

HERA

HEALTH RESEARCH FOR ACTION

THE UNITED REPUBLIC OF TANZANIA

TECHNICAL REVIEW OF HEALTH SERVICE
DELIVERY AT DISTRICT LEVEL

MARCH 2004

FINAL REPORT

Independent Technical Review on behalf of the Ministry of Health,
the President's Office Regional Administration and Local Government
and
the Government of Tanzania

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List of Acronyms

AMMP	Adult Mortality Morbidity Project
BF	Basket Fund
CHBF	Council Health Basket Fund
CHF	Community Health Fund
CHMT	Council Health Management Team
CCHP	Comprehensive Council Health Plan
CSSC	Christian Social Services Commission
CSD	Civil Service Department
DC	District Council
DDH	Designated District Hospital
DED	District Executive Officer
DMO	District Medical Officer
EHP	Essential Health Package
GoT	Government of Tanzania
GTZ	(Deutsche) Gesellschaft für Technische Zusammenarbeit
HAART	Highly Active Antiretroviral Therapy
HFC	Health Facility Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	human Resources
HRD	Human Resources Development
HSB	Health Services Board
HSPS	Health Sector Programme Support
HSR	Health Sector Reform
HSSP	Health Sector Strategic Paper
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ITN	Insecticide Treated Net
LGA	Local Government Authority
LGR	Local Government Reform
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
MTUHA	Health Management Information System (Kiswahili expression)
NACP	National AIDS Control Programme
NIMR	National Institute for Medical Research
NSS	National Statistical Services
OC	Other Charges
PER	Public Expenditure Review
PORALG	President's Office Regional Administration and Local Government
PRSP	Poverty Reduction Strategy Paper
PWC	Price Waterhouse Coopers
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RS	Regional Secretariat
RT	Review Team
SDSS	Sentinel Demographic Surveillance System
SMI	Safe Motherhood Initiative
SWAp	Sector Wide Approach
TACAIDS	Tanzania Commission for HIV/AIDS

TEHIP	Tanzania Essential Health Intervention Programme
ToR	Terms of Reference
VA	Voluntary Agency
VCT	Voluntary Counselling and Testing

Introduction

The technical review was carried out from 26 January to 12 February 2004 by the technical Review Team (RT)¹.

The objective of this year's technical review is stated in the Terms of Reference (ToR)² as: *"To review the health service delivery at district level with a focus on progress made **against last year's recommendations**. To provide a concise report detailing progress since last year, and constraints / recommendations"*

Furthermore, its *"findings and recommendations should be clear and meaningful to staff at district level, should be feasible to implement, and be clearly prioritised"*

The ToR list selected issues to focus on during this review, which can be grouped as:

- Implementation of services
- Planning and budgeting
- Accounting and auditing
- Regional support
- Stakeholder involvement and advocacy of reforms

The methodology as suggested in the ToR was followed; document review, interviews with key informants, and site visits. Primary data were not supposed to be collected.

Four districts were visited; Kinondoni, Hai, Babati and Muheza. These districts were selected to include a variety of performance, urban and rural setting, and with or without project support. The selection of districts and the number is by no means supposed to be representative, but rather to provide a broad illustration of issues. Kinondoni was included to measure progress since last year's visit. Kisarawe, which was visited last year, could not be included because it was being visited by the Hospital Reforms consultants. Muheza was added because the MoH had just completed a study on staffing levels, which would complement the RT's work. Babati was chosen to see how it was fairing with relatively limited support from the newly established Regional level.

The RT is fully aware of the limitations of this type of brief technical review, which by definition cannot go into depth. There are strong indications however that the issues raised during this technical review apply to some degree to most districts in the country. The issues and recommendations described in this document are thus merely meant to give guidance to the implementation, monitoring and policy development of health services.

As was recommended in last year's technical review, a short technical review should ideally be followed by a more in depth study which can provide well informed specific answers to the many questions that this review could only touch on.

This report presents the selected issues as listed above. Each section begins with a summary of applicable last year's recommendations. Achievements and observations are discussed, followed by recommendations stated as desired situations. These recommendations are also presented in a table, indicating who is suggested to be responsible for their realisation. This table serves as a summary of recommendations.

Comment [T1]: Note that footnote has changed into Final Report

¹ Prof. Hiza, Victoria Kipendi and Thomas van der Heijden.

² See Annex 1.

The RT would like to convey its sincere gratitude to the MoH , PORALG and Civil Service Department staff at Central, Regional and Council level who all showed a heart warming commitment to improve health services.

Being an independent review the RT obviously takes full responsibility for all errors, inaccuracies and other limitations of this report.

February 29th 2004,

The Review Team

Summary of recommendations

Accounting, financial reporting and auditing/ Quality and timely preparation of progress reports and plans	New Health Basket and Health Block Grant manual finalised in time and used for Financial Year 2004/2005	2004	Central Regional	MoH/RS	No
Accounting, financial reporting and auditing/ Accountability status of Basket Fund	Auditors provided with appropriate manuals	2004	Central	MoH/PORALG	No
	Supportive supervision to CHMTs provided	2004	Regional	RS	No
	Sanctions taken if misuse of Block and Basket Grants is confirmed				
Regional Secretariat	A strong case for an effective composition of the health staff in the RS is made	2004	Central	MoH/PORALG	No
	Task analysis for each RHMT member made, indicating responsibilities, authority and instruments of authority	2004	Central Regional	MoH/PORALG	No
	The capacity of RHMTs strengthened, not only in support supervision skills but also specifically in developing a proactive approach and attitude	2004	Central Regional	MoH/PORALG	No
	RMOs and RHMT members with action oriented attitude recruited	medium term	Central Regional	MoH/PORALG	No
	Dissemination of capacity building experiences formalised	medium term	Central Regional	MoH/PORALG	Yes
Stakeholder involvement/ service planning and delivery/advocacy HSR	RHMT confirm during supervision that all stakeholders really participate	2004	Regional	RS	No
	advocacy of HSR should be done in a way coherent with all other sectors' reform advocacy	medium term	Central Regional	RS	No
	Private/public partnership study carried out	2004	Central	MoH/PORALG	YES

