which seemed to work very well but came in more or less in the form of chance than joint planned intervention. When MHHCACP was preparing staff for public health intervention through HCB programmes, the municipality was also doing the same. For example, one nurse was trained at Mtumba and posted to Ihumwa dispensary in 2003.

One nurse tells the story that:

> ...I was chosen to attend a course in home based health care at Mtumba in 2003. In the same year, I was posted to this dispensary as a nurse but also to provide HBHC. When I arrived here I went to the village chairman who introduced me to the people through public meeting. He urged all those with problems of long illness including HIV Aids to show up so that they could receive assistance. It helped me because since then relatives of people with long illness came to ask for my services.

Although the village chairman acknowledged that there was a time that village leaders attended a course in community education which was useful in sensitising the community in matters of socio economic development, the programme was in principle top down. Despite this limitation the experience from Ihumwa village is a success case. The Ihumwa village HBC consisted of 4 stakeholders. These were, MHHCACP, DMC, Village government, the Community and Volunteers. In the following section, a description of the role each stakeholder is provided.

Each of the above stakeholders played an important role in the partnership. This made the lives of the patients and their families much better and there was no evidence that there were patients who could not be attended due to inadequate support services.

Each partner made contribution to the HBC package although some contributed more than others (due to better ability) which indeed is the essence of joining forces.

Firstly, MHHCACP provided trained personnel for home visiting, counselling, and supervision of home based health care providers.

Secondly, was HIV Aids testing through Angaza centre

Thirdly, was provision of medicines directly to the clients or through the village dispensary. The value could not be found.

Fourthly, was monthly distribution of food and other items to each client as indicated in table 10.

Table 1. List of items contributed by Mackay house health centre

	Contributions	Value in Tshs
1	50 kgs of maize flour	5500
2	12 kgs of beans	5000
3	12 Kgs of groundnuts	6000
4	Cash	4000
5	Mosquito net (provided only once)	3500
6	Second hand clothes and school uniforms for children	3000
	Total value	**27,000**

Source: Compiled from interviews

It was difficult to estimate the value of second hand clothes and school uniforms for children of the clients because it depended on the number of children and also size of the clothes. Therefore, the figure was just to give a rough picture. Each home based care provider was given a bicycle (worth Tshs. 75,000), folder, kit bag and umbrella. A token allowance of 13,000 was paid per month.

The DMC also provided a nurse who was specialised in home based care. She worked hand in hand with MHHCACP home based health care providers including home visiting, counseling, treatment and reference to the general hospital. Other contributions are listed in the table below.

Table 2. Contributions from DMC

Contributions		Value in Tshs.
1	5 Kgs of sugar	35,00
2	12 Kgs of maize flour	2500
3	Cash (for the care taker of the patient at home)	1,020
	Total	**7,020**

Source: Complied from interviews

The total support that went to the clients was substantial. Indeed it was far beyond the income of an average household which ranged between 8000 -15,000 per month.

Other supports were through the dispensary including diagnosis, treatment as recommended by the MCHHCACP.

Much as the role of the municipality is appreciated, the support cannot be sustainable because it is donor driven. The municipality was just a conveyor belt for donations from Belgian government while MCHHCACP would not stand without Care International.

The role of the village government was to raise community awareness on the problem of HIV Aids and the need to seek health care support through the village dispensary and MHHCACP. It was also the role of the village chairman to see to it that the goods donated reached the targeted beneficiaries.

The plan to involve village government was a more of a matter of procedure than planned involvement. It happened in the course of implementing the programme as the village chairperson said;

> ...They came with a form listed all items that were supposed to be given to the identified clients. I was asked to verify that the goods were received and spent as expected so that they could report to their bosses. My role is to sensitise our people so that they can show up to receive the services.

The community awareness creation was done by village officials through meetings. In any case, there was no organised and coordinated way of defining the parameters of collaboration in a systematic way. It all depended on individual initiatives of programme officers than formally institutionalised system of PPP. As a result, it was not possible to find any document outlining terms and conditions of the collaboration.

The community had no formal contribution other than being asked to participate in the programme. The community could have been involved in identifying and selecting the volunteers. However, this was not the case. Volunteers were obtained through individual initiatives and networking within the DCT church system. During visits by supervisors, the meeting point with home based health care providers was at the home of one of the pastors although it was also learned that in some villages, village government offices were used. So, there was no evidence that there was a formalised joint forum where each stakeholder could account for actions or inactions other than normal project performance reporting system to the superior organ with limited formal feedback. Indeed accountability or lack of it did not seem to be an issue. One reason could that the church based projects are run by people who are seen as models of high moral values and the possibilities of being unaccountable were negligible. On the other hand, the accountability through the village government to the municipal level usually depends on the activeness of the local councilors and it is when the project has caused political crisis. In the case of Ihumwa village programme, life seemed to be quite normal and people were happy with the programme although it could have been improved if the community was better involved. Hombolo Hospital has also partnership with the municipality. The next section describes its development and related institutional

and accountability issues.

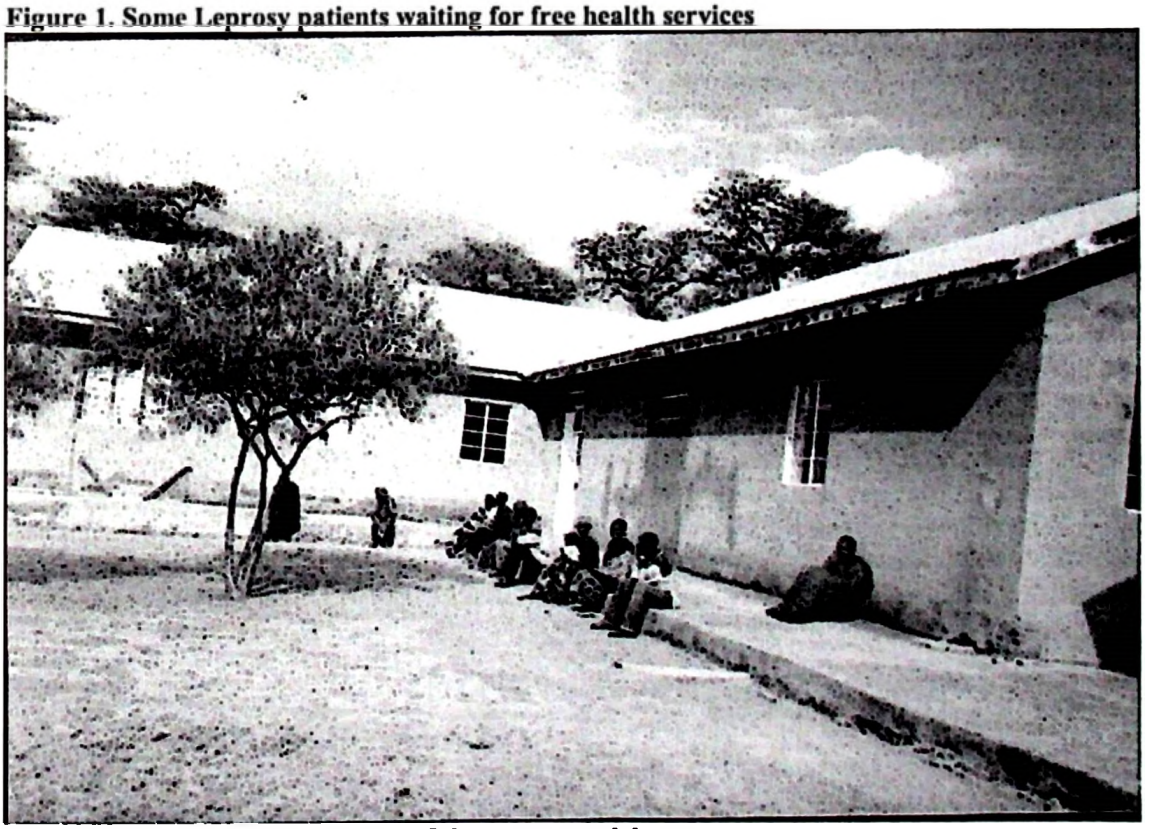
2. Hombolo Hospital

- **The background**

Hombolo hospital is located in Hombolo Makulu ward, Hombolo division which is classified as a rural area. Hombolo Hospital has a long history which dates back to the 1930s. It was started by colonial government as a specialised hospital for the treatment of leprosy in an area around Kilimatinde. In 1962, just a year after independence it was shifted to Hombolo due to shortage of water but now under the ownership of the Anglican Church, Diocese of Central Tanganyika (DCT). It was not possible to get information on how it changed ownership or whether even under colonial government it was under the same missionaries. It was officially opened by the government in 1963. It changed name and became known as Hombolo Leprosarium Centre. "Hombolo" meant "Maji ya Uzima" (Water of Life). It was funded through partnership with Germany faith based organisations which contributed 98% of the budget and the remaining 2% came from the government of Tanzania. Treatment of leprosy was seen as a temporary function because it was the government plan to reduce leprosy to minimal levels by the year 2000 and then eliminate it. This target was also used by donors to reduce funding to the hospital gradually. In 1998 funding from Germany ceased while there were about 40 leprosy cases under treatment. This shortage of fund forced the hospital management to change focus from specialising in leprosy alone into general practitioner in the same year. It was registered as a hospital with 51 bedding capacity and changed name to Hombolo Hospital. This new name was neither known to the municipal officials nor the patients. There is use of "Hombolo Health Centre" and "Hombolo Leprosarium Centre" interchangeably. This is a confusion which is still going on.

In 2000, the financial crisis forced the management to stop attending leprosy cases although it was a difficult decision to tell patients "go away". Some patients had no homes to go while others were not ready to face the stigma associated with leprosy at their homes. As a result, some patients decided to build their own homes around the hospital. They continued to receive free health services as neighbours in need.

Figure 1. Some Leprosy patients waiting for free health services



Source: Photographed by consent of the group participants

- **The nature and motives of partnership**

There are two versions on the story about how PPP started. On the part of Hombolo, it was said that, from 2000 to 2004 the hospital faced critical financial constraints which led to inability to pay for electricity bills, repair vehicles, buy medicines and pay salaries. During the same period DCT requested support from the municipality but it was only in 2003 after the appeal to the minister of health that is when the municipality started to collaborate with Hombolo. The partnership came into operation in 2004 and evolved out of Hombolos' desperation for survival. There was no formal discussion that involved all the partners on terms and conditions of collaboration. It was in the form of "requesting for something from the municipality and you get feedback or not" depending on the will and commitment of the one or few municipal officials". As a result, there were strong feelings of mistrust, dissatisfactions and frustrations in the process of collaboration because of lack of transparency in the whole collaboration process.

Few statements made by the head of the hospital give light in this regard. This will become clearer when we shall look at the way contributions to the partnership were made. Even the institutional status of the health centre was not clear. For example, although Hombolo was registered as a hospital in 1998, it was at times referred as health centre and also used as a designated district hospital because it received government grants through basket funding. According to one official from the municipality, it did not qualify for designated district hospital because it had no qualified staff although in terms of resource allocation it was treated as a DDH.

- **Contributions to the partnership and effects**

Since the type of partnership was not developed jointly by following some specific principles, even stakeholders contributions to the partnership lacked transparency and mutual considerations of each others strengths and limitations. For example, it was alleged that in 2003, the municipality promised to pay 3 million Tanzanian shillings for supporting the running of the hospital but that figure remained in the books of accounts of the Dodoma municipal council. There was no way to demand for it because it was upon the discretion of the government to issue it or not. In the 2004/2005 financial year, the municipality supplied various items.

In the 2004/2005 financial year, the municipality supplied Hombolo Hospital 22 mattresses, blankets, 200 bed covers (shuka), 200 mosquito nets, 2 wheel chairs,1 stretcher, and 80 buckets, However, records from the municipality showed that Hombolo was allocated Tshs. 15,262,816 for the 2004/2005 financial year. However, no records for the value of the items delivered could be accessed and this figure was not revealed to the Hombolo management. The disappointing part of the contribution is that it took the form of supply rather than demand driven. No considerations were made on the real needs of the centre and as a result little was appreciated by the Hombolo management. The following statements reflect such dissatisfactions.

> "...we do not understand why they brought all these goods for... we have never told them we need such items and of that quantity... we need money to repair water tanks and buy a new water pump". Referring to accountability for the goods received he said... I am not interested in accounting for goods that I did not request.

There were complaints that they had no representative in the municipal health management where they could speak their voice. This complaint was perhaps a reflection of non effective representation than lack of it because all faith based health service providers had elected their representative to the municipal health board (lead agent) who used to attend such meetings. Although it was noted that in principle Hombolo had to participate in planning process of the municipality (as a DDH), the style of the involvement in the council budget process was questionable as the manager said.

> ... One day we received a later asking us to prepare our budget and present it to the municipality on the same day... this was impossible. We had to forget about it.

When asked for comments, one official from the municipality acknowledged that it was possible that they did not receive budgets from Hombolo. However, the blame was passed back that "they are a

problem...they do not like to cooperate... sometimes we have to do for them because we do not have an option".

In 2004 Hombolo managed to secure Tshs. 18 million from Tanzania Leprosy Mission International part of which was used to repair one Land rover.
Collaboration in staffing matters was also an area of criticisms as one officer said;

> "...in 1998 they brought one nurse here to provide MCH services. She left just after a year. Since then we have been asking for replacement but all in vain.."

The problem of insufficient health staff is a common problem not only in Hombolo but also in government owned dispensaries and health centres in the municipality and the country at large.

Lack of effective communication and respect of the Hombolo management as a partner was also a concern. It was felt that the way communication was made between the municipality and Hombolo was un-procedural and reflected disrespect as one comment was mad that;

> In the morning, a nurse would come with a letter and tell me she is invited by the municipality to attend a seminar on the same day... I wonder why the municipality does not communicate to me so that I can plan my work schedules early enough. As a result, patients miss services without good reasons... "we told them that since most patients who suffer from leprosy prefer treatment in this centre, the government could give us the medicines to treat them... there were exchange of words... they said they could get treatment at Hombolo bwawani health centre. .But when they go there, they do not get services. ...they come back... according to our ethics, you cannot leave a patient to die because cannot pay for the services.

It was not possible to establish the basis for this complaint because there were possibilities for other explanations. For example, if there were feelings that the head of the hospital was likely to be un-cooperative, bypassing communication could be intentional and perhaps initiated by the staff themselves.

Hombolo provides MCH staff for delivering services at Hombolo and Zepise village through outreach programme. Since staff involvement was not initially planned and agreed upon, it is perceived as a burden to the hospital as a comment was mad that;

> ...they take my nurses for MCH services including outreach programmes ate Zepise village (about 5 kms). Although they pay them Tshs. 3000 as outreach service allowance... what about my work which remains undone?

This appears to be the problem of trying to save two different interests. That is providing "commercial" services at the same time meeting the spiritual obligation of saving humanity. Although church based health services are not meant for profit, at the end of the day operating costs have to be covered. In the situation where there is shortage of staff it also means no services and no income. On the other side of the coin providing MCH services also means opening up opportunities for patients who will be ready to pay for other services including laboratory tastes. Therefore it is the question of "take and give" than about making loss. Indeed, some of these complaints may be due to existing personalised tensions between the two stakeholders than the substance of the allegations because, according to the DMC budget, 50% of staff salaries of Hombolo hospital were paid through basket funding.

Such tensions continued to affect the way collaborations were interpreted. Negative syndrome was the state of the art in the whole institutional arrangement. In fact, it was perceived that every action taken by the DMC was not in favour of the progress of the hospital. A series of allegations give the whole picture as shown below;

> ... we wanted to run training programmes for disability prevention because we are experts but they do not allow us. They want to bring their staff to work with us here and get paid allowances and leave us empty handed. ...every time our nurses go to get

> vaccines from Mlowa Bwawani Health centre because we do not have refrigerator here. This causes a lot of inconveniences. We have asked for it since 2001 but to date nothing... Nowadays I am seen as a trouble maker... when the municipal officials see my face they say there comes a nuisance. Some times they do not come to collect health reports. I send someone and pay the transport costs and lunch.

In one of the days the researcher was conducting the study, MCH services were neither delivered at Hombolo nor Zepise. Mothers with children on their backs waited for hours only to be told that there were no vaccines because the Mlowa Bwawani Health Centre did not receive the share for hombolo.
The same negativity and mistrust and the problems of accountability are expressed by one DMC official as he said;

> ...Have you been at Hombolo?... did you see how the place is dilapidated?... why neglect their own buildings... they are not serious...if they cannot take care of their own property how do you think they can take care of our refrigerator?... we pay them 50% for salaries we do not know if they pay the other 50%.

Other areas of collaboration were joint practical training sessions for leprosy where Hombolo is paid to supply lunch. In other types of training staff were fully paid by the municipality. For example, the clinical officer attended a course in Morogoro on Integrated Logistics System and was paid Tshs. 150,000 as allowances. Such trainings are organised by the MoH through donor support.

Of all the supplies received by Hombolo hospital, the mattresses were said to be very useful because the old ones which were used by leprosy patients were stigmatised and bicycles for transport.
If the problems of informality, lack of transparency, and mistrust are solved, partnership between the municipality and Hombolo would be a commendable endeavour in improving quality health care in the area. The tensions are counterproductive despite resources committed because of lack of strong appreciation of the role of each partner. Now let us turn to the third PPP case.

3. Dr. Matovolwa Health Centre

- **Introduction**

Dr. Matovolwa Health Centre is located in area "A" Chamwino ward Urban division, just about 1.5 kms from the town centre. It was stated by a retired clinical doctor in 1994 with the objective of providing preventive and curative health services. According to the owner, the source of capital was own personal savings and the pension benefits after retirement. He is owner- manager and also a representative of purely for profit health service providers in the Municipal Health Board.

- **The nature and motives of partnership arrangement**

Although working with the municipality had advantages including increasing the number of customers, the hospital management said that the partnership was initiated after learning that there were no services around and there were long queues in the Makole government health centre. A latter was written to the Municipal director asking for collaboration to run MCH clinic services. According to him, the request was honoured without any formal letter or terms and conditions of the collaboration.

- **Contributions to the partnership and effects**

Each partner had several contributions to facilitate MCH service delivery. See the checklist
Staff contribution was in terms of two MCH nurses who were employed by the municipality but provide services under Dr. Matovolwa's roof. These nurses were supervised jointly by Dr. Matovolwa and the municipal MCH incharge. During national immunisation campaign Dr. Matovolwa released his nurses to work hand in hand with municipal nurses.

Contribution in terms of informal support can best be described as "living with a good neighbour". There were occasions when MCH clinic accessories such as weighing and BP machines were not in working order. These items were borrowed from Dr. Matovolwa health centre.

In some cases MCH nurses asked for medical advise from Dr. Matovolwa when faced with a serious and urgent health problem.

Partnership in curative services was only during outbreak of cholera. There were joint efforts to provide health education and treatment of victims.

There was also joint diagnose and treatment of STIs. The municipality provided reagents while Dr. Matovolwa claimed to conduct laboratory tests under subsidised rates. The patient paid an average of Tshs. 300 instead of Tshs. 500 which was considered to be the market rate. However, faith based service providers were offering cheaper services ranging from Tshs. 200 to 300 for malaria taste.
It was the opinion that the municipality should make more contributions to the partnership including electricity bills and office repair and maintenance. Efforts to ask for such contributions were already made without response.
From DMC point of view, accountability was not seen to a be a problem as long as there was smooth supervision, record keeping and submission of monthly reports as required by supervisory guidelines of the MTUHA system. The only problem noted by municipal officials was the tendency for private health providers to hide some information that might give negative image such as overcharging patients. This is not a surprise because any businessperson is likely to strongly incline to profit maximisation than any other humanitarian consideration. However, since this area was not under the domain of partnership because the areas of partnership were only those related to free public services, issues of overcharging for some health services were not of much concern here.
Like other cases already covered in this chapter and even others to follow, strong concerns for accountability were raised as one informant said.

> ...cases of defective BP and weighing machines and slow response from the municipality were reported. This is where the private health provider rescued the situation because services could not be effectively delivered. ... even when the working tools here require repair or replacement... no body cares... I do not know why they behave like this.

By making reference to the emergency health problems, acting responsibly and the problems of lack of effective accountability system it was commented that;

> ... there is an ambulance for emergency services. It was used when there was an outbreak of cholera. Patients suspected of suffering from cholera were also treated in anticipation that the municipality will in some way refund. They have not paid anything while Cholera is a public issue to be accounted for to the community. ... we are doing a very risky business because if anything with MCH services patients goes wrong we do not know where to go or who to ask because it does not seem that government officials interested. ...I do not think that the public officials know the meaning of accountability because they do not even come to ask how we are coping.

According to the private sector representative, the municipal hospital management committee and health board could be useful in addressing issues of accountability but such meetings were held when there was an urgent issue to address.
It was an opinion that the problems on PPP and institutional arrangement centred on lack of enough preparations, lack of continuity in training, frequent change of key staff, and poor coordination. Despite the limitations, and alleged loses, the management was ready to continue with the collaboration in anticipation that one the collaboration will improve. The following section presents the fourth case.

4. St. Mary Immaculate Dispensary

- **Introduction**

St. Mary Immaculate dispensary is located in Miuji ward about 10 kilometres along the Kondoa road. It was started in 1991 by the St. Mary Immaculate Sisters of Roman Catholic Church. The main objective was to provide health care services as part of its religious mission of saving humanity spiritually and healthwise. The dispensary provided subsidised health services under support from the headquarters and other institutions abroad. There were three nuns and three ordinary staff employed by the dispensary.

- **Partnership with the DMC**

Partnership with the Dodoma Municipal Council started in 1992 in MCH services. According to the Sister in charge, right from the planning stage, there were two rooms set for MCH services. However, before opening the dispensary, it was the municipality which requested for a room to run MCH services in order to reduce distance and queuing at the Makole Municipal Health Centre. The MCH service unit was run by 2 MCH nurses from the municipality but worked closely with the sisters. The MCH wing

covered people in the surrounding area and those from Mnadani, Mpamaa and Ndachi villages (see figure 2 for Ndachi village MCH provision process). All these institutional arrangements were going on for years without any jointly agreed and documented terms and conditions of the partnership.

- **Contributions to the partnership and effects**

Each stakeholder contributed differently to the partnership ranging from materials, labour and cash.
The community contributes in terms of individuals who attends clinic. Each mother pays Tshs. 100 for car fuel and Tshs. 50 for ferrous.
In all cases studied, it was only St. Mary Immaculate dispensary where there was most serious commitment of resources by all key stakeholders in the provision of MCH services. The most interesting feature is the way deficiencies were complemented through joint understanding between the parties. For example, when there was shortage of malaria drugs from the municipality, mothers were given the drugs by the dispensary at the rate of Tshs. 100 per dose against Tshs. 500 in other private service providers. Mothers were also given Ferrous Sulphate for Tshs. 50. Ndachi village which is located about 8 kilometres was able to get outreach MCH services three times per month through combine efforts. The municipality provided vaccines, nurses and out of pocket allowance of Tshs. 5000 per trip per staff including the one from St. Mary Immaculate dispensary. St. Mary Immaculate contributed 1 staff, Land rover for transport and a driver. Mothers paid Tshs. 100 per service for fuel regardless of the number of children attended at the clinic. On average, the amount collected per trip was not more than Tshs. 3000 which barely covered for fuel costs. In the course of attending MCH services, clients were able to get other services at a reasonable cost which was the prime objective of all the stakeholders.
Like all other cases of partnerships, lack of strong institutional arrangement also meant weak mechanisms for accountability. For example, the dispensary gave quarterly health records to the municipality but for all those years no feedback. This was also the situation in other cases studied. When some working tools like BP or weighing machine were not functioning, the municipal nurses had to borrow from the dispensary. There were times when municipal staff had to rely on support from the dispensary because of shortages of supplies from the municipality for a very long time. Shortage of clinic cards was common. While in some other places, notebooks (were used for recording health progress, the dispensary photocopied the cards for free. Supervision from the municipality was rare and erratic and more procedural than meant for improvement of health services.

In terms of involvement in decision making, it was said that the decision to start outreach services at Ndachi village and ask mothers to contribute cash and St. Immaculate Land rover and be paid an allowance of Tshs. 5000 was reached through consensus of the stakeholders concerned but the date of that meeting, place and members could not be established. The Ndachi village chairman also said that the people accepted to pay after were told of the transport problem but could not tell when the meeting was held and by who or even who told them to make such contributions.

The working office for service delivery at Ndachi (see figure...)was outside the home of the ten cell leader of the ruling party (CCM). He said that he volunteered to use his home after failure to get public office in the village. This was rather a political anomaly because, this year (2005) is for multiparty elections from village to national level. If people were getting services at the home of the member of the ruling party, it is unlikely that elections will be fair and free for the opposition parties.
However, according to the village chairman, this problem was temporary because were efforts were underway to build a primary school in the village. It was expected that in the future services will be provided in the school buildings. The last case study was Ntyuka dispensary which was a result of community initiative. It is described in the following section.

5. Ntyuka Dispensary Project

- **Introduction**

Ntyuka dispensary is located in Ntyuka village which is about 7 kilometres from Dodoma town along the Mvumi road. Administratively it is one of 40 villages of the municipality. The dispensary was initiated by the community in order to solve the problem of walking to the town centre in search for health services. Through community under the leadership of the local councillor, ward and village government, the villagers started the construction project in 1993. In appreciation of community initiative, the foundation stone was laid in the same year by the then Prime Minister honourable John

Malechela. He contributed 20 bags of cement and 30 corrugated metal sheets. Although these initiatives were instrumental in the realisation of the urge to have a health facility in the area, unfortunately, it was as if the Prime Minister came to put the progress into a halt. It stayed stand still for 12 years. It was only in 20004, when progress restarted and seemed very promising. What went wrong for all those years cannot be told with precision because it depends on who gives the story. However, meeting with the community gave some clues and indeed pointing to the role of leadership in effective PPPs. The following section provides a brief account of the nature of the partnership between the community, NGOs and the Municipality as seen today.

- **The nature of the partnership**

There are several stories that try to capture the genesis of the partnership and the process taken to make it work. The Ntyuka dispensary was built through four different partnership arrangements. Each of these partnerships is described below.

(a) Ntyuka village - DMC partnership

This is partnership between the people of Ntyuka and the Dodoma municipal council through their village government. It is not an easy task to tell how the collaboration started because it was not possible to get unbiased information due to lack of documented evidence, and most of those who were in office by then were no longer there for various reasons including deaths and transfers. All in all, the village government officials and the councillor said that they were the ones who initiated the idea and mobilised the community to contribute labour and cash and later asked for support from the municipality. On the other hand the municipal officials said that it was a planned intervention aimed at combining community effort and that of municipality to improve health services (no documented evidence). Despite lack of clear origin of the idea and initiation of collaboration with the municipality, there was one consensus that personal efforts of one of the municipal health officers made the collaboration possible. Therefore, collaboration started through informal networks and relationships and developed into formalised system (but the informal seems to dominate) where now the municipality participates actively.

- **Contributions to the collaboration and effects**

The community contributed labour, cash and materials while the municipality provided technical support, transport and cash.

Table 3. Contributions to the construction of the Ntyuka dispensary

Partner	Contributions	
Community	1	Labour
	2	Stones and sand
	3	Cash (Tshs. 500 per adult)
	4	Land
Village government	1	Sensitisation
	2	Coordination
	3	Supervision
Dodoma Municipal Council	1	Technician
	2	Transport
	3	Cash (Tshs. 2.4 million)

Source: Meeting with village government officials

The community provided labour for collection of sand, stones, and (construction) in the initial phase of the dispensary building. The village was also the source of the sand and stones. Cash was used to buy cement, water and timber. The municipal technician was responsible for the drawings, site planning and setting of the building structures. One lorry from the municipal council was used to ferry materials to the building site. The cash was used to buy materials and pay some skilled workers in the construction work. This level of collaboration helped to build four rooms and veranda up to roofing stage.

Although, both DMC and the community were now participating in the dispensary project actively, lack of clear grounded foundation for PPP led to difficulties that contributed to unusually delayed completion of the project and weak accountability mechanisms since 1993. Now it also leaves unanswered questions about the future institutional arrangements, accountability, growth and sustainability of the health project.

There was neither formalised project write up, nor clear and formalised contractual engagement that

bound the people, community leadership and the municipal council. As a result there were gross irresponsibility by both community leadership and the municipality. Since there were no formalised and robust systems of accountability, the people were disappointed and this had the most significant impact on project completion. Some statements from community leaders and the people support this position as one community member comments in a meeting held at the project site (see figure...

> The problem in our village is poor community sensitisation and mobilisation. We were ready but the leadership was a big problem. It is only when we got a new village government... now you can see we are here for work". Another member added...people contributed money but no one can tell how it was spent... we are very disappointed.

The dispensary was built on what was called "village land". This term was ambiguous because there was no such land because each piece of land belonged to a particular household. Indeed, in the dispensary building site there was no formal demarcation between public and personal or family land. This was a result of improper planning from the very initial stages of the project which could have taken care of the issue of land. This was serious bottle neck because the setting of the house was delayed for hours (see figure 6) as the owner of the plot resisted with bitterness unless was told how would be compensated. Later due to fear of community anger and pressure from the higher government authorities he gave in with despair.

Figure 2. Village leaders, DMC technician and community setting the foundation for staff house near the dispensary building

Source: Photographed by consent of the group participants

When the village chairman was consulted on the land issue he commented that;

> ...he is complaining about his plot but he will also benefit from the health services... we are going to continue with construction... If you talk of compensation, it means I have to pay from my own pocket or go to jail... The municipal council has no any plan on compensation.

The Village Land Act 1999 recognises the power of village government in planning and allocating land for public utilities. However, taking individual plot meant for building residential houses for family members without any compensation including reallocation is something unusual and signifying lack of accountability to the citizenry. More interestingly, Dodoma municipality is a complicated scenario because while the Land Act 1999 and Local Authorities Act, 1982 give local authorities power to plan for land use, in Dodoma municipality all land and its development is controlled by the Capital Development Authority (CDA) which is a different government authority established by Capital Development Authority Act 1973 for the purpose of developing the area into a modern capital city of Tanzania. More details are in section 4.1 of this report. However, this contradiction was not known to the community leadership.

The problem of poor leadership was also observed as the village chairman noted that:

> ...This construction work was supposed to be supervised by the village social development committee but no one is around here... it is a problem...some might be drinking local brew while we are here... you try to bring leaders and people together but it does not work as expected... we do not have many people here who can be good leaders.

There were also feelings among the village government officials that the municipality was not supportive enough and nothing could be done about it as one leader said:

> ..we have been asking for support from the municipality for a long time but it is very frustrating. It reaches a time they see you as a trouble maker and only demanding what you do not deserve. ...even their contribution was in piecemeal... sometimes you get Tshs. 400,000... you wait again for a long time. It is only one official who helps us to push things in an informal manner and we are grateful for that.

Although it appears now that the dispensary will be opened in the near future due to other supports from two partners as it will be briefed later, water is now the most critical problem because the dispensary cannot operate without water. People walk for 7 kilometres to buy water from the Dodoma township. 20 litres of water were sold at Tshs. 20. Those who could afford bus fair used the local commuter buses. Dodoma municipality has plenty of water, and the nearest distribution tank is just about 4 kilometres from the village. According to the village executive officer, consultation with Dodoma Urban Water and Sewerage Authority (DOWASA) revealed that the costs for supplying water to the village were around Tshs. 40 million. If health and water projects were integrated from planning stage it could have been easier to develop a better modality for partnership. Referring to community readiness to participate in their projects one old man said;

> We are ready to dig trenches for laying pipes... our wives have to walk at night all the way to town and sometimes deliver at home or on the way... we can even contribute 10,000 each for the water project. ... Let them tell us and they shall see our commitment.

Joint efforts from the DMC and the community were not enough to finish up the project. Village leadership in a friendly and informal consultation with one health officer from the municipality was advised and linked to two NGOs. The next section will focus on the emergence of the second partner who collaborates with Ntyuka village in the dispensary project.

(b) Ntyuka Village Community – CMSR- Tanzania partnership

CMSR (Centro Mondialita Svillupo Reciprocco) is a local NGO not for profit, affiliated to the parent CMSR International with headquarters in Livorno, Italy. It was registered in Tanzania in 1977 but started to operate as a local institution in 1979. The objective of CMSR in Tanzania is to promote health, education, water supply and social development of the people particularly the poor and at risk. It works through partnership with international NGOs and donor community including WHO, CARE and Italian government.

- **The nature and motives of partnership with Ntyuka village community**

Partnership with CMSR started in April 2005. The village executive officer and the councillor proudly were proud that the partnership was the result of their own efforts on one hand, and guidance from one of the municipal health officers on the other.

> ... we noted that our building was rotting, the roofing sheets donated by honourable Samuel Malechela (the one who laid the foundation stone) were also rotting. Money

> from the municipality was not enough. Our people were contributing money and labour to construct a shallow dam for harvesting rain water... there is hunger... we decided to look for other sources of support.

It started through informal discussions with one of the municipal health officers (classified as friend) who advised them to visit CMSR for some ideas because he knew CMSR did support community initiatives. CMSR officials were met. After several consultations, site visits by CMSR and proposal writing, finally their request was honoured.

- **Contributions to the partnership**

Table 4. Contributions to the dispensary project

Partner	Items	
CMSR	1	Funding (Tshs. 7,500,000)
	2	Technical advise
	3	Supervision
	4	Identified and paid contractors to supply water for construction work
	5	Identified and paid contractors for civil work
Community	1	Unskilled labour
	2	Land
	3	Supervision

Source: Meeting with village government

There was strong commitment from both parties to ensure that all the finishing work was completed so that the dispensary could be opened as soon as possible. Therefore, although the village asked for 2 million, expert visit by CMSR engineer suggested for 7.5 million which was almost four times the amount requested. However, by the time the site was visited, village leadership was not aware of the actual costs of support from CMSR and there was no provision for a toilet. It was the researcher who broke the news that the toilet was part the CMSR contribution since it was not sensible to build dispensary without toilet.

CMSR decided to work directly without using formal municipal bureaucracy because the community and the government had already played their roles and more formal engagement with the municipal bureaucracy would have continued to delay the work. According to the CMSR official, the municipal leadership was yet to be informed officially, and it was planned that will be informed when submitting a quarterly project development report which was administrative matter. Village government officials did also say that the municipal management was aware of the collaboration (through the health officer) and nothing more because there was no any formal communication from the village government. CMSR was very concerned about the problem of water but no decision was made on how it could be solved. CMSR was not the only NGO approached for support. Other initiatives bore fruits and added another dimension in the partnership as described in the following section.

(c) ALPDA- Ntyuka-Canadian Embassy community partnership

- **The nature and motives**

ALPDA (Agricultural and Livestock Production and Development Association) is a local NGO registered in 2002. It aims at working with the community to reduce poverty through initiation and development of various projects as part of complementing government efforts. According to the chairman, ALPDA noted that the dispensary building was at a stand still for a long time and tried to intervene. The management approached the village leaders for advise. It was agreed that a technical proposal be written and support from ALPDA so that assistance could be sought from donors. Finally a proposal for renovation of the building was sent to the Canadian Embassy in 2004. The Embassy accepted to support the community initiative but under condition that the municipality make commitment to contribute to the partnership.

- **Contributions to the partnership and effects**

The initial plan of ALPDA – Community partnership changed its face after inclusion of the Canadian Embassy and DMC while at the same time CMSR was providing support. This was an interesting case where many actors come together for a common social goal. Table 17 summarises the contributions to the construction of the dispensary project since 1993.

Table 5. Summary of total stakeholders Contributions to the Ntyuka dispensary

Partners		Contributions	
1	ALPDA	1	Advice
		2	Coordination
		3	Accounts for the donor money
2	Canadian Embassy	1	Funds (Tshs. 8,000,000) for staff house and toilet
3	DMC	1	Funds (Tshs. 4,500,000
		2	Technician for drawings and structure settings
		3	Lorry and fuel for transport
4	CMSR1	1	Funding (Tshs. 7,500,000)
		2	Technical advise
		3	Supervision
		4	Identified and paid contractors to supply water for construction work
		5	Identified and paid contractors for civil work
5	Community2	1	Unskilled labour
		2	Cash
		3	Sand and stones
6	Village government	1	Coordination
		2	Community mobilisation
		3	Supervision
7	Individual community members3	1	Land for the construction of the buildings
8	Samuel Malechela (MP)4	1	20 bags of cement
		2	30 corrugated metal sheets

Source: Interviews and community meeting

Table 19 displays the state of PPP for construction of Ntyuka dispensary in September 2005. Pulling the resources together will not only enable the completion of the dispensary but also provide for one staff house and toilet. It was planned that efforts to mobilise resources would continue so that the problem of shortage of water will be solved and the dispensary be upgraded into a health centre.

Weaknesses of PPP

Although he attended a course in PPP in Morogoro organised by the ministry of health:

---

1 The contributions are transferred from table 16

2 The contributions are transferred from table 16

3 It is a forced contribution than partnership because the village government took the land by force.

4Was former Prime Minister and Member of Parliament (MP). Contributions were made in 1993.

- No enough preparations. Some doctors were not trained
- Directors less informed... Acknowledge by the Municipal director
- Although training covered most key staff. Some councillors, Accountants are no longer in service
- No clear coordination

- Lack of continuity in training

6. Aga Khan Health Centre

- **Introduction**

Dodoma Aga Khan Health centre is a faith based organisation under Ismailia Muslim Community which is a world wide religious health service provider. It is located at the heart of the town centre. In Tanzania the headquarters were in Dar es Salaam. It provides both preventive and curative health services.

- **The nature and motives of the partnership**

Like many other PPP cases, it was not clear when and how the collaboration with the municipality started because there was no document to make reference, and also it was difficult to know the persons who initiated it. However, it was said that in the early 1990s and in the course of supervising the health centre the DMC requested for a room to provide mother and child health services (MCH). The Aga Khan management accepted the idea by providing one room specifically for MCH services.

- **Contributions to the partnership**

Although there was no documentation on how the two organisations had to work in order to provide public health services, there was one common social goal of improving public health service delivery through combined efforts. The contribution of each partner is indicated in Appendix 4.

- **The type of partnership**

Usually partnership menu available for choice depends on the nature of services, strengths of the partners in terms of resources and expertise and the maturity of the national policy and regulatory framework for PPPs. In the case of PPP between the Aga Khan Dispensary and DMC, it is not an easy task to fix the type of collaboration to conventional typologies. It only fits the simplest definition of sharing resources of common good without even be much concerned about the details of the collaboration and issues of accountability. As a result, skepticism and dissatisfactions among staff invlpved in PPPs were common. For example... one senior staff from Aga Khan said..

...they brought nurses here who were competent enough... it was like dumping the unwanted ones. I trained them... when they learned that they were now good they shifted them to other clinics... I warned them... these days I am told that the municipality conduct courses for nurses but these ones are always left out. I think there is a misunderstanding somewhere. One nurse complained that she had stayed for 5 years without training despite many enquiries while her colleagues in government clinics attended several courses every year.

There were occasions where Aga Khan staff went for courses organised by the MoH or the DMC. Some of the courses were fully funded by the MoH while others Aga Khan paid for transport, per-diems and accommodation, but there were no forum for reaching in such collaboration agreements.

At times training was designed by the MoH and each dispensary/health centre/Hospital was allocated a quota. The was an allegation that there were cases of abuse of the system by the municipality as one very senior official commented;

> ...there was workshop on drugs procurement...there were 2 slots for Aga Khan but we were not invited... they sent their own people because there was payment of Tshs 50,000 per day per participant as an allowance.... People from MoH came to ask me about procurement. I refused to answer... they gave me documents on procurement issues to sign. I also refused. I told them I know nothing about procurement because I was not involved in their training. One time there was training for MTUHA but we were also not invited. ... they brought me MTUHA forms to fill in. I said I will fill them when I want. Sometimes I do and sometimes not... I think they do not like us because we are better remunerated.

The partnership benefits each stakeholder in the following way

Partnerships have increased the number of customers to the private sector and hence more profits. This has created capacities to recruit more qualified staff, more laboratory services like biochemistry analysis and varieties of drugs. The doctor in charge of Aga Khan Health Centre made the following comment.

> "Many patients from Makole Urban Health Centre are referred to Aga Khan for biochemistry tests or even drugs because of lack of or shortages of reagents and equipments. We charge them for the tests but if they want to buy drugs from pharmacies, they are free to choose... More people including members of parliament and many international and local organisations with offices in Dodoma have registered for our services. As a result we have significantly improved our services. For example, we can treat malaria with a dose of Fansidar at the cost of only Tshs.300 while others spend up to Tshs. 1000. The customer has to choose"

7. Tumaini Dispensary

- **The nature and motives**

Tumaini dispensary is a family business owned jointly by Dr. M. Aligawesa and Mrs Aligawesa. Dr. Aligawesa is a government employee and the head of Mirembe mental illness referral hospital in Tanzania. Mrs Aligawesa is a nurse by profession but decided to retire from public office in order to manage the dispensary.

The dispensary started in 2000 as a clinic for counseling drug addicts. The major reason for starting health service business was the urge to be self employed and become own manager.

As it applies to other cases, it was not an easy task to establish how the partnership with the municipality started. However, the manager applied from the council for a license to operating a dispensary. Later he was supplied with MTUHA stationeries, family planning toolkits, condoms, and vaccines in order to provide such services on behalf of the council. There were no serious discussions about the collaborations. Out of the need to preserve the vaccines, the manager applied for support from Care International. He was given a refrigerator as an initiative to support the collaboration. The dispensary employed 4 permanent 2 temporary staff for OPD services and home based care for people with HIV AIDS.

8. Veyula Dispensary

Italian based Ivrea Sisters started Veyula dispensary in 1985 with the objective of providing basic health care to the surrounding community. Like in all other cases collaboration with the municipality started and is working in an informal manner

The partnership with the municipality is through the provision of MCH services, training and sharing of few resources as indicated in Appendix 4. It was not possible to get more details about the collaboration because the officials and staff who were in office were not informed and those who initiated the collaborations could not be remembered for consultation. The list of contributions is found in Appendix 4.

9. Nzuguni Dispensary

Nzuguni dispensary is located in Nzuguni ward about 5 kilometers off Dar es Salaam road. Sisters of Mary Immaculate (with headquarters in India) started it in 1986 as religious based private dispensary in order to provide basic health care to the Nzuguni community. Like in the case of Veyula dispensary, it was not possible to tell how partnership started because of lack of any documented evidence and the founder of the dispensary was not accessible for information. However, it appears that when the dispensary started to operate the council provided some basic working equipments (weighing scale, buckets, and refrigerator) and vaccines for MCH services. Therefore, the partnership was initiated by the municipality whereby the dispensary took the role of the recipient of complementary resources for mother and child services. The contributions to the PPPs are summarized in Appendix 4.

10. Michese village dispensary

Michese village had no dispensary. For a long time it depended on health services from Mkonze ward, which by then was not operating due to winds destruction in 1999. The community depended on health services from the town centre.

- **The nature and motives of the partnership and contributions**

Konoike which is Japanese based Company won tender for road construction under Tanzania Roads management. Earthling materials were requested from Capital City Authority (CDA), which has mandate for Dodoma municipality development (capital city). CDA in agreement with the ministry of natural resources awarded the permission to extract sand, stones and compaction soil from Michese village free. However, the village government noted the right to benefit from the project. After some consultation with the political structures and the municipality as well as community resistance, finally Konoike built the dispensary in 2004 as compensation for use of village roads and materials for roadwork. The value of the building was Tanzanian Shillings 17 Million. After completion of the dispensary building, the villagers had to come in by constructing pit latrine through labour and cash contribution worth shillings 470,500. There were plans to build staff houses, and furnish the dispensary through support from the ministry of health. The process of getting the required items was considered by village government officials to be bureaucratic, non-transparent, and frustrating. Some of the statements uttered by the village officials were... the municipal director said there is no money but we shall lay the foundation stone during the UHURU TORCH rally...people worked day and night in anticipation that the dispensary would be open. They did not. People are no longer interested... they refused to plant trees... ants are about to finish the building... they said the budget is with the ministry of health...after was willing to open it during.

Case 11. Bihawana dispensary

- **The partnership**

Bihawana is located in Mbabala ward in Dodoma municipal council. It is not known when the dispensary started. However, anecdote information suggests that the Italian Passions Fathers started it as an infirmary centre. Later it was under the management of Miserecodia Sisters. There two staff members. The first is a nun who is the in charge of the dispensary and the second is an attendant who is paid on weekly basis depending on collections from the patients. The dispensary saves about 20 patients a day mostly women and children. It provides general outpatient services as well as reproductive and child health services. The area of partnership is in immunisation, provision of data to the council through the MTUHA system, training and supervision of the dispensary although it was not clear the partnership started or who initiated it. Other contributions are found in Appendix 4.

12.Mvumi hospital

- **Introduction**

Mvumi hospital is located in Mvumi area which is about 50 kilometres from Dodoma town centre. The hospital started in 1935 under the ownership of the Anglican Church, Diocese of Central Tanganyika. Both the Dodoma district council and the then Ministry of Health recognises Mvumi hospital as a Designated District Hospital (DDH). However, and indeed surprisingly, the hospital officials were of different opinion as one key person said;

> Some people refer Mvumi hospital as a Designated District Hospital but it is not.... We are struggling to be but the process is long and not straightforward although this is a big hospital.

By 2005, there were 137 staff members including doctors, nurses, paramedical and supporting staff. It provides the following services:
Firstly, Inpatient medical, surgical, pediatrics and maternity services
Secondly, Reproductive and child health
Thirdly, Paramedical supportive services

Fourthly, Specialised eye services
It also runs nursing, laboratory and clinical courses for pre service and in-service students from all over the country.
It was not possible to establish when collaboration with government started. However, it was before the government reforms in the 1990s. According to the Dr. In charge, although there was no formal date or forum that put PPP in place, collaboration with government has been there in order to;

- Share limited resources
- Share experience
- Combine efforts
- Avoid duplication
- Complement each other

All these had to be achieved through joint development of Comprehensive District Development Plan. Despite the good intention of the PPP, it there had never been any formal joint planning for health service delivery. The practice has been the submission of annual budgets to the full council for approval. It is more ceremonial and an anticipation that more grants could come fourth.
The following are the characteristics of the PPP

- **The nature and motives of partnership**

Although there was no documented evidence on the genesis and basis of collaboration between the hospital, the council and other partners including the ministry of health, donors and international NGOs, it was very clear that without collaboration Mvumi hospital could not provide sustainable health services. For example it was noted that attrition rate for medical staff and nurses was very high due to inability to provide market based reward packages. Although the hospital was working hand in hand with the government, the partnership was more between Mvumi, the Ministry of health and international NGOs than with the council because:
Firstly, the money for MCH services came from donors such as Danish Development Aid (DANIDA) through the Expanded Immunisation Programme (EPI) that is a national programme through the ministry of health. Therefore, the council was a mere conveyor belt. In terms of accountability for the money, Mvumi had to account to both the district council and the ministry of health.
Secondly, the relationship with the Dodoma district council is supervisory as a duty of any District Medical Officer (DMO) because there was no other framework.
Thirdly, the ministry of health and not the District council seconded most of specialized medical staff working in the medical wards and training centres. For the list of contributions see Appendix 4.

13. Chikopelo dispensary

- **Introduction**

Chikopelo dispensary is one of the dispensaries under the Roman Catholic Church in Dodoma. It is located in Chipanga division, Chipanga ward about 64 kilometres from Dodoma urban centre. The dispensary started as an infirmary centre for the Chikopelo mission but since there is no public health service facility around, it grew into a dispensary. It offers outpatient services and mother and child services including delivery. It has one clinical officer, a nurse and laboratory technician. Although it has, large buildings to accommodate many patients the main customers were mothers and children who come for vaccination. The dispensary does not provide laboratory services because there is no electricity. As a result, there were tendencies to give patients drugs such as fansidar for malaria and antibiotics without laboratory investigation.

- **The partnership and motives**

The way partnership between Chikopelo dispensary and the Dodoma district council started is not different from other unclear experiences. No records, no formal agreements but collaboration were there in terms of sharing resources, supervision and recording keeping for the government. In short, the collaboration constituted contributions and sharing resources as shown in Appendix 4.

Minor cases of collaborations with the Dodoma District Council

There were less important PPP cases that were not worthy detailed study but are also important to describe briefly here just for the purpose of awareness. These are Mlowa bwawani, Itiso and Bahi Roman Catholic dispensaries in Dodoma district council. According to the Dodoma Diocese Health Secretary, these dispensaries were the results of efforts of Holy Ghost missionaries who started mission work in Kondoa district in 1907. Later, Passion Fathers spread the missionary work to other parts of Dodoma. Therefore, churches were built in different places including Mlowa Bwawani, Itiso and Bahi. In order to cater for health services for the church community, infirmary centers were started within the parish buildings. As demand for services from the surrounding communities, these centres grew into dispensaries where patients were charged minimal costs in order to sustain the services. The heads of the dispensaries were parish priests being supported by nuns as secretaries cum practitioners. Usually services were delivered by nuns with minimum medical qualifications or just learned through experience. Other supporting staff were usually medical attendants who had no formal medical education. They learned from experience and by doing. Partnership with the municipal council has been in the form of "invitation for training" which is offered by the ministry of health to all health providers in the country. The dispensaries benefited through training of their staff. Unlike other cases, there were no partnerships in reproductive and child health because there were government owned dispensaries near these missionary dispensaries. According to the coordinator, the partnership has not taken serious roots because there were no significant commitments from all parties concerned. The church saw the dispensaries as small projects for the parish priest "to earn some income" while the government officials looked at the church based health providers as private domains. These experiences are similar in Chikopelo dispensary. The only difference is that the municipality uses Chikopelo dispensary for MCH services because there was no government dispensary around the area.

