A Public Private Partnership in Tanzania:
CCBRT, Dar es Salaam City Council and Private Local and International Partners

Integration of High Quality Maternal & Child Health with HIV/AIDS Services into an efficient Comprehensive Disability Programme
In developing countries, most persons living with disability have an impairment that can actually be cured. If they had access to the right medical attention along with quality treatment, eg up to 80% of people with blindness in Tanzania could have their sight returned to them.

Improving quality of life for persons with disabilities is the primary aim of CCBRT (Comprehensive Community Based Rehabilitation in Tanzania). However, most persons with disabilities are poor to very poor. To help achieve the goal of ‘equity in health care’, the Non-Governmental Organization (NGO) has developed the ‘Robin Hood system’ of health care financing, whereby patients contribute up to 50% of the cost to ‘serve all’ with the same high quality care.

Much was achieved during 2006. 63,500 consultations and 7,000 surgeries were carried out at the Eye Department in Dar es Salaam. While in the Rehabilitation Department over 1,600 surgeries were performed. These surgeries included fistula repair, plastic surgery, neurosurgery for children and reconstructive surgery for children born with congenital deformities. Plans are already in place to develop a rehabilitation centre through which a wider range of services will be provided.

CCBRT originated from a desire to enhance people’s quality of life and to rehabilitate patients into the community. Striving to achieve these aims is fundamental to CCBRT’s activities. Many children with disabilities are excluded from regular education but being part of a normal school environment is what they wish for. Throughout Sub-Saharan Africa, CCBRT has prepared and brought more disabled children to normal education than any other organization.

As an organization with a focus on improving the lives of persons with disabilities (PWDs), CCBRT also feels a moral duty to contribute as much as possible to preventing impairment and disability, rather than ‘only’ serving the ever growing numbers of persons with disabilities whose impairments and disabilities could have been prevented.

As giving life to a child remains one of the most dangerous and disabling moments in the life of African women and infants, improving Maternal and Child Health (MCH) is one of the highest priorities in poverty alleviation agreements between the Tanzania Government and its Partners. Until now, however, very few improvements have been made in this area.

It is a major challenge to develop systems of MCH that are able to provide high quality services to both rich and poor whilst maintaining financially viable. The CCBRT Hospital is an example of such a system. CCBRT and its Partners believe that the problems of maternal and child health can be addressed in a similar way.

The Dar es Salaam City Council (DCC), CCBRT and a number of International and Local Private and Alliance Partners have agreed (or are still considering) to combine efforts and costs to create a MCH/HIV Hospital in Dar es Salaam. This will work as a Public/Private Partnership complementing the DCC Municipal Hospitals. It would be an extension of the successful system of the CCBRT Disability Hospital which provides high quality services and is accessible to rich and poor.

The new MCH/HIV Hospital will not only provide MCH/HIV services (education, medical, follow up) to mothers and children ‘of today’, thereby preventing maternal and child mortality and disability, it will also be available for quality in-service training to future generations of MCH/HIV and disability medical and nursing staff in Tanzania.
Tanzanian Health Services: History and Today

Historically, in Tanzania as elsewhere in Africa, it was mainly the Church and missionary institutions which provided health care in rural areas (where most of the people were living). Governments ‘took care’ of the cities. After Independence, thousands of public health centers were built by the new African governments. However, in the last 20 years, most people providing health services left to work at private urban hospitals or abroad.

These urban, private hospitals serve middle class and wealthier patients only, leaving the 80 to 90 % poor people in cities (mostly living on less than 1 US$ per day) to government health services. In practice this means they are deprived of being attended by one of the few medical doctors, many of whom have other responsibilities in management, administration and teaching. Nurses or clinical assistants take care of the patients’ health problems, being the only affordable staff. These medical employees feel badly paid, and moral and working ethics are consequently often low. The lack of tradition in formal management makes corruption easy and ‘normal’.

In Dar es Salaam, the City Council (Government) Health system has to serve 6 million people with affordable care. Preventative services and curative first line care have priority and 62,000 patients are served per week. AIDS, Malaria, Tuberculosis and Cholera are striking hard on the ever increasing and thereby impoverishing population. These diseases have prompted a great flexibility in priorities from the 56 dispensaries, 5 health centers and 3 district hospitals which make up the Public Health system, and are spread over the whole city. At present 60% of bed capacity in District Hospitals is used for AIDS patients and the system is greatly overstretched.

The World Health Organization (WHO) estimates that 10% of any population has a disability, meaning that some 25% of the entire population, such as families, caregivers and communities of persons with disabilities, is adversely affected by the presence of disabilities (UN, Despouy, 2004). Only 2% of people living with a disability in developing countries have access to rehabilitation and appropriate basic services (DFID, 2000).

Disability services – rights, community and hospital based A survey conducted in 1994 on the availability and accessibility of services for persons living with disabilities in and around Dar es Salaam confirmed the need for a comprehensive and accessible programme.

CCBRT was created with an overall objective to improve the quality of life of persons living with a disability, their families and caretakers. Since then and in response to the high needs it grew fast to become one of Africa’s largest multi-component disability programmes. More specifically for the coming five years, it aims to impact the lives of 500,000 poor blind, physically impaired, deaf, epileptic and otherwise disabled, as well as their care takers (90% women) by providing comprehensive home, community and hospital based medical, rehabilitation and education services.

It targets especially women and children, focusing on the urban and peri-urban areas of Dar es Salaam. CCBRT now intends to further expand the area of ‘inreach’ intervention to so far underserved target regions such as Pwani, Morogoro, Tanga, and the islands of Zanzibar and Pemba with a total population of 10 million people.

CCBRT is a multi-component disability programme. It comprises a community-based rehabilitation (CBR) programme as well as hospital-based services, an international training programme, an orphans programme and a holistic HIV/AIDS programme in collaboration with the City Authorities. It also provides human rights and legal aid counseling to those living with HIV/AIDS or other disabilities, and to orphans and their family members at 3 places in Dar es Salaam.
In 2007, the CCBRT counts on 300 committed and skilled health and social workers. CCBRT is also strongly focused on capacity building through training of varying levels of staff in all areas of work. CCBRT is a nationally registered NGO and its constitution and registration enables it to establish programmes wherever in Tanzania it so desires. It plans to expand its disability services in three main areas:

(a) extending its services as explained above,
(b) intensifying its capacity building component and creating a rehabilitation centre to cover some of the services which do not, as far yet, exist such as speech therapy,
(c) the production of personalized mobility and position devices for children with cerebral palsy and other impairments/disabilities.

MOTHER & CHILD CARE (MCH)

The health services under most pressure in Tanzania are those affecting people with no financial and political clout: mothers and children. 80% of the population consists of women and children. The city has no specialized obstetric unit where deliveries are safe and where difficult cases can be brought. Neither is there a pediatric hospital. It seems accepted as an overall problem in Sub-Saharan Africa, that ‘Health budgets of African governments are inadequate to deal with obstetric cases.’ \(^2\) Reports become ever grimmer, with many women delivering babies unattended. In Tanzania, only 35.8% of deliveries take place in the presence of a trained person. \(^1\) The infant mortality rate (IMR) in Dar es Salaam stands at 12%. \(^4\) Women think increasingly that it is safer to deliver at home (even though this might not be the case). The most dangerous period in a woman's life is that of pregnancy and specifically of delivering a baby and for the infants to be born.

Studies increasingly show the overwhelming impact of mother child care on the life expectancy of mothers and newborn babies. As far as maternal deaths (1.64%) and peri-natal deaths (10.3%) concern in Dar es Salaam, it is known that for each mother or child dying through peri-natal conditions, many more remain disabled, often however with no reliable figures available. During a recent research project - 'Peri-natal Care Assessment' \(^6\) in Dar es Salaam, it was shown that 25.4% of fresh stillbirth death and 48.3% of neonatal deaths were due to birth asphyxia, which is also known as a major cause of disability in newborn babies. A survey by CCBRT on the causes of cerebral palsy in children served by the CBR Program (Community Based Rehabilitation Program) showed that 75% of the mothers could clearly relate the cause of impairment of their child to incidents surrounding the birth of the child. The CCBRT Fistulae (VVF) department figures also indicate that most fistulae are due to sub-standard mother child care.

The city of Dar es Salaam does not have a hospital that can bridge the gap between the three overcharged District Hospitals and the Muhimbili National Hospital (MNH). As pregnancy, delivery and childhood happens across all socio-economic groups of the population, there is a great need to be filled. What is lacking in Dar es Salaam is a hospital that is open to all who need MCH, with high quality services, with affordable prices and good management, including an education component (for staff and for the expecting parents), along with day to day monitoring and evaluation.