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	One set of additional guidelines determined and users informed	2004	Council	MoH/PORALG	No
	RHMTs trained to use guidelines in their support to CHMTs				
	CCHP assessment criteria made available to CHMTs	2004	Regional	RS/MoH/PORALG	No
Planning, budgeting/HMIS	RHMTs involved in operationalising the HIS for CHMTs' management	2004	Central Regional Council	MoH/RS	No
	Sufficient quantity of registers and forms in stock				
Accounting, financial reporting and auditing/ Quality and timely preparation of progress reports and plans	New Health Basket and Health Block Grant manual finalised in time and used for Financial Year 2004/2005	2004	Central Regional	MoH/RS	No
Accounting, financial reporting and auditing/ Accountability status of Basket Fund	Auditors provided with appropriate manuals	2004	Central	MoH/PORALG	No
	Supportive supervision to CHMTs provided	2004	Regional	RS	No
	Sanctions taken if misuse of Block and Basket Grants is confirmed				
Regional Secretariat	A strong case for an effective composition of the health staff in the RS is made	2004	Central	MoH/PORALG	No
	Task analysis for each RHMT member made, indicating responsibilities, authority and instruments of authority	2004	Central Regional	MoH/PORALG	No
	The capacity of RHMTs strengthened, not only in support supervision skills but also specifically in developing a proactive approach and attitude	2004	Central Regional	MoH/PORALG	No
	RMOs and RHMT members with action oriented attitude recruited	medium term	Central Regional	MoH/PORALG	No
	Dissemination of capacity building experiences formalised	medium term	Central Regional	MoH/PORALG	Yes
Stakeholder involvement/ service planning and delivery/advocacy HSR	RHMT confirm during supervision that all stakeholders really participate	2004	Regional	RS	No
	advocacy of HSR should be done in a way coherent with all other sectors' reform advocacy	medium term	Central Regional	RS	No
	Private/public partnership study carried out	2004	Central	MoH/PORALG	YES

1. Implementation of services

The technical review looked at the following aspects of service implementation:

- human resources,
- drugs, medical supplies, basic equipment and transport,
- financial resources,
- essential interventions.

These aspects are well addressed in the new policy document Health Sector Strategic Plan 2003-2008 (HSSP). It emphasizes components, including the District Component which highlights greater integration of health services, the important role of human resources and collaboration with the Civil Service Department and PORALG. Strengthening of District Health Services in all its aspects is expected to result in quality care.

HSSP's objective to "improve quality of district health services", is to be realised through:

- ✓ Improved management of district health services and service delivery using Essential Health Package (EHP) inclusive of Malaria, HIV/AIDS, TB, IMCI, EPI, SMI and Nutrition.
- ✓ Improved **availability and utilization of resources** i.e. **personnel**, drugs supplies and equipment
- ✓ Improved communication and transport between different levels of the health service pyramid
- ✓ Introducing **performance based incentives and staff benefits** linked to service delivery

The MoH, under the CMO's office is currently preparing a policy document to establish the "Tanzania Quality Improvement Framework". This policy will provide the tools and mechanisms for quality assurance at all levels of care.

To what extent this strong guidance already is and should be applied at various levels is discussed in the next paragraphs.

The RT took note of the various initiatives to prepare for the introduction of HAART in the country. Although not specifically a focus for this technical review it became clear that the introduction of HAART will be an enormous additional burden on the health delivery system.

Besides interviews with key informants a sense of clients' perception of services was obtained through exit interviews with 12 clients who had just made use of the health facilities visited by the RT. Although not claiming to be representative in any way, these interviews indicated that changes in Council health facilities have not gone unnoticed in the visited districts and that there are some unresolved management issues:

- Exit interviews at three health facilities:
- + aware of big improvements in services
 - + drug availability much better
 - + awareness of free services (pregnant, under five, chronic diseases)
 - exemption mechanism for the poor not clear to service providers and clients
 - no receipts given to patients who paid for services
 - aware that waiting time is long due to staff shortage

1.1. Human resources, availability of right mix of staff

2003 recommendations: Assess implications of 1999 establishment norms, do district analysis of skills and manpower needs, develop district HR development plan, introduce performance based incentives, set time frame for decentralising staff matters

The HSSP gives a clear direction to address human resources for health. Most of the 2003 recommendations have however not yet been directly addressed. As a first step a Human Resources for Health Task Force has been formed with the mandate to take up all human resource issues. It is expected that action taken by the Task Force will become visible during 2004.

The staffing patterns in the visited districts show a remarkable understaffing in terms of number and cadres as per 1999 norms³. Several dispensaries were reportedly solely staffed by Medical Attendants, who have not received any training in clinical skills. Remote health facilities are more likely to be understaffed since posting there was mentioned to be less attractive. Councils have the powers to establish incentive packages for less attractive postings, like housing or school fees, but do not make use of these. There was minimal evidence that workload (e.g. measured through MTUHA) was taken into account for staff deployment. The reasons for understaffing given by some CHMTs were that they had not received permits for the requested numbers and cadres. One CHMT mentioned that Clinical Officers had been requested, but that only permits for Medical Attendants had been received. Further exploration with another Council's Personnel Officer revealed that in June 2003 approval had been received for employment of 159 new Council staff, including 23 for the health department. Because of unfamiliarity with procedures no recruitment at all had taken place. Since recruitment needs to take place within 3 months after the permits have been issued, these recruitment opportunities for this Council's health department have now expired.

