University College Cork
CORK-SINGIDA PARTNERSHIP
NEWSLETTER: SEPTEMBER 2013

Dear Colleagues,

Fr. Ollie O'Brien, who played a major role in setting up the Cork-Singida partnership, visited UCC in May. Following his visit he provided us with a detailed account of the history of the Partnership and of the challenges Makiungu Hospital has faced and is facing, placed against the background of developments in Tanzania.

Fr. Ollie's account follows. We would be very pleased to hear (m.mansfield@ucc.ie) comments from members.

Please mention the Partnership to people in your Department who may be interested. As a background to your efforts, we intend to place this Newsletter on the net to all Exchange Users in the next few weeks. An Authorisation Form may be found at the bottom of this page.

The staff at Makiungu Hospital have asked us to thank you all for your continuing support,

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PAYMENT FORM

I hereby authorise UCC to deduct from my wages/salary each week/month, the sum of € _____ with immediate effect. I further authorise UCC to pay over the amount deducted to the Treasurers of Cork Singida at UCC. I understand that this authority may be revoked by me, in writing, at any time.

Signed _____

Department/Unit _____

Date _____

In the event that I am already a member, this authorisation prevails over any previous authorisation. October 2013.

Please return this form to **Tony O' Riordan** in the Payroll Office, UCC.

THE MAKIUNGU –UCC PARTNERSHIP (A brief historical review)

Shortly after gaining independence in the I950s and 60s many of the newly elected African leaders attempted to produce an alternative to the capitalist economic systems inherited from the former colonial regimes. These road maps for social and economic development could be generally described as versions of Marxism blended with traditional African values and modes of living. A typical example was Julius K. Nyerere's 1967 blueprint for political, social and economic development entitled 'Ujamaa'. This was a quite radical policy shift which touched all sectors of Tanzanian life. In this essay we will be taking a look at how it impacted on, in particular, the health and social services, what happened subsequently and in more recent times.

The Kiswahili word 'ujamaa' is probably best translated by the English word 'familyhood' but the political theme it was intended to convey in order to be properly understood, needs to be combined with 'kujitegemea' meaning self-reliance. In effect what we are talking about is Nyerere's rather unique form of socialism. From approximately 1970 the programme was in full swing not only with nationalisation of the banks, housing, land and industry but also health and educational institutions, though not all of them. The new policy was not lacking in admirable good intentions and it would be difficult to disagree with the rationale of wanting to provide a more extensive, equitable and effective health policy. Two of the largest Mission administered Teaching Hospitals were incorporated into the new programme of nationalisation, as indeed were many 'lesser' institutions spread throughout the country. Private practice (for profit) in the health sector was virtually eliminated in the pursuit of the great and noble goal of a free health services for all. It is a truism that good intentions or even the most sincere promises will not deliver when essential elements of the equation are not in place. It didn't take long for most people to know and some to 'feel' that the health services were getting worse rather than better. Regrettably, it can take longer for those in power and capable of changing course to realise that such is the case. Poor implementation, acts of God such as famine or acts of man such as war are sometimes put forward as rationalisations.

Makiungu Hospital wasn't nationalised but (like some more) went through a really rough period in the 19970s and early 80s. You know it is bad when you can't buy cotton wool in a country where raw cotton was once the third or fourth export crop. Though health services were theoretically free, there was an acute shortage of drugs in the statutory health units. As a consequence, sick people were flocking to Makiungu from all quarters even from the Regional capital Singida thereby placing a massive burden and excessive demands due to overcrowding in the wards and the amount of medicines required on a daily basis. Both human and financial resources were pushed to the limit and sometimes beyond. At this point in time the Hospital was seriously dependent on the importation of drugs, equipment and general supplies. Not only that, but tyres and spare parts for vehicles. Importation for non professionals is a complex matter which combined with roads and fuel shortages put a huge strain on the administration. Indicative of the national financial meltdown were the oil tankers awaiting payment on the high seas before entering the port of Dar es Salaam to discharge fuel to keep the country moving for the next few days. Back in the Hospital, patients and their families simply did not have the money to pay for medicines and services. It always was and still is a fee paying but 'not for profit' hospital. Refusing treatment and turning away patients, often very ill people, was never part of the ethos of the Hospital. But the cumulative impact on finances of the issues described above were actually very serious and a matter of grave concern at the time, both for the owner, the Diocese of Singida and the Administrators the Medical Missionaries of Mary. 'Not for profit' is one thing but serious loss making is quite another. These were trying times when the temptation to scale down or walk away could not be discounted. If nationalisation were still an option (it wasn't) it might have been considered.

There was a change of political leadership in the mid 1980s marked by a significant shift in economic policy with the introduction of a new liberalization policy, culminating ultimately in a 'mixed economy'. The new leadership inherited a stable, cohesive and peaceful country with a strong national and cultural identity for which people were grateful to Nyerere. Additionally, it was a massive relief to be able to buy cotton wool, gauze, fuel and fuel filters if you were a hospital

administrator, though money was still in short supply. There followed 10 years of what we may dare to call 'normalcy' which resulted in some new initiatives by the Hospital Administration which previously would have been unthinkable. A start was made on much needed maintenance, a lick of paint here and there, acquisition of a new IV Fluids Unit, (rather more ambitious) a new outpatient department, new pharmacy and staff houses, not necessarily in that precise order. The transport situation had previously been utterly pathetic. At this point it was gradually improved with assistance from Irish Aid and the recently established UCC – Makiungu Hospital Partnership. Liberalisation resulted in another very helpful initiative of the Ministry of Health through the establishment of the **Medical Stores Department**, a semi-autonomous body responsible for the procurement, supply and distribution of drugs and equipment for health units registered with the Ministry of Health. A major administrative improvement was the strategic locations of the outlets throughout this vast country which ensured easier access. The NGO health units were authorised to participate in the scheme providing them with access to drugs and supplies at the most competitive of prices; available **VAT free.**

Another significant shift in policy was the restoration of private practice. Administratively, these private clinics (for profit) are bracketed in the same category as the Voluntary or Mission Health Units which are entirely not for profit. For some strange reason they all come in under NGO while one could reasonably argue they are two quite exclusive categories.

There has been a vast improvement in the scope and the quality of the training and learning courses to be availed of throughout the entire sector by both the statutory and voluntary services. One which comes to mind is the Kilimanjaro Christian Medical Centre (and University) in Moshi which is rapidly gaining a well deserved international reputation, especially in the areas of ophthalmology and dermatology. Candidates from Makiungu are sponsored in such places for upgrading. All of this and the major improvements in wages and salary scales were long overdue simply because they were very necessary but we shall have to see what was the effect on a moderately sized rural hospital like Makiungu.

The **restoration of private practice** (for profit) through a strange quirk fate had the following impact on Makiungu. If the medical service is available on your own street why would Singida Town residents travel to Makiungu? These were the clients who could afford to pay so their non attendance resulted in a significant dip in numbers and obviously in income for the Hospital.

The other issue is that of **the wage bill.** It has to be said that for various reasons the Mission health units tended to operate on 'the cheap labour' of both expatriates and local personnel. By cheap labour we mean that the expatriates were of course volunteering in the strict sense of the word but over a period of time the numbers had been dwindling. In the second case - that of local personnel – they had always received the statutory wage according to the rule book but the remuneration was really very low. The point was reached where it became necessary to employ more and more local personnel on appreciably higher salary scales and this proved to be 'a real financial shock for the system'. This by no means denies the fact that the wage structure needed to be revised upwards in the interests of fairness and reward for hard work on the part of the hospital personnel. The related issues of promoting staff for **upgrading and then retaining** them, always was a challenge in a rural setting, hence nothing new for Makiungu in the I990s. But what was new was increasing migration to the towns and cities, with greater (and possibly better) job opportunities in BOTH the Statutory and Private Service (for profit) and the perception that life is better in the urban areas in any case. (According to a recent HABITAT report, life in terms of social services IS much better in African towns and cities vis a vis the rural areas).

In the period around and after the year 2000, other trends can be identified which could be said to have had a negative impact on funding for an NGO like Makiungu. About that time there appeared to be a clear preference on the part of western Governments to deal directly i.e. **government to government for the disbursement of overseas development aid**. Perhaps this was a political correctness issue, an attempt to bury 'the strings attached' accusation or a nice gesture of confidence in African Governments, I am not sure. In the interest of fairness it has to be said that IRISH AID have always supported NGO capital development projects and the plaques throughout the Hospital are clear evidence that this is so. Access to this form of development aid is now

processed through the umbrella group Mission Cara which makes a good deal of sense, administratively. While still on finances there is one more fairly obvious point to be made. Back in the 1950s and 60s there would have been considerable numbers of highly qualified **expatriate staff** (MMM Sisters) in a place like Makiungu. Through their contacts of family and friends and through liaison with missionary donor organizations they would have contributed handsomely to the income of the Hospital. While not entirely finished this is now largely diminished. It would be so easy if we could blame all this on the Irish Central Bank, or any Old Bank or even the Celtic Tiger but as we all know, 'There are no Tigers in Africa' not even celtic tigers.

It became fairly obvious that the 'storm clouds' were gathering for institutions like Makiungu. Maybe it was because historically it was taken for granted that places like this could somehow manage to cope and deliver a quality service regardless of the prevailing challenges. Therefore it took some time for the Ministry of Health to realise the gravity of the situation viz. that without some form of intervention, many medium sized rural mission hospitals were doomed. While the MOH coffers were not exactly overflowing it was nevertheless well known that exports of gold and minerals, coffee and fresh cut flowers along with the rapidly expanding tourist industry placed the Government in a much better position to meet the needs of an admittedly fast growing population. Nor should we forget the still substantial contribution from bilateral development aid.

The MOH **created a new category** of what are now called **District Designated Hospitals** (DDH) sometimes called Municipal in what can approximately be described as a public – private partnership. Our hospital in Makiungu achieved this status, which amounted to an enormous relief. Specifically what it meant was that some basic salaries were paid by the MOH with a regular allocation of free drugs. At this juncture at least, reason had prevailed resulting in a form of cooperation for the most effective and efficient use of scarce resources both human and financial to meet the changing needs of the population now near the 50 million mark in Tanzania. (Just by way of comment: there is a temptation at this juncture to compare and contrast PPP in Tanzania and Ireland. Suffice to say that in Tanzania it is ONLY the 'not for profit' NGOs which benefit from this arrangement).

Moving forward, I would point to two emerging and related trends that will have an impact on the health and social services. Nobody doubts that the **cash economy** vis a vis subsistence farming is growing significantly. As a consequence, greater numbers of families can and should have at least some form of basic **health insurance** policy. After fifty years of independence there is now a widespread realisation that life is not a free for all, which was not always the case. In the cities and towns having health cover is virtually the norm as evidenced by the rapid spread of private practice for profit. It is hardly a surprise that few or none at all exist in the rural areas. Clearly, the health insurance campaign needs to be intensified in the rural areas to bring more and more families into the scheme. This is obvious for two reasons the first being that the MOH cannot even contemplate providing an entirely free health service and as we have seen there are limits to what the NGOs like Makiungu can do. The old adage that prevention is better than cure applies here. In fact if there is a financial crisis in the health sector I cannot see a cure coming from Government or Donors, hence the absolute necessity of a universal health insurance scheme. All of this 'policy talk' is not to deny that there are some genuinely needy people who as human beings have a right not to have to die from malaria or a chest infection that could be cured by a not too expensive dose of antibiotics. This is but one of ways which donor groups and the good friends and partners of Makiungu Hospital can assist but it most certainly is not the strategy for future funding of this or any other health unit of its kind in Tanzania.

Makiungu has always been conscious of the importance of retaining Staff. This is made all the more difficult in what is perceived to be a less attractive rural area compared to the bright lights of Arusha, Mwanza and DaresSalaam. Improving the skills and expertise of Staff by encouraging them and more importantly facilitating them to participate in up-grading courses, represents a major boost for morale and consequently efficiency. But these are rewards that regrettably can vanish overnight if Staff decide to walk away. From a donor viewpoint, funding for this purpose is possibly less high profile and therefore less attractive than for a vehicle or building. UCC has shared this insight into the importance of Staff upgrading and the financial support given has made

it a key component of management policy. But what about the smaller health units in Singida? How do they fare when it comes to recruiting and retaining Staff?
The Doctor in Charge of Makiungu Hospital is ex officio the supervisor of all other health units in the Diocese of Singida. Some of these are located in even more remote places than Makiungu where staffing issues can be even more acute and challenging than what we have been discussing. Perhaps the UCC Partnership could reach out to some of these areas? If such were to happen it is important to know that all the health units are officially registered with the MOH and participate in the national health programme at regional level where the person in charge is the Regional Medical Officer based in Singiida. The responsible Church authority is the Diocese of Singida, the legal owner of the health units (but with some documented exceptions). Liaison would be through the Doctor in Charge of Makiungu and the Diocesan Health Secretary.
Finally, The UCC Partnership may be interested to know of a Centre for Physically and Mentally challenged children located at Siuyu, about 8 kms from Makiungu