Appendix 6: Checklist data, measurement and value labels

SERVICE : Service provided by different providers 1
Measurement Level: Nominal
Column Width: 34 Alignment: Right
Print Format: F8
Write Format: F8

Value	Label
1	Established common objectives
2	Shared risks
3	Provides staff and pays salaries
4	Provides working office
5	Provides refrigerator
6	Pays electricity bills
7	Use own furniture and fittings
8	Joint training (shared expertise)
9	Supervises staff
10	Pays for security services
11	Provides informal support
12	Sphygmomanometer
13	Stethoscope
14	Screen
15	Examination coach
16	Weighing scale
17	Family planning kit
18	Fetal scope
19	Joint emegent service
20	Laboratory
21	Medication
22	Free consultation services
23	Referral services
24	Provides office maintenance
25	Provides special duty allowances
26	Joint meeting
27	Joint planning
28	Jointly fund staff training
29	Joint research (shared expertise)
30	Joint consultancy (shared expertise)
31	Joint publication (shared expertise)
32	Provides transport
33	Provides stationary (Mtuha)
34	Provides health data (Mtuha)
35	Provides food items
36	Provides cash
37	Clothes
38	Mosquito net
39	Vaccine kit
40	Bedding materials
41	Wheel chairs
42	Stretcher
43	Buckets
44	Stove
45	Manual labour
46	Land
47	Joint funding of aga khan tainning

48 Supervise treatment of TB
49 Provides medication for the epileptic
50 Juice and sweets to others and children
51 Free medical services to tha poor
52 Free accommodation
53 Bed grant
54 Free house
55 Free water
56 Clinical tray

PARTNER1: Partnership in providing services- Case ONE 2
Measurement Level: Scale
Column Width: 34 Alignment: Right
Print Format: F8
Write Format: F8

Value Label

0 None
1 MHHCAP Alone
2 DMC Alone
3 Village Government Alone
4 Community Alone
5 Partnership between MHHCAP and DMC
6 Partnership between MHHCAP, DMC and Vilg Govt
7 Partnership between MHHCAP, DMC, Vilg Govt and Community
8 Partnership between DMC, Vilg Govt and Community
9 Partnership between Vilg Govt and Community
10 Partnership between DMC and Community
11 Partnership between MHHCAP, Vilg Govt and Community
12 Partnership between MHHCAP and Community

PARTNER2: Partnership in providing services – Case TWO 3
Measurement Level: Scale
Column Width: 16 Alignment: Right
Print Format: F8
Write Format: F8

Value Label

0 None
1 Hombolo Hospital Alone
2 DMC Alone
3 Partnership between Homblo and DMC

PARTNER3: Partnership in providing service – Case THREE 4
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value Label

.00 none
1.00 Dr. matovolwa health center alone
2.00 DMC alone
3.00 Dr. Matovolwa health centre and DMC

PARTNER4: Partnership in providing service- Case FOUR 5
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value	Label
.00	none
1.00	St marry immaculate alone
2.00	DMC alone
3.00	St marry immaculate and DMC

PARTNER5: Partnership in providing service- Case FIVE 6
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value	Label
.00	None
1.00	Community alone
2.00	DMCalone
3.00	CMCR alone
4.00	ALPDA alone
5.00	Canadian Embassy alone
6.00	Community and DMC
7.00	Community and CMCR
8.00	Community and ALPDA
9.00	Community and Canadian Embassy
10.00	DMC and CMCR
11.00	DMC and ALPDA
12.00	DMC and Canadian Embassy
13.00	CMCR and ALPDA
14.00	CMCR and Canadian Embassy
15.00	ALPDA and Canadian Embassy
16.00	CMCR, ALPDA and Canadian Embassy
17.00	DMC, CMCR, ALPDA and Canadian Embassy
18.00	Community, DMC, CMCR,ALPDA and Canadian Embassy
19.00	Community, DMC, CMCR and ALPDA
20.00	DMC,CMCR and Canadian Embassy

PARTNER6: Partnership in providing service - Case SIX 7
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value	Label
.00	None
1.00	Aga Khan Health center alone
2.00	DMC alone
3.00	Aga Khan Health center and DMC

PARTNER7: Partnership in providing service- Case SEVEN 8
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value Label

.00 None
1.00 Tumaini dispensary alone
2.00 DMC alone
3.00 Tumaini dispensary and DMC

PARTNER8: Partnership in providing service - Case EIGHT 9
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value Label

.00 None
1.00 Veyula dispensary alone
2.00 DMC alone
3.00 Veyula dispensary and DMC

PARTNER 9: Partnership in providing service- Case NINE 10
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value Label

.00 None
1.00 Nzuguni dispensary alone
2.00 DMC alone
3.00 Nzuguni dispensary and DMC

PATNER10: Partnership in providing service – Case TEN 11
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value Label

.00 None
1.00 Bihawana dispensary alone
2.00 DMC alone
3.00 Bihawana dispensary and DMC

PATNER11: Partnership in providing service - Case ELEVEN 12
Measurement Level: Nominal
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value Label

.00 None
1.00 Mvumi hospital alone
2.00 DMC alone
3.00 Mvumi hospital and DMC

PATNER12: Partnership in providing service – Case TWELVE 13
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value Label

.00 None
1.00 Konoike alone
2.00 DMCalone
3.00 Michesa Village Government alone
4.00 Community alone
5.00 Michese village and Community
6.00 Konoike and Community
7.00 Konoike and Michese village government
8.00 DMC and Michese village

PATNER13: Partnership in providing service – Case THIRTEEN
Measurement Level: Scale
Column Width: Unknown Alignment: Right
Print Format: F8.2
Write Format: F8.2

Value Label

.00 None
1.00 Chikopelo dispensary alone
2.00 DDC alone
3.00 Chikopelo Dispensary and DDC

Appendix 7: Questionnaire data measurement and value labels

RESPNO: Number of years of respondent 1
Measurement Level: Nominal
RESPCH: Number of children
Measurement Level: Nominal

CURATHEC: Currently attended health service center 3
Measurement Level: Scale

Value	Label
1.00	Hombolo Hospital
2.00	Nzuguni
3.00	Veyula
4.00	Chikopelo
5.00	Tumaini Dispensary
6.00	Bihawana Dispensary
7.00	Matovolwa Health centre
8.00	Aga Khan Hospital
9.00	Mackay-House-Ihumwa
10.00	Mvumi Hospital
11.00	St. Mary Immaculate

URBARURA: Urban or Rural 4
Measurement Level: Nominal

Value	Label
1.00	Urban
2.00	Rural

WARD: Ward of the respondent 5
Measurement Level: Scale

Value	Label
1.00	Hombolo Makulu
2.00	Nzuguni
3.00	Msalato
4.00	Chali
5.00	Chipanga
6.00	Hazina
7.00	Mbabal
8.00	Kizota
9.00	Madukani
10.00	Ihumwa
11.00	Mvumi
12.00	Miyuji

STREET: Street of the respondent 6
Measurement Level: Scale

Value	Label
1.00	Hombolo Bwawani
2.00	Msamaria
3.00	Kolimba
4.00	Maweni
5.00	Ihala
6.00	Nalawanda
7.00	Machaka
8.00	Shuleni
9.00	Veyula
10.00	Muungano
11.00	Mwenyengeta
12.00	Chikopelo
13.00	Azimio
14.00	Mtakuja
15.00	Nguvukazi
16.00	Mwenge
17.00	Mlezi
18.00	Bihawana
19.00	Jamali
20.00	Cairo
21.00	Chihembe
22.00	Jamhuri
23.00	Kati B
24.00	Sudan
25.00	Tatangwe
26.00	Malecela
27.00	Aganacli
28.00	Ndachi
29.00	Miuji

RESDAREA: Area of residence 7
Measurement Level: Nominal

Value	Label
1.00	Ndachi
2.00	Msalato
3.00	Veyula
4.00	Mchemwa
5.00	Nzasa
6.00	Ihala
7.00	Nalawanda
8.00	Machaka
9.00	Shuleni
10.00	Maweni
11.00	Hombolo Barabarani
12.00	Msamaria
13.00	Kolimba
14.00	Machaka
15.00	Muungano
16.00	Mwenyengeta
17.00	Chikopelo
18.00	Azimio

