

The logo for HERA (Health Research for Action) features the word "HERA" in a large, bold, black, hand-drawn style font. The letters are slightly irregular, giving it a grassroots or community-oriented feel. The logo is centered within a grey rectangular background that has a yellow horizontal bar above and below it.

HEALTH RESEARCH FOR ACTION

**THE UNITED REPUBLIC OF TANZANIA**

**TECHNICAL REVIEW OF HEALTH SERVICE  
DELIVERY AT DISTRICT LEVEL**

**MARCH 2003**

**FINAL REPORT**

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

Table of contents

List of Acronyms .....	4
Introduction .....	6
Summary .....	8
1 General review of district health services .....	12
2 Planning and budgeting .....	13
2.1 Requirements for a well performing planning and budgeting process .....	13
2.1.1 Issues related to planning and budgeting guidelines .....	13
2.1.1.1 Planning guidelines.....	13
2.1.1.2 Budgeting guidelines .....	15
2.1.1.3 Procedures for expenditure and procurement .....	16
2.1.2 Issues related to the planning and budgeting process .....	16
2.1.2.1 Comprehensive planning and budgeting process.....	16
2.1.2.2 The role of sub-district structures .....	18
2.1.2.3 The case of the private sector .....	20
2.1.2.4 The role of the RS and RHMT .....	20
2.1.2.5 Budgeting process .....	21
2.1.3 Skills for planning and budgeting .....	21
2.2 Information requirements for developing an appropriate comprehensive council health plan and budget .....	22
2.2.1 Up-to-date and coherent national policies and guidelines .....	22
2.2.2 Availability and analysis of valid local data .....	23
2.2.3 Local priority setting .....	24
3 Implementation of the council health services.....	26
3.1 Issues related to funding .....	26
3.1.1 Resource allocation formula .....	26
3.1.2 Level of funds and cash flow.....	27
3.1.3 Procedures and ceilings.....	29
3.1.4 Expenditures .....	29
3.1.5 Accountability.....	29
3.2 Issues related to non-financial resources .....	29
3.2.1 Human resources and skills .....	30
3.2.2 Transport.....	31
3.2.3 Equipment.....	31
3.2.4 Drugs, medical supplies and diagnostics.....	32
3.2.5 Communication .....	32
3.2.6 Capital development .....	33
3.3 Issues related to systems development .....	33
3.3.1 Referral system.....	33
3.3.2 Motivation of staff.....	34
3.3.3 Building community involvement.....	34
3.3.4 Involving all stakeholders.....	35
3.3.5 Public-private mix.....	36
3.4 Issues related to service delivery .....	36
3.4.1 Quality of services.....	36
3.4.2 District hospital.....	37
3.4.3 Regional Hospital.....	37
4 Supportive supervision, monitoring, reporting and auditing .....	37
4.1 Supportive supervision.....	37
4.2 Monitoring and indicators .....	38
4.3 Technical and financial reporting .....	39
4.4 Technical and Financial Auditing .....	40
5 Support structures .....	41

5.1	The role of the RS and the RHMT.....	41
5.2	The role of the Zonal Training Centres .....	43
6	Advocacy of the reforms.....	43
7	Main recommendations .....	45

**Annex 1.** Proposals for adapting the procedures regarding the use of council health basket funds.

**Annex 2.** List of literature

**Annex 3.** Terms of Reference

## List of acronyms

<b>AMMP</b>	Adult Mortality Morbidity Project
<b>BF</b>	Basket Fund
<b>CHBF</b>	Council Health Basket Fund
<b>CBO</b>	Community Based Organisation
<b>CHF</b>	Community Health Fund
<b>CHMT</b>	Council Health Management Team
<b>CHP</b>	Council Health Plan
<b>CMR</b>	Child Mortality Rate
<b>CSD</b>	Civil Service Department
<b>CT</b>	Council Treasurer
<b>CTU</b>	Central Transport Unit
<b>DC</b>	District Council
<b>DDH</b>	Designated District Hospital
<b>DED</b>	District Executive Officer
<b>DES</b>	Dar Es Salaam
<b>DHMT</b>	District Health Management Team
<b>DMO</b>	District Medical Officer
<b>DP</b>	Development Partner
<b>DPO</b>	District Planning Officer / Council Planning Officer
<b>EDP</b>	Essential Drug Programme
<b>EHP</b>	Essential Health Package
<b>ELCT</b>	Evangelical Lutheran Church in Tanzania
<b>FP</b>	Family Planning
<b>GoT</b>	Government of Tanzania
<b>GTZ</b>	(Deutsche) Gesellschaft für Technische Zusammenarbeit
<b>HAART</b>	Highly Active Anti-Retroviral Therapy
<b>HBC</b>	Home Based Care
<b>HFC</b>	Health Facility Committee
<b>HIPC</b>	Heavily Indebted poor Countries Initiative
<b>HIV</b>	Human Immunodeficiency Virus
<b>HMIS</b>	Health Management Information System
<b>HR</b>	human Resources
<b>HRD</b>	Human Resources Development
<b>HSB</b>	Health Services Board
<b>HSR</b>	Health Sector Reform
<b>IEC</b>	Information Education Communication
<b>IFMS</b>	Integrated Financial Management System
<b>IMCI</b>	Integrated Management of Childhood Interventions
<b>IMR</b>	Infant Mortality Rate
<b>LA</b>	Local Authority
<b>LG</b>	Local Government
<b>LGR</b>	Local Government Reform
<b>MCH</b>	Maternal and Child Health
<b>MMR</b>	Maternal Mortality Rate
<b>MoH</b>	Ministry of Health
<b>MSD</b>	Medical Stores Department
<b>MTEF</b>	Medium Term Expenditure Framework
<b>MTUHA</b>	Health Management Information System (Kiswahili expression)
<b>NACP</b>	National AIDS Control Programme
<b>NGO</b>	Non-Government Organisation
<b>NIMR</b>	National Institute for Medical Research