Subsequent discussions with Civil Service Department's officials showed that there is a general unfamiliarity at Council level with recruitment procedures resulting in (nationwide) **47% of vacant positions in LGA health sector, for which permits have been issued (and for which by definition has been budgeted) are NOT filled**. Unfamiliarity was also illustrated by inability of Council Personnel Officer to actively recruit inside or outside the District. In one of the visited Districts the Nurse Training Institute which is part of the District Hospital was never actively approached for recruitment.

Anecdotal evidence suggest that many currently unemployed health professionals would like to be employed by LGA. If this can be confirmed, then there is clearly an **untapped Human Resources reservoir** that could be made of use if creative and proactive recruitment is done.

The RT learned that the CSD does not have the mandate to change the composition of a request from LGA. The CHMT's claim that they received staff other than they had asked for, can most likely be explained by changes in the request that were made in the Council, without consulting the CHMT. Reports from another District indicate that health staff transfers were instructed by the DED without consultations with the DMO. The reported tension and "de-link" between DMO and DED in some Councils seem to be of wider concern as this issue was raised during the 2003 DMO Annual Conference.

³ see Annex 3, staffing patterns in Hai, Babati and Muheza Districts.

The 2003 recommendation to further decentralise staff matters cannot be looked into for the health sector alone since this is a general issue applying to all sectors and should be part of the general policy development on devolution.

Recommendations:

- Human Resources for Health Task Force becomes fully operational;
- Existing potential of Human Resource for health assessed;
- Councils enabled to recruit effectively within existing resources, e.g. from training institutions;
- Relevant information from the Public Service Act 2002 and Regulations 2003 actively disseminated;
- Councils enabled to provide incentive package for hardship posts, like staff housing;
- Recruitment and staff deployment (transfer) procedures and practices monitored.

1.2. Drugs, medical supplies, basic equipment, transport

2003 recommendation: set time frame for decentralising transport and drug budgets to Council level; consider setting minimum % for maintenance of buildings and equipment.

The recommendation to decentralise was last year effectively worked on through different ongoing processes for drug and transport management. The introduction of the “indent system” in several Districts which replaces the drugs “kit system” represents a very concrete decentralisation of needs assessment and management to the primary level. Another form of decentralising the drug budget is to some extent addressed through more flexibility in the use of the MSD account for each Council. If MSD can temporarily not provide the ordered drugs, Councils are now under certain conditions allowed to purchase elsewhere using funds from their MSD account.

The decentralised management of transport for health services is currently being worked on by MoH/PORALG through training of District Transport Officers. Once these Officers are ready, a district transport management system will be established, including the vehicles for health.

The new (final draft) “Health Basket and Health Block Grant Guidelines...” do not mention a minimum for maintenance but indicate that repairs should not exceed 20% of the allocated Basket Funds. This seems reasonable in view of the additional funds expected to become available for rehabilitation under the Rehabilitation of Primary facilities Strategy.

The RT found that the **availability of drugs, medical supplies and basic equipment has improved significantly** in the visited districts. MSD has more drugs and supplies available and the quality of equipment has improved. No current stock outs were reported. Marked improvements were seen in Kinondoni where CHMT and MSD staff have regular meetings. Transport in terms of vehicles and fuel was reported as adequate.

In Hai District the drug kit system has recently been replaced by the indent system. The indent system was perceived by health workers as very positive. In the units visited, the responsibility and autonomy given to the dispensary staff had **visibly resulted in an increased self-esteem**. The private dispensaries in Hai that were visited by the RT seemed to be fairly under utilised. This was reportedly caused by the increased utilisation of public facilities.

The lack of transparency in the allocation of funds that are deposited for each Council with MSD was seen by CHMTs and RHMTs as unnecessary and undesirable. It is documented in the PER 2003 that there are great variations in drug allocations to different Regions, varying

from plus 125% to minus 54% from the normal. The MoH uses a formula⁴ for the allocation of funds (deposited at MSD) for the different levels. This formula has several arbitrary aspects and does not take the actual workload or performance of each health facility into account, nor local Burden of Disease (BoD) or poverty indicators. This formula does not explain the variations noted in the PER. Though this allocation formula may be appropriate in an initial stage of national drug distribution, in the current context of decentralisation and PRS, more rational formulas for all levels need to be worked out and be made available.

The RT sees no reason why the recipient of funds should not be informed about the deposits made to their account with MSD, as this information is readily available at the MoH. The planned method of informing Councils and the general public through large newspaper advertisement (which was reportedly not realised because of lack of funds) looks somewhat overdone compared to regular sending a simple copy of the payment order. Follow up on the utilisation of funds and the balance at MSD is the responsibility of the account holder, but this was never made explicitly clear to the recipients.

Recommendations:

- MoH avails timely information to each MSD account holder on funds sent in their name to MSD;
- Instructions are sent to account holders on monitoring balances on MSD accounts by the account holders;
- The allocation formulas currently used for drugs and supplies are reviewed and made available.

1.3. Financial resources

2003 recommendations: none specifically made, but general principles of comprehensiveness in including all resources for district health services apply.

The RT noted that there are several other financial resources available to the Council health services, besides basket and block grants. These other sources of funding include:

- user fees,
- drug capitalisation fund,
- National Health Insurance Fund (NHIF), and
- Community Health Fund (CHF),
- Other occasional funds.

The management of these sources is not yet fully operational, especially the NHIF and CHF. If well managed, these additional funds will be important in a more sustainable overall services improvement.

User fees provide a relatively small contribution to the cost of health services. These funds are however very much appreciated by the health facility management as these funds are often the only ones that can be used at their discretion to improve services. Exemption mechanisms are not well understood by clients and health workers, as illustrated in a recent yet unpublished study by Women's Dignity Programme and GRAFCO on access to health care for poor women. This study indicates that poor women have very limited access to health services because exemption provisions are not accessible to them.

This seems due to poor advocacy of HSR in the community and weak hospital management. Guidelines on cost sharing and hospital drug capitalisation, which were widely disseminated when cost sharing was introduced, stipulate the mechanisms to be followed. The ongoing

⁴ See Annex 3 Allocation Formula.

process of establishing District Health Boards (DHB) and Health Facility Committees (HFC) will ensure community participation and better utilisation of exemption mechanisms. The hospital reforms are expected to improve hospital management.

The current debate on user fees has received a new input from the October 2003 workshop of the Poverty Eradication Division of the Vice President's Office:

The Government should consider suspending cost sharing for basic health services at least until the time when an effective system of exemptions for the poor is put in place. In preparing for this, a cost-benefit assessment should be undertaken to determine how much is gained by fees as compared to how much is lost by excluding the poor.

The RT expresses caution about suspending a system which took considerable effort to establish and which has clear benefits. It would now be more relevant to fully understand why the current exemption mechanism is not functioning.

The NHIF which was established in 2001 is not yet operational in many government facilities. Only 30% of the public facilities are providing the services to NHIF clients. Of the accredited religious/NGOs health facilities only 47.5 % make use of this source.

Table 1: Implementation of NHIF in Govt health facilities

Level of facility	# active facilities	# of all facilities	% performance
Hospitals	85	85	100
Health centres	171	292	50
Dispensaries	677	2683	25
Total	933	3060	30

Table 2: Implementation of NHIF Accredited religious/NGOs health facilities

Facility	# active	#accredited	%performance
Hospital	70	78	90
Health centres	42	71	59
Dispensaries	121	341	35
Total	233	490	47.5

The Community Health Fund (CHF) which is a community-based source of funding of health services is operational in 36 pilot Councils. There has been a fall in receipts and a stronger reliance on the matching grant that is provided. The fall in receipts has been attributed, anecdotally, to falling registration, partly due to members losing interest after paying and not appearing to benefit from the scheme, thus losing confidence in the scheme. Other reasons seems to be the increasing coverage of the NHIF, as some past members of the CHF were public servants and the case of misuse of funds by Igunga LGA.

District councils continue to receive funds from other sources for health services improvement but do not always include these in the Comprehensive Council Health Plan (CCHP). Activities and funds from organisations like CARE and Axios and also from TACAIDS were in some instances not reflected in the CCHP. Non-monetary sources, like health vehicles operated by Voluntary Agency (VA) hospitals and projects were often found omitted in CCHPs.

It was suggested to the RT that NHIF and CHF are used to provide the required 15% community contribution for the rehabilitation of primary level facilities, since these funds originate from the community that utilises the facility.

Recommendations:

- The utilisation of NHIF and CHF funds actively promoted;
- Functioning of exemption mechanism understood;
- The comprehensiveness of CCHPs including all resources irrespective of their sources actively promoted;
- Organisations working at district level commit themselves to be included in CCHP;
- NHIF and CHF at primary level utilised for the 15% community requirement for rehabilitation.

1.4. Availability of communication system to facilitate referrals within the district

The referral system in the visited districts is still not very effective as most referrals are self referrals. Last year several Councils have purchased radio communication equipment (and vehicles), so it can be expected that formal referrals will take off if well guided by the RHMT.

1.5. Essential interventions according to EHP guidelines

2003 recommendations: MoH to review all disease specific guidelines in a comprehensive way and come up with a coherent set of guidelines.

For the implementation of all EHP interventions a variety of guidelines has to be followed. Recently an inventory of intervention management and clinical care guidelines has been made. This overview of manuals is the first step towards the selection and update of a coherent set. The RT could not identify a uniform MoH mechanism through which different categories of guidelines are harmonised, vetted and made part of a coherent set for different levels of health services.

A review of CCHPs and reports shows that all six EHP components are included and implemented. However, it could not be established to what extent the magnitude of each EHP intervention reflects the actual BoD in the district since BoD is usually not explicitly used. Hai CCHP is an exception, as BoD data through the AMMP allow a more specific targeting of EHP interventions. Nutrition activities were listed in most CCHPs, while in all visited districts activities were mentioned, ranging from micronutrients to growth monitoring.

Reviewing implementation per CHMT shows a clear trend of improving implementation. For one CHMT the implementation grew from 43% in 2001 to 86% in 2003 and the carried forward activities decreased from 50% in 2001 to 12% in 2003. Better planning has also contributed to these results but better implementing capacity is the main factor. On the health facility rehabilitation component the RT was informed that a health facility rehabilitation action plan is about to be agreed on jointly by MoH and PORALG.

Recommendations:

- Guideline inventory reviewed, one set of valid documents determined and users regularly informed;
- Mechanism to develop and update guidelines to form a coherent set for each level is established.

2. Planning, budgeting

The issues of multiple planning guidelines, restrictions on the use of basket funds, and the use of HMIS are here discussed.

2.1. Multiple planning guidelines

2003 recommendation: Harmonise guidelines for block grant and basket funds; keep planning format simple; MoH review all policy guidelines and define coherent set.

A new single set of council health planning and management guidelines has been developed, covering procedures for both Health Basket and Health Block Grants on disbursement, preparation of Comprehensive Health Plans, Financial and Technical Reports by Councils. It is in a "final draft" stage.

Observations:

- Single set of guidelines is an enormous achievement
- Combines the planning of the two main sources of funding
- Synchronises the planning cycles of LGA and central government as per 1 July 2004
- Covers the whole planning cycle
- Stipulates the roles of each level
- Gives useful guidance to the RS' role and mandate
- Priority setting process not yet fully worked out
- Performance indicators still the 19 MTUHA dependant ones
- Sets out that the guidelines will be further developed based on experiences
- Document still has some work in progress aspects
- Does it accommodate the criteria and modalities of a new MoU between MoH, PORALG and partners?
- Is the reporting format and procedure simple enough?

The TR noted that multiple management and policy guidelines can still be found at all levels, but with unknown status of their validity. Documents do not state which other documents they supersede or complement. The introduction of the new Block and Basket Grants guidelines could be used to review and decide what other guidelines (if any) should continue to exist to complement the new guidelines.

It is generally accepted wisdom that guidelines can only be useful if accompanied by appropriate facilitation. The introduction of the se new Block and Basket Grants guidelines should thus go together with capacity building of RHMTs to facilitate.

It was suggested that making the assessment criteria used by RHMTs for CCHPs available to the RHMT will provide appropriate additional guidance.

Recommendations:

- Block and basket grants guidelines field tested on user-friendliness (particularly simplicity) before finalising and full scale introduction;
- Performance indicators are in line with newly agreed indicators;
- Guidelines match with new MoU;
- One set of additional guidelines determined and users informed;
- RHMTs trained to use guidelines in their support to CHMTs;
- CCHP assessment criteria made available to CHMTs.

2.2. Restrictions on the use of basket funds

2003 recommendation: release to some extent restrictions on basket funds and harmonise restrictions for both block grant and basket funds.

In the new guidelines, Block Grant (Other Charges component) and Basket fund have now similar cost centres with similar ranges. Previous rigid ceilings have been adapted into ranges with minimum and maximum. This provides a reasonable flexibility. CHMTs are also given the option to divert from the ranges if local circumstances necessitate such. Timely consultations are required to receive permission. Items which were previously not allowed can now be purchased with basket funds. The 2003 recommendation has thus been carried out.

2.3. HMIS

2003 recommendation: refocus and invest in MTUHA minimum information package at district and facility level.

Following the recommendations of the 2003 Technical Review a Task Group on HIS was established to address the need for coordination and harmonisation of health information. The work of the Task Group is about to be completed.

The recently completed Workshop⁵ of "Health Information for Decision-Making: Reconciling Systems and Approaches", has as main recommendation:

An effective Health Information System (HIS) should comprise three core elements:

- *Facility-based information system (i.e. HMIS) geared towards Council Health Management Team analysis and use;*
- *Demographic sentinel surveillance system encompassing the spectrum of variation in the country and the ability to gather population-based information at the household level.*
- *Coordinated regular and ad-hoc surveys, including examples such as the Reproductive and Child Health Survey, HIV/AIDS, studies on antimalarials drug resistance and surveys relevant for the private sector.*

The first core element is most relevant for planning and implementation of district health services. Another relevant recommendation is that the 12 PORALG health indicators should be harmonised with the 19 key MoH indicators. What is not yet addressed in the other recommendations and planned next steps is the mechanisms to support the CHMT in making HIS operational.

During recent years shortages of MTUHA forms and registers, due to delayed printing at central level, has severely compromised data collection and reporting. Some CHMTs managed to produce improvised forms themselves in order to continue data collection.

Recommendations:

- RHMTs involved in operationalising the HIS for CHMTs' management;
- Sufficient quantity of registers and forms in stock.
- Developments coordinated with PORALG
- Workshop recommendations implemented

⁵ Health Information for Decision Making: Reconciling Systems and Approaches, Report from workshop in Morogoro 3-5 February 2004.

Deleted: pr

3. Accounting, financial reporting and auditing

Several aspects of the financial administrative mechanisms have been addressed during last year.

3.1. Quality and timely preparation of progress reports and plans

Although not explicitly leading to a recommendation, in the 2003 Technical review it was noted that there was an average delay of one quarter in the release of funds from the centre to Councils. This was due to different factors at all levels:

- Poor quality of CCHP and progress reports which were not properly scrutinized by RS/RHMT thus delaying the BFC meeting
- Long and bureaucratic disbursement procedure which was used to release funds to councils from holding account (from holding account to Vote 52 – MoH, then to vote 56-PORALG, then to Treasury and finally to LGA account no 6; four transactions)
- Holding account having insufficient funds at the start.

The situation has now greatly improved:

- Training of RS/RHMT in assessing the progress reports from their respective councils has improved thus reducing the centre's burden and time of assessing.
- The disbursement mechanism has been shortened by releasing funds from the Consolidated Fund at the Treasury (captured under Vote 56 for administrative purposes) via Telegraphic Transfer to account no.6 of the Councils
- Holding account now has sufficient funds for 2 quarters at any given time
- According to the new harmonised planning guidelines the burden of report writing which was 2.5-3 months (including planning) will be reduced

The RT noted that the funds for the fourth quarter of 2003 were released in November, which illustrates a significant improvement.

Recommendation:

- New Health Basket and Health Block Grant manual finalised in time and used for Financial Year 2004/2005.

3.2. Accounting staff in CHMT

The visited districts expressed some positive changes (besides the negative ones mentioned in paragraph 2.) in the relation between the CHMT and DED's office. In Kinondoni there is an Accountant within the CHMT. Hai Council has an Accountant who specifically deals with health issues. All visited CHMTs have active Health Secretaries who initiate payments for health activities once these have been agreed on by CHMTS. Overall the RT has the impression that financial management capacity has increased.

3.3. Progress made to streamline Separate Audits of Basket funds and the others in account number 6

2003 recommendation: review auditing procedures of account no. 6

The 2001 and 2002 Price Waterhouse Coopers audit of the BF in district councils had difficulties in tracing the basket funds expenditures. This is because the funds are deposited in LGA account no.6 in which funds from all sources for the health sector are deposited.

PWC recommended to have in 2003 a joint audit of the entire account for health activities to obtain a better picture of how the consolidated account no.6 is managed.

PWC's recommendation for the 2003 audit could reportedly not easily be implemented because of legal hurdles. Auditing of all government funds, whatever the source is constitutionally the mandate of the Controller and Auditor General (CAG). An auditing firm for auditing BF can only be appointed by CAG and will thus report to him only. However the interests of the partners can be taken into account in the ToR for the audit. The audit report will then be made available to the partners following government channels as stipulated in the MoU.

This would be a one off exercise because from 2004 onwards the newly introduced GFS codes, indicating the source of funding and cost centres, are expected to be fully operational.

3.4. Accountability status of Basket Fund

The RT reviewed the 2001 and 2002 final consolidated report on audits of funds disbursed to 82 LGAs (37 phase one 45 phase two) under the LG Health Basket Fund⁶. The 2001 council performance is as follows:

- None got a clean audit opinion (rank A) (0%),
- 57 were given a qualified audit opinion (rank B; few major concerns) (70%)
- 25 disclaimer of opinion (rank C; major errors) (30%)

The situation was much similar in 2002 . Many of the auditors conclusion were based on planning and disbursement manuals which were outdated as updates frequently made by MoH and PORALG were not made available to the auditors. However, clear cases of misuse of Basket Funds were raised. Reportedly misuse is hardly followed by sanctions from a higher authority.

Many of the other audit findings are managerial issues which could have been identified and corrected by the RS/RHMT during routine supportive supervision.

Recommendations:

- Auditors provided with appropriate manuals;
- Supportive supervision to CHMTs provided;
- Sanctions taken if misuse of Block and Basket Grants is confirmed.

4. Regional Secretariat

2003 recommendation: agree on composition of RHMT; develop RHMT capacity; assure appropriate funding of RHMT; bring together experiences from district health programmes that have invested in strengthening RHMTs.

The policy development on RHMT composition was reported as a strong case being made by the MoH in the Inter Ministerial Technical Committee (IMTC) paper for four health sector professionals under the RS; i.e. RMO, RHO, RNO and Health Secretary. Other specialties, like the Pharmacist or Laboratory Technician are proposed to be drawn from Regional Hospital as need arises. The Cabinet has referred the matter back to the sectoral Ministries to decide on the composition, based on technical merits.

Deleted: ⁶ see Annex 5 for a summary of findings.

The RT found that RHMTs' supportive supervision was reported only in 1 out of 4 of the visited CHMTs. However, reports of this supervision could not be traced in CHMT's files. Some RHMTs participated fully in the CHMTs' planning process, but other RHMTs limit their role to assessment of plans and reports. RHMTs in "project supported" Regions apparently carry out supportive supervision more frequently. RHMT's authority to supervise was questioned by one CHMT as expertise level of RHMT was not perceived as significantly higher. The RT observed crucial information gaps at CHMT level with serious consequences for health services⁷ that would not have existed if basic communication and supervision had taken place. The RT is of the opinion that the **RHMT plays the pivotal role in health sector reform**, but can only be effective if it has an **adequate mandate and a proactive and dynamic attitude**.

The tasks of the RHMT are not well defined (illustrated by 3 different job descriptions for RMOs) and can only be distilled from the various documents on restructuring the Regional Secretariat. A comment often heard is that the RHMT's role has become futile because it "just advises" and does not "control funds". In several documents it is made clear that the RS' role is to monitor the implementation of government policies by LGA. Specifically for the health sector this means that there is a variety of rules and regulations to adhere to and where non-adherence would lead to sanctions to be applied. The RMO, being the extended arm of the MoH will be the first to monitor adherence to rules and to take action if necessary. Several obvious ethical and quality issues, like performance of health staff and epidemic response can be thought of. The new "*Health Basket and Health Block Grants Guidelines..*" stipulate the monitoring roles for the RHMT, with serious sanctions that can be applied, namely approving or not approving plans and reports. Nevertheless, a single task analysis of each RHMT member needs to be further developed, indicating responsibilities, authority and **instruments of authority**.

The main efforts made to strengthen capacity of RS/RHMTs over the last year are the August 2003 training for RS (including RHMT) and discussions held during the RMOs' conference. The August 2003 training aimed at enabling the RS to assess CCHPs and reports. This formerly centralised function was handed over to all RS and the RS staff were trained in using assessment tools.

Funds for RHMTs (from HSPS sources) are reportedly under spent. The main reason mentioned is that not all planned supervision is done, particularly not the supervision to be carried out jointly with other (non-health) RS staff. RHMT make also use of council basket funds when they are carrying out activities on demand from CHMTs.

Last year's recommendation to bring together experiences from district health programmes that have invested in strengthening RHMTs has not been fully implemented. One major development which does bring the experience together is the newly formulated Health Sector Programme Support III (Danida funded). This MoH programme has a "Support to Quality District Health Services" component that will roll out proven interventions to strengthen district health services in Kagera and Mwanza Regions, later to be extended to Shinyanga and Mara Regions. Although not specifically focusing on the Regional level support role, many aspects of this programme will clearly strengthen the RHMTs. Dissemination of experiences will be an important aspect of this programme and could be the centre for dissemination of all similar initiatives (Tanga, TEHIP).

⁷ Besides the missed recruitment opportunities in par. 1., one hospital was found to have missed basket funding for 3 years by lack of information.

Recommendations:

- A strong case for an effective composition of the health staff in the RS be made;
- Task analysis for each RHMT member made, indicating responsibilities, authority and instruments of authority;
- The capacity of RHMTs strengthened, not only in support supervision skills but also specifically in developing a proactive approach and attitude;
- RMOs and RHMT members with a proven action oriented attitude appointed;
- Dissemination of capacity building experiences formalised.

5. Stakeholder involvement and advocacy of reforms

5.1. Service planning and delivery

2003 recommendation: perform district-based study to improve private/public partnership.

This study has yet to be commissioned. Further policy development for private/public partnerships has not yet taken place.

The composition of the CCHP planning team is stated in each plan as including representation from VA institutions. Anecdotal evidence suggests that the degree of real participation varies greatly. CSSC has developed a policy in which one so called lead agency represents the VA sector in the district health planning process. CSSC has now established zonal support offices to assist these lead agencies in planning. One VA hospital reported that partnership meant that the basket allocation was provided in kind without any consultations on what and how much the VA hospital would need.

Recommendation:

- RHMT confirm during supervision that all stakeholders really participate in the CCHP;
- District-based study to improve private/public partnership carried out.

5.2. Governance (Health boards, health facility committees etc)

Boards have been inaugurated in 18 district Councils; 86 have been sensitised and the exercise is expected to be completed in June 2004. As the Boards had just been established (except for Kinondoni) no information on their functioning was available.

The establishment of Health Facility Committees was reported to be in its infancy in the visited districts. The expectations of HFCs' role as reflected in the 2003 PORALG/MoH Rehabilitation Strategy, are high because they will be key actors in the rehabilitation process.

The new development of CCHPs being adopted in full Council meetings is a positive because this will also increase ownership.

5.3. Advocacy of HSR

2003 recommendations: advocate HSR issues up to community level.

Main policy documents (HSSP, Technical Review 2003 Report, and Joint 2003 Review) were found on desks in visited DMO's offices. During the 2003 DMO's meeting presentations on main HSR policy and practice issues were made. However, other information made available to the RT indicated that RHMTs are generally unaware of policies despite active dissemination by MoH.

Besides initial steps to introduce the establishment of HFCs, no evidence of other developments could be found. For example the recommended communication and publication of annual budgets for specific health facilities to the communities were not found.

Several other sectors will communicate their specific reform issues to the community. In order to minimise transaction cost and confusion it is suggested that that "reform packages" from sectoral ministries are harmonised at LGA level and communicated in a coherent way.

Recommendation:

- Advocacy of HSR should be done in a way coherent with all other sectors' reform advocacy.

Annex 1: Terms of Reference for Technical Review 2004

TOR for Technical Review 2004 Health service delivery at district level

Introduction

As an input to the Annual Joint Health Sector Review it has been decided to conduct an independent technical review with a focus on health service delivery issues at the district level. The resulting report will be an important resource document for the Policy Review.

The purpose of the technical review is to provide an objective assessment of progress, constraints and opportunities in health service delivery at district level, with a specific focus on certain areas. The findings and recommendations arising should be clear and meaningful to staff at the district level, should be feasible to implement and be clearly prioritised.

Last year's Technical Review report provided an excellent diagnostic of a whole range of service delivery issues at the district level. The report was of good quality and provided sensible, prioritised recommendations. What made the Technical Review especially useful was that its findings and recommendations were considered in detail by MOH and PORALG in advance of the Policy Review so that the discussion could focus on the way forward, with reference to recommendations, which were agreeable to Government.

Building on the success of last year's technical review, this year the exercise will review progress made against last years recommendations of the Technical Review of health service delivery at district level.

Objective

- To review the health service delivery at district level with a focus on progress made against last year's recommendations.
- To provide a concise report detailing progress since last year, and constraints/recommendations.

Scope of work

The Review Team will mainly focus on following issues during its work:

Review relevant literature/ available district progress reports, interview of relevant personnel in the MOH, PORALG, CSSC and some key stakeholders to get their impression on progress or lack of progress. Undertake field visits to a few selected districts and assess progress made since the last review in the following key areas:

1. Issues related to implementation of services such as availability of right mix of staff, drugs, medical supplies, basic equipment, transport, financial resources, availability of communication system to facilitate referrals within the district
2. Whether essential interventions are being implemented according to EHP guidelines with focus on disease and health conditions responsible for disease burden (HIV/AIDS, Malaria, TB, IMCI, EPI, SMI)
3. Issues relating to planning, budgeting such as (multiple guidelines, restrictions on the use of basket funds, multiple instructions from PORALG/MOH)

4. Issues relating to accounting and financial reporting of account number 6, quality of reports availability of accounts staff, timely preparation of financial reports
5. Financial audits progress made to streamline Separate Audits of Basket funds and the others in account number 6, accountability status of Basket funds
6. Supportive supervision provided by the Region and efforts made to strengthen capacity of the region to provide support district health service delivery
7. HMIS and use of it for decision making, monitoring of health service delivery
8. Stakeholder involvement in service delivery, participation in planning, governance (Health boards, health facility committees etc)
9. Progress made in advocacy of reforms down below the district to cover the HC, Dispensary and Community
10. Based on the assessment come up with recommendations on way forward.

Methodology

Given the limited time available, the assessment cannot go into great depth, nor can it be expected to gather primary data. The team should rely upon interviews with key informants, documentation already prepared, and such relevant data as may be available at the national and district levels. The study team is encouraged to split up to be able to cover the district level information gather during the time available.

Also due to time limits, it will not be feasible to cover a large sample of districts. It is proposed that at least four districts be covered, at least two of which featured in last year's review. The technical review last year visited 5 districts (Morogoro Rural, Dodoma, Kondoa, Kisarawe and Kinondoni).

Team

Thomas van der Heijden, MD - Public Health Specialist, Team Leader
Victoria Kipendi, MD – Regional Medical Officer
Prof Phillip Hiza MD FRCS (Former CMO, Former Executive director CSSC)

The team leader will be responsible for the output of the team as a whole, including managing and quality-assuring the contributions of individual team members.

Timing

January – early February 2004
Team Leader will Attend Main Health Review in March 2004

Outputs

- A Debriefing Note and presentation to the Technical Committee February (refer to annex 1)
- A Report, with a short main text, supplemented by annexes if deemed necessary, and as much as possible referring to existing texts and documentation – draft for comments issued as indicated on annex 1.
- A presentation at the Main Sector Review Meeting – March 2004.

Annex 2: Allocation formula for Budgets deposited with MSD on behalf of users

Allocation formula for Budgets deposited with MSD on behalf of users (as explained by the Chief Pharmacist):

Allocation for drugs is effected on quarterly basis depending on the Cash Budget System

56 % of the total drug budget is allocated to Kits for Council Health facilities

Of the remainder, 45% is allocated to District Hospitals, 35% to Regional Hospitals, 12.5% to Referral Hospitals and 7.5 % to Specialised Hospitals. The allocation to individual District Hospitals is based on per capita allocation for the Population and to individual Regional Hospitals is based on per capita for the population of the Region as follows:

>1,000,000-<1,500,000	75 % of the Population
>1,500,000-<2,000,000	70% of the Population
>2,000,000-<2,500,000	60% of the population
>2,500,000	50 % of the population

Specific circumstances are taken into consideration to adjust the allocation (like high number of road traffic accident near certain hospital)

Annex 3: Staffing Levels

STAFFING LEVELS: These tables show number of health facilities and numbers of staff per category; The 1999 staff norms are listed

MUHEZA DISTRICT

	Health Centres	Dispensaries
	4	34
AMOs	1	
COs	2	25
Nurse Midwife	4	5
Midwives	-	33
MCHA	-	28

BABATI DISTRICT

	Health Centres	Dispensaries
	1	16
CO	3	11
Nursing Officer	-	-
Nurse Midwife	4	11

HAI DISTRICT

	Health Centres	Dispensaries
	3	27
CO	6	29
Nurse Midwives/PHNB	10	31

1999 Staffing Levels:

Dispensary

2 Clinical Officer
2 Nurse/Midwives
1 Medical Attendant

Health Centre Rural

2 AMO
1 Nursing Officer
4 Nurse/Midwives
4 PHN

Health Centre Urban

2 AMO
2 NO
4N/M
5PHN

Annex 4: List of documents

1. Technical review of health services at the district level *March 2003*
2. Tanzania joint health reviews *28-30 April 2003 main report May 2003*
3. Tanzania Joint health review *28-30 April 2003 Annexes*
4. Preparation of rehabilitation strategy and funding mechanism for health facilities *final report Nov. 2003.*
5. Assessment of performance of councils experience from 37 phase 1 of the joint health sector /local govt reforms in Tanzania *July 2003*
6. Planning guide for local authorities regarding utilization of the health basket fund. *August 2002*
7. Health basket and block grants guidelines for the disbursement of funds, preparation of comprehensive council health plans, financial and technical reports by councils Final draft Dec. 2003
8. Health sector PER update FY 2003 *Final draft Jan 2004*
9. Technical report of the joint MoH/Partners annual review of the health sector *12-21 march 2001 Final report*
10. Second health sector strategic plan (HSSP) *July2003-June 2008 MoH April 2003*
11. Tanzania joint health review *11-13 March 2002 Main report Final report 2002*
12. Health sector development program 11 (HSDP phase 11). Report on the assessment of financial management arrangements
13. MoH Council health basket Final consolidated audit report on our audits of funds disbursed to 82 LGAs under the LG health basket fund for the *year ending Dec.2001*
14. AS ABOVE *year ending Dec.2002*
15. Second Health Sector Strategic Plan (HSSP) *July 2003-August 2008 Volume 11 Annexes*
16. Physical./Technical report of the first quarter *July- Sept. 2003*
17. Medium term expenditure framework 2003/2004-2005-2006 Activities costing tables Volume 11 *July 2003*
18. Medium term expenditure frameworkb2003/2004- 2005-2008 Volume 1 *July 2003*
19. Detailed cash flow for govt and pooled funds for *July-June 2003/2004*
20. Annual implementation report (Physical and technical) for *July 2002-June 2003*
21. National Health Policy MoH *Oct 2003*
22. CCHPs for the 2001,2002, 2003 and Jan-Mar 2004
23. Quarterly Progress Reports, 2002-2003, Kinondoni Mun., Muheza DC, Hai DC, Babati DC
24. The Public Service Act 2002, Regulations 2003