---

1. CCBRT Disability detailed Four-Year plan available
2. Kasonde, WHO. 2004
3. Unicef, Tanzania Reproductive and Child Health Survey, 1999
6. Urassa DP et al., 2006.
HIV/AIDS MAKES POOR PEOPLE EVEN POORER

The strong connection to poverty means that poor people, and in particular those with disabilities and their families are more likely to get HIV/AIDS. At the same time, they are far less likely to benefit from any type of mainstream HIV/AIDS service delivery.

This situation undermines the effect of any rehabilitation efforts. HIV/AIDS destroys lives, family income and jeopardizes the future of millions of children. Trained and experienced health workers and community leaders are equally decimated thus further compromising the achievement of (other) development goals.

So far, HIV service delivery has been very fragmented, leading to half solutions. The lack of services and human resources at community level is hampering wide scale implementation of successful interventions such as ARV treatment. Moreover, stigma and lack of confidential testing opportunities contribute to very late testing for HIV which leads to a delayed start of ART and subsequent discouraging results.

The challenge is to develop a model that provides holistic HIV care starting with HIV counseling and testing in the early stages of the infection (or even better: before infection ever would take place), followed by prevention of further transmission, nutrition, medical care and ART, home based care, legal aid and services for AIDS orphans.

Mother-child services have been identified as an ideal entry point for preventing disability, and for the provision of holistic HIV care. Once pregnant mothers have been HIV tested, there is an opportunity for HIV prevention and treatment services for the whole family. Such services include PMTCT and provision of ARV, but provide also an opportunity to secure a safe delivery and strengthening of antenatal and postnatal services. These efforts combined would help prevent mother and child mortality as well as disability in both.

A triple challenge for CCBRT: How to 1) contribute to prevention of disability through improved MCH, 2) mitigate the consequences of HIV/AIDS and 3) at the same time make those quality services accessible to the poor and to the disabled as well?

It is a major challenge to develop systems of health care that are able to provide high quality services to both rich and poor whilst maintaining financially viable. CCBRT’s Disability Hospital is an example of a success story in creating such equity in health care, with high quality medical and rehabilitation services accessible to rich and poor. CCBRT and its Partners believe that the problems of mother & child are and HIV can be addressed in a combined system.

As proper mother and child care is required by all people, and as such a responsibility of the community at large, to be provided 365 days a year and 24 hours a day, it will be more financially viable in case it is organized as a Public/Private Partnership. This could utilize the management skills and creativity of the Private sector (local and international), and the financial support, public endorsement and support from the National and Local Government.

The Board of CCBRT and the City Council of Dar es Salaam have thereto decided to join efforts in a Public Private Partnership, to achieve high quality disability and mother & child care with integrated holistic HIV/AIDS Services. By doing so, equity in care should be achieved. Equity is defined as accessibility and affordability for all social classes.
The Government of Tanzania already has provided CCBRT with a large plot (4.7 hectares) next to the existing CCBRT hospital at Msasani/Dar es Salaam. CCBRT and DCC have also developed a Memorandum of Understanding (MoU), soon to be signed. In that MoU, the Government has indicated that CCBRT will become the Regional Designated Hospital of Dar es Salaam and that they will approve and provide a yearly bulk grant covering the salaries for the staff of the existing CCBRT disability hospital as well as for those of the new MCH and HIV Departments that are still to be built. It will also provide ‘other costs’ for hospital supplies at the same level as other Regional Hospitals. Management will be in hands of the Board of CCBRT which will appoint a Manager. Local and International MCH and HIV specialists will be recruited for service delivery and training purposes.

The new ‘Regional’ hospital will, in addition to the existing curative and rehabilitation departments, develop a high volume, high quality maternity and HIV/AIDS department. This will provide a number of services:

- Education to future mothers on reproductive health and HIV/ARV
- Holistic HIV/AIDS services (Voluntary Counselling and Testing, ARV, Home Based Care, Legal Aid, orphan care)
- Post and ante natal clinics as well as doing deliveries
- Taking care of mother and child until eventual post delivery symptoms are gone
- HIV/AIDS education will also be provided to staff of other organizations and private companies, including the development of HIV/AIDS Workplace Policies.

CCBRT is in the process of negotiations with International NGOs and Private Organizations seeking their support.

Also a number of Private international and national Partners have decided to become involved with the project (or are considering whether to) whilst others are being approached. Commercial enterprises view this type of development as an exciting way to improve their corporate public relations to the outside world (Corporate Social Responsibility) as well as within their own Human Resource Development (provision of high quality medical care to staff and family). Private companies also see a business interest as this model programme will develop and be used for teaching purposes for future midwives and other staff involved with running MCH and HIV/AIDS units in Tanzania. Some also see a chance that it will be copied in other countries, as well.