<b>NSS</b>	National Statistical Services
<b>OC</b>	Other Charges
<b>PE</b>	Personnel Emolument
<b>PER</b>	Public Expenditure Review
<b>PHC</b>	Primary Health Care
<b>PORALG</b>	President's Office Regional and Local Government
<b>PRBS</b>	Poverty Reduction Budget Support
<b>PRSC</b>	Poverty Reduction Support Credit
<b>PRSP</b>	Poverty Reduction Strategy Paper
<b>PWC</b>	Price Waterhouse Coopers
<b>RHMT</b>	Regional Health Management Team
<b>RHST</b>	Regional Health Support Team
<b>RMO</b>	Regional Medical Officer
<b>RS</b>	Regional Secretariat
<b>RT</b>	Review Team
<b>SDSS</b>	Sentinel Demographic Surveillance System
<b>SMI</b>	Safe Motherhood Initiative
<b>STI</b>	Sexually Transmitted Infection
<b>SWAp</b>	Sector Wide Approach
<b>TACAIDS</b>	Tanzania Commission for HIV/AIDS
<b>TEHIP</b>	Tanzania Essential Health Intervention Programme
<b>ToT</b>	Training of Trainers
<b>ToR</b>	Terms of Reference
<b>VA</b>	Voluntary Agency
<b>VCT</b>	Voluntary Counselling and Testing

## Introduction

The technical review was carried out as planned from February 3<sup>rd</sup> to 17<sup>th</sup>. The Technical Review Team (RT)<sup>1</sup> has visited 5 districts (Morogoro Rural, Dodoma, Kondoa, Kisarawe and Kinondoni). Four Phase I Districts were selected in both urban and rural settings on basis of their performance (two good and two poor performing districts according to the ranking of Phase I districts in the NIMR performance indicator assessment 2002). The one additional rural Phase II district was selected on basis of the presence of a longer term donor support project (TEHIP). Time constraints for the review have also influenced the selection of districts.

The RT used the methodology proposed in the TOR (document review, interviews, site visits). MTUHA data for 2002 and NIMR performance assessment data (Phase I councils, 2002) were not yet available to the team.

The RT recognises the limitations of a short technical review of a small sample of districts. However, most issues reported in this report apply to most of the 5 districts visited and therefore represent most likely issues that cut across most Phase I and II districts in Tanzania. On the other hand, it is likely that some aspects of the analysis may not apply to districts that have had longer-term specific management support through specific sectoral or intersectoral projects.

The main limitation of a short technical review is the depth of the analysis that is possible within the time available. Therefore, although this report takes into account most of the comments on the debriefing note (made by different partners), it is impossible to provide well-informed answers to all questions asked, as some issues would need much more in-depth study and are beyond the capacity of this type of review (for example drug management, transport, community involvement, district hospital services, human resources are only briefly covered in this review and would require more in-depth analysis to come up with comprehensive recommendations).

Therefore there may be a case to have a much more in-depth analysis (more time, larger sample) of district health service performance annually, but not so close to the main review. Also each review could focus on a selection of specific aspects that require more information or a more in-depth analysis rather than to cover the full spectrum.

Financial aspects related to the district basket fund are covered in detail in a separate report by Price Waterhouse Coopers (PWC). At the time when the RT has finalised the draft technical review report, the PWC report was not yet available. Therefore, only the financial elements presented in the debriefing note have been incorporated in the technical review report. For more details, we refer the reader to the PWC report.

Comments were received on the debriefing note from TEHIP, the Swiss Agency for Development and Cooperation, WHO, GTZ and UNFPA. Comments on the draft report were provided by the MoH, Danida, ELCT, MSD, TA to PORALG, and TA to Kagera. All relevant comments have been taken into account in the final report.

The 2003 technical review report covers only one main strategy: district health services. And looks at district health service performance from the viewpoint of Council Health Management Teams (CHMT) and LG. The report presents a short general appraisal of district health services (section 1). Planning and budgeting for better health (section 2) both looks at what the requirements are for a performing planning and budgeting process (section 2.1, including guidelines and process) and what information should be available at council level to develop a

---

<sup>1</sup> Leo Devillé, Health System Specialist; Victoria Kipendi, Regional Medical Officer; Thomas van der Heijden, Public Health Specialist; and Revocatus Sangu (Financial Expert, PWC).

comprehensive council health plan (section 2.2). Issues related to implementing the council health plan (section 3) include financial resources (3.1), non-financial resources (3.2), systems development (3.3) and service delivery (3.4). Supportive supervision, monitoring, reporting and auditing is discussed in section 4. The role of the two main support structures, the Regional Secretariat – Regional Health Management Team and the Zonal Training Centres, is presented in section 5. Section 6 questions the efficiency of the Health Sector Reform advocacy. And main recommendations are summarised in section 7.

The RT would like to thