

**TOPIC: IS THE GOVERNMENT SEEN TO SAY AND ACT ACCORDING TO THE  
PUBLIC PRIVATE PARTNERSHIP POLICY?  
MVUMI HOSPITAL EXPERIENCE**

**INTRODUCTION:**

Mvumi Hospital is owned by the Anglican Church Diocese of Central Tanganyika, it has been in operation since 1935. It is 45km away from Dodoma Municipal town, South east. It is the only Hospital in Dodoma, officially it has a bed capacity of 190, functionally there are 280 beds. The hospital has training institutions. Clinical officers training school (COCT), Nurse Training school(NTS) and laboratory Assistant training school.

**SERVICES PROVIDED**

- OPD
- IN PATIENTS [Medical, surgical, paediatrics, maternity services]
- Community Health services Reproductive and child health, supervision of peripheral health facilities
- Specialized services:- Eye operations
- Other paramedical supportive services

**PUBLIC PRIVATE PARTNERSHIP**

**Background:**

Before HSR Mvumi hospital had been collaborating with the government in the following activities:-

- i] Human resources for health (staff secondment)
- ii] Finance:       Staff grand  
                      Bed grand
- iii] Guidelines/protocols
- iv] Control of our breaks – cholera and meningitis

With the introduction of HSR and Public private partnership the collaboration was formalized and strengthened.

In 1994 CSSC facilitated a joint church and government programmes for sustainable development of social services. This programme had two components:-

- Support to church health services nationwide, and support to health services in four districts based on enhanced church government partnership- Dodoma district was involved.
- The second components of the programme had the following goals and objectives

**Goal:**

- i] To strengthen management teams [both government and church] as preparation for the HSR which was done.

**Specific objectives:-**

- i] To promote sharing of responsibilities and resources to achieve health services provision
- ii] To improve accessibility to quality care at affordable costs for the majority of the population.

**Strategy:** Through joint development of district health plan by involving key stakeholders in the district in line with HSR.

**REASON FOR PUBLIC PRIVATE PARTNERSHIP:**

Include:-

- Sharing limited resources
- Share experiences
- Combine efforts to face multiple causes of health problems
- Avoid duplication hence cover a wider area
- Compliment each other

**MAIN ACTORS INVOLVED**

NAME	POSITION	ROLE
MOH	Responsible and accountable for all health issues in the country	<ul style="list-style-type: none"> <li>- Formulate health policy</li> <li>- Provide guidelines/protocols</li> <li>- Provide human resources support</li> <li>- Provide human resources support</li> <li>- Provide technical advice</li> </ul>
RHMT	Coordinator between MoH and local government at district level	<ul style="list-style-type: none"> <li>- Interpret health policy</li> <li>- Provide technical support</li> </ul>
LOCAL GOVERNMENT	Owner of health facilities	<ul style="list-style-type: none"> <li>- Provide resources support</li> </ul>
DHMT	Coordinator Health activities in the district	<ul style="list-style-type: none"> <li>- Develop district health plan involving key stakeholders</li> <li>- Implements, monitor, evaluate plan</li> <li>- Perform supportive supervision to all health facilities etc.</li> </ul>
DIOCES AND MEDICAL BOARD	Owner church health facility – Mvumi Hospital	<ul style="list-style-type: none"> <li>- Formulate policy</li> <li>- Provide resources support</li> <li>- Approve facility health plan</li> </ul>
MVUMI HOSPITAL	Health provider	<ul style="list-style-type: none"> <li>- Implementation of health policy</li> </ul>

NAME	POSITION	ROLE
MANAGEMENT TEAM		- Prepare health plan - Implementation of health plan.

### PROCESSES INVOLVED

- Training of DHMT including key stakeholders on District health planning
- Training of DHMT and key stakeholders on joint supervision
- Mobilization of community to participate in rehabilitation of health units
- Allocating service are for each health facility.
- Rehabilitation of infrastructure and equipment

### BUDGET IMPLICATIONS

Basket fund allocation to church hospital has been increasing since 2001. Depending on district basket fund allocation.

Grant from MoH has been changing depending on bed capacity

- Budgetary contribution from Basket grand and MoH to the hospital budget are 10.5% and 19.8% respectively. This does not include salaries to seconded staff.

### OUR EXPERIENCE

#### a) INPUTS FROM GOVERNMENT [Central, local government]

- Finance: Staff and bed grant
- Human resources for health; seconded staff
- guidelines/protocols
- Selected drug supplies/equipment's for vertical programs

#### b) INPUTS FROM HOSPITAL

- Human resources for health
- Vehicles

#### c) OUTCOMES

- free reproductive and child health services [Antenatal, postnatal]
- subsidized prices for delivery services
- conduct supportive supervision to 14 government health facilities in services area
- utilization of same supportive supervision check list
- Low services prices, more attendances

#### d) ACHIEVEMENTS ON QUALITY OF HEALTH SERVICES

- *Maternal mortality rate have ranged from 337 per 100,000, 201 to 190 per 100,000, 2004 average 379 per 100,000 below national maternal mortality of 529 per 100,000.*
- *Under five mortality rte has dropped to 78.8 per 1000, below national rate of 154 per 1000*
- *ANC new attendance is 97%*
- *TT<sub>2+</sub> vaccination coverage is 98%*
- *DPT<sub>3</sub> Immunization below 1 year is 98%*
- *Polio vaccination is 100%*
- *Hospital delivery has increased*
- *These are hospital figures, those from the community would be different – higher.*

### PROBLEMS/CONSTRAINT

- Absence of joint district health planning sessions involving key stakeholders
- Stakeholders [Mvumi hospital] asked to prepare and submit to DHMT its own health plan which is included in district health plan.

- Absence of regular meetings with stakeholder to review performance and problems encountered.

### **RECOMMENDATION**

- there be a joint session during developing a joint district health plan will full participation of key stakeholders
- There be regular meeting involving DHMT and key stakeholders to review performance, health problems in the district – budget it in the CCHPs
- District should take inventory a rare resources and find a way to utilize it effectively e.g. human resources, equipment etc.
- Government assists allocating rare or difficult to recruit human resources to church facilities e.g pharmacists, radiographer, laboratory technicians etc.
- LGAs, CSSC and church leaders regularly review hospital bed capacity
- Church hospital submit to MOH payment rolls regularly