The following will be the responsibilities of the Public and Private Partners involved:

<table>
<thead>
<tr>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government of Tanzania</strong></td>
<td><strong>CCBRT</strong></td>
</tr>
<tr>
<td>- Provide Plot for Hospital (4.7 hectares)</td>
<td>- Management of Hospital</td>
</tr>
<tr>
<td>- Staff Salaries</td>
<td>- Engage into International Partnerships</td>
</tr>
<tr>
<td>- Pay for current expenditures (other cost)</td>
<td></td>
</tr>
<tr>
<td><strong>Dar es Salaam City Council (DCC)</strong></td>
<td><strong>International Partners</strong></td>
</tr>
<tr>
<td>- Recognition of CCBRT as Regional Designated Hospital Dar es Salaam</td>
<td>- Private Enterprises*: expertise, funding, indirect and direct business interest and commitment</td>
</tr>
<tr>
<td>- Advise CCBRT Board through Committee</td>
<td>- Private INGO: networking, expertise and funding</td>
</tr>
<tr>
<td>- Contract and follow up</td>
<td><strong>Local Private (Business and NGO) Partners</strong></td>
</tr>
<tr>
<td></td>
<td>- Knowledge, experience</td>
</tr>
<tr>
<td></td>
<td>- Resources</td>
</tr>
<tr>
<td></td>
<td>- Transfer patients.</td>
</tr>
</tbody>
</table>

7 Names are still withheld. They concern a major international bank, a major international pharmaceutical company, and other international and national companies.
This Public Private Partnership will aim at the following targets and indicators of success over a 5-year period:

1. Comprehensive Community and Hospital Based Disability services:

   - Prevention/reduction of disability through the provision of ability restoring/impairment reducing surgeries;
     - Eye surgeries: 35,000
     - Orthopaedic and plastic reconstructive surgeries: 5,000
     - Fistulae surgeries: 1,200
     - Neuro-surgery: 800

   - Provision of corrective devices to fully or partially restore the ability to see, hear, to be mobile or to function;
     - Low Vision devices and spectacles: 100,000
     - Orthopaedic and Mobility devices: 10,000

   - Hospital/centre based provision of therapy/advice sessions to increase ability or reduce impairment;
     - Eye examinations: 300,000
     - Physiotherapy sessions: 50,000
     - Other (epilepsy): 3,000

   - Community based therapy sessions by community health workers and professionals;
     - Home based therapy sessions: 10,000
     - Community based group sessions: 1,000

   - Community based functional training in daily living skills: 250

   - Formal/inclusive education to increase chances of integration, employment and of self realization;
     - Visually impaired/blind: In collaboration with The Society of the Blind
     - Physically impaired: 300
     - Hearing impaired: 300
     - Orphans: 500

   - Disability Hospital and Community Programme Staff Trained to Achieve Clear Goals: 200

2. Mother Child Care Component:

<table>
<thead>
<tr>
<th>(Total Deliveries 37,4158)</th>
<th>Actual Situation in Muhimbili National Hospital</th>
<th>Objective of Project as to MDG</th>
<th>Difference (realizing that the projects will often receive late referrals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality - Lives of mothers saved</td>
<td>613 (= 1.64 %)</td>
<td>50% reduction</td>
<td>306 mothers surviving</td>
</tr>
<tr>
<td>Mothers morbidity/disability due to complications prevented</td>
<td>9,808 Mothers¹² sick and/or disabled (= mortality x 16)</td>
<td>50% reduction (See 9.) (MDG: reduce 3/4)</td>
<td>4,904 mothers not sick/disabled</td>
</tr>
<tr>
<td>Children preserved from orphan status</td>
<td>1,839 children orphaned (= mortality x3)</td>
<td>919 less children orphaned</td>
<td>919 children preserved from orphan status</td>
</tr>
<tr>
<td>Perinatal lives saved</td>
<td>4,489 children dying¹³ (= 12 %)¹⁴</td>
<td>50% reduction (See 9.) (MDG: reduce 2/3)</td>
<td>2,244 lives of children saved</td>
</tr>
<tr>
<td>Perinatal disability prevented</td>
<td>4,489 (= 12 %) (estimated at least equal to perinatal deaths)</td>
<td>50% reduction</td>
<td>2,244 children not disabled</td>
</tr>
<tr>
<td>Perinatal HIV infection prevented (PMTCT)</td>
<td>10% of women HIV+ 40 % transmission = 1,496 children HIV+</td>
<td>65% reduction</td>
<td>972 children HIV prevented</td>
</tr>
<tr>
<td>MCH Staff Trained and Guided to Achieve Clear Goals:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. HIV/AIDS Holistic Care Component:

- Education on HIV/AIDS, Reproductive Health, Malaria, TB (37,415 x 3) 112,245
- People aware of HIV status (number new people (re) tested by MCH + HIV project) 80,000
- HIV+ people timely on ARV, able to educate children (also referrals) 20,000
- Persons not widowed and economically more viable 20,000
- Young orphans prevented (20,000 x 3) 60,000
- Orphans inheriting the belongings of their parents (through legal aid) 2,000
- Orphans prevented from becoming street children (estimate) 1,600
- HIV/AIDS Staff Trained and Guided to Achieve Clear Goals 200

---

8 In 5 years: year 1 = 15 per day; year 2 = 25 per day; years 3-5 = appr.35 per day.
10 The Baobab Hospital will aim at saving ‘all’ lives, and certainly aim higher than a 50% reduction in the actual figures. However, it is important to consider that other hospitals, from rural as well as urban areas, will make very late transfers towards the Baobab hospital which will considerably increase the mortality rate. We will however aim to increasing the expertise of the hospital to deal with maternal trauma and hopefully be able to reach our ultimate aim of decreasing the rate by 75%.
11 This figure excludes women delivering at home.
13 This figure excludes children born at home.
15 37,415 is the number of deliveries: each lady will be required to bring at least 2 other persons for education (daughter, husband, partner, sister,...)
The Budget Requirement and Composition of the Regional Designated Hospital will be as follows (Euro).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Construction new Disability components</td>
<td>- 12 months running disability components</td>
<td>12 months running all existing Disability and new MCH/HIV components</td>
<td>Expatriate staff MCH/HIV</td>
<td>Expatriate staff MCH/HIV</td>
<td>Expatriate staff MCH/HIV</td>
<td>Plot 5 hec.</td>
</tr>
<tr>
<td>- All running of existing disability components (hospital and community based)</td>
<td>- 30% construction and installation of new MCH/HIV components</td>
<td>6 months running costs MCH/HIV</td>
<td>Expatriate staff MCH/HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government of Tanzania (Public)</td>
<td>(Plot 5 hec.) 367,438</td>
<td>1,115,446</td>
<td>1,708,524</td>
<td>1,675,190</td>
<td>1,821,459</td>
<td>Plot 5,689,057</td>
</tr>
<tr>
<td>Private Business Partners National and International</td>
<td>1,939,800</td>
<td>1,045,728</td>
<td>723,671</td>
<td>641,612</td>
<td>771,523</td>
<td>5,122,595</td>
</tr>
<tr>
<td>Private INGO Partners and Co-Funders</td>
<td>5,698,475</td>
<td>4,565,580</td>
<td>4,233,039</td>
<td>4,217,782</td>
<td>4,467,312</td>
<td>23,172,190</td>
</tr>
<tr>
<td>Global Alliances and/or Major HIV/AIDS Partnership</td>
<td>0</td>
<td>ARV Medicines + 160,129</td>
<td>ARV Medicines + 165,260</td>
<td>ARV Medicines + 160,024</td>
<td>ARV Medicines + 174,588</td>
<td>ARV Medicines + 665,902</td>
</tr>
<tr>
<td>Gross Budget Needs</td>
<td>Plot 8,005,774</td>
<td>ARV + 6,886,884</td>
<td>ARV + 6,820,695</td>
<td>ARV + 6,705,509</td>
<td>ARV + 7,234,883</td>
<td>Plot + ARV + 35,653,747 euro</td>
</tr>
<tr>
<td>Income from Patients/CCBRT</td>
<td>401,471</td>
<td>787,205</td>
<td>1,691,780</td>
<td>2,209,090</td>
<td>2,209,090</td>
<td>7,298,636</td>
</tr>
<tr>
<td>Net Budget</td>
<td>7,604,303</td>
<td>6,099,679</td>
<td>5,128,915</td>
<td>4,496,419</td>
<td>5,025,793</td>
<td>28,355,111</td>
</tr>
</tbody>
</table>

Grand Total 2007 – 2012 (5 financial years) = 28,355,111 Euro + Plot + ARV Medicines for 20,000 patients.

16 Minor calculation differences are due to the fact that decimals were not copied from excel sheet.