19.00	Mkonze
20.00	Mlezi
21.00	Kikuyu Flats
22.00	Iwelewele
23.00	Usheleleni
24.00	Bihawana
25.00	Manda
26.00	Ilolo
27.00	Vilindoni
28.00	Kivukoni
29.00	Kizota
30.00	Area A
31.00	Chinangali
32.00	Nkuhungu
33.00	Mjimpya
34.00	Air Port
35.00	Barabara ya 10
36.00	Barabara ya 8
37.00	Chamwino
38.00	Maili Mbili
39.00	Barabara ya 9
40.00	Majengo
41.00	Kigamboni
42.00	Ihumwa
43.00	Malecela
44.00	Kati
45.00	Jamhuri
46.00	Chihembe
47.00	Sudani
48.00	Tatangwe
49.00	Cairo
50.00	Aganaeli
51.00	Mtakuja
52.00	Nguvukazi
53.00	Bwawani
54.00	Mwenge
55.00	Iringa Road
56.00	Hazina

GENDER: Sex of respondent 8
Measurement Level: Scale

Value	Label
1.00	Female
2.00	Male

AGE: Age of respondents 9
Measurement Level: Scale

MARST: Marital status 10
Measurement Level: Scale

Value	Label
1.00	Single
2.00	Married
3.00	Divorced
4.00	Widow
5.00	Widower
6.00	Cohabiting

NOCH: Number of children 11
Measurement Level: Scale

EDLE: Level of education 12
Measurement Level: Scale

Value	Label
1.00	Primary School
2.00	Secondary School
3.00	College
4.00	University
5.00	Technical Education
6.00	No Formal Education

SOFINCO: Source of income 13
Measurement Level: Scale

Value	Label
1.00	Crop production
2.00	Animal production
3.00	Formal employment
4.00	Informal employment
5.00	Crop and animal production
6.00	Crop production and formal employment
7.00	Formal small business
8.00	No activity
9.00	Crop and animal production and informal sector employment
10.00	Crop production and informal sector employment

MOAVINC: Monthly average income 14
Measurement Level: Scale

ANAVINCO: Annual average income 15
Measurement Level: Scale

PREVATHE: Previously attended health service center 16
Measurement Level: Scale

Value	Label
1.00	Hombolo Bwawani
2.00	Chipanga
3.00	General hospital
4.00	Makole health centre
5.00	Mkonze
6.00	Kikuyu dispensary
7.00	Mvumi
8.00	Mbabala
9.00	Isanga
10.00	Wajenzi
11.00	Mlezi
12.00	Maweni
13.00	Makutupora
14.00	Veyula
15.00	Magereza
16.00	Chihanga
17.00	St. Gema
18.00	Mpwayungu
19.00	Tumaini
20.00	NA

AVDISHE: Average distance to health service center 17
Measurement Level: Scale

COSHCONT: Cost sharing for health services 18
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA- Not Applicable

BULMATCO: Contribution of building materials 19
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

MANPCONT: Labour contribution 20
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

CASHCONT: Cash contribution 21
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

WORTBUMA: Building materials contribution 22
Measurement Level: Scale

WORTCOMA: Labour contribution 23
Measurement Level: Scale

WORTCASH: Cash worth contribution 24
Measurement Level: Scale

FAPLSEPR: Family planning services in the previous center 25
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA- Not Applicable

MEDEXSE: Medical examination services in the previous center 26
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA- Not Applicable

VITASE: Vitamin A 27
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA- Not Applicable

CHILBRSE: Delivery services 28
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA- Not Applicable

VACSE: Immunisation services 29
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

MEDLABSE: Medical laboratory services 30
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

TRETSE: Treatment services 31
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

REFSE: Referral services 32
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

CONSHIVS: Counseling and testing for HIV/AIDS 33
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA- Not Applicable

CONSTEME: Counseling, testing and medication for HIV /AIDS 34
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

HELEDUSE: Health education 35
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

TBMED: TB medication 36
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA –Not Applicable

EYEMED: Medication 37
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA – Not Applicable

MOSQNE: Mosquito net 38
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA –Not Applicable

WORMMED: Drugs for worms 39
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA- Not Applicable

MALARDR: Drugs for malaria 40
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

DHEALTCE: Categories of health centre 41
Measurement Level: Scale

Value	Label
1.00	Hospital
2.00	Health centre
3.00	Dispensary

DOWNSHIP: Type of ownership 42
Measurement Level: Scale

Value	Label
1.00	Government
2.00	Private for profit
3.00	Community
4.00	R. C Missionary
5.00	Other non-governmental organisation

EFAMILPL: Family planning services 43
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EMEDIEXA: Medical examination 44
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EVITAMIA: Received vitamin A 45
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EDELIVER: Delivery services 46
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EIMMUNIZ: Immunisation services 47
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

ELABORAT: Laboratory services 48
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

ETREATME: Treatment services 49
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EREFERAL: Referral services 50
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

ECOUHIVT: Counseling and HIV test 51
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

ECOUHIVM: Counseling, test and medication for HIV/AIDS 52
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EHEALHED: Health education services 53
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EMOSQNET: Mosquito net services 54
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EPNDOL: Panadol 55
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	Na
4.00	No response

EMETB: TB drugs 56
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EMEEYE: Eye medication 57
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EWORMED: Drugs for worms 58
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

EMALMED: Malaria drugs 59
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No

FDURSERV: Duration of services 60
Measurement Level: Scale

GATTDUPR: Frequency of attendance to the health centre during pregnancy 61
Measurement Level: Scale

Value	Label
1.00	Always
2.00	Frequently
3.00	Fairly frequently
4.00	Rarely
5.00	Not at all
6.00	NA

GREASON1: Reason for not attending services 62
Measurement Level: Nominal

Value	Label
1	Not used to
2	If the patient is very sick
3	Baby delivery services are obtained at the general hospital
4	Distance
5	NA

HFREQATT: Frequency of attending this current health centre 63
Measurement Level: Scale

Value	Label
1.00	Always
2.00	Frequently
3.00	Fairly frequently
4.00	Rarely
5.00	Not at all
6.00	NA
7.00	No response

HREASON: Reasons for not attending current health centre 64
Measurement Level: Scale

Value	Label
1.00	Cost
2.00	If patient is very sick
3.00	Used to
4.00	Didn't fall sick
5.00	Far distance
6.00	Near distance
7.00	Nurse harassment
8.00	Reliable services
9.00	Investigation
10.00	NA
11.00	Investigation cost and if he patient is very sick
12.00	No response

IFREQATT: Frequency of attendance in this health centre for family 65
Measurement Level: Scale

Value	Label
1.00	Always
2.00	Frequently
3.00	Farly frequently
4.00	Rarely
5.00	Not at all
6.00	No reason

IREASON: Reasons for not attending services 66
Measurement Level: Scale

Value	Label
1.00	Costs
2.00	If patient is very sick
3.00	Too far- distance
4.00	Used to
5.00	Reliable services
6.00	Investigations
7.00	Referrals
8.00	NA
9.00	Not HIV/Aids victim
10.00	Investigation costs and if the patient is very sick
11.00	No response

JDOSEEK: Do you seek services from other centers 67
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA
4.00	No response

JREASONS: Reasons for seeking services from other centers 68
Measurement Level: Scale

Value	Label
1.00	Referrals
2.00	If patient is very sick
3.00	Investigations
4.00	Cost
5.00	Distance from home
6.00	Child birth
7.00	Used to
8.00	Counseling
9.00	No response
10.00	NA
11.00	Good service
12.00	Referral, cost and investigations

K1MPHSER: Reduced distance to health centre 69
Measurement Level: Scale

KEXTRASE: Extra health services in the new centre 70
Measurement Level: Scale

K2YEARAG: There is no services in government hospital 71
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

K2YEARS: Come tomorrow in government hospital 72
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

K2YEARRE: Responsible Hospital 73
Measurement Level: Scale

Value	Label
1.00	Makole
2.00	General hospital
3.00	Bwawani
4.00	NA
5.00	General hospital and Makole
6.00	Miuji and general hospital

KHEALTHS: Have you attended this health centre but you didn't get service 74
Measurement Level: Scale

Value	Label
1.00	Yes
2.00	No
3.00	NA

KTIMESER: How many hours of waiting time for services were reduced 75
Measurement Level: Scale

KTIMEWAL: Time for walking to health services was reduced by 76
Measurement Level: Scale

KFARE: Cash relief for not paying transport costs 77
Measurement Level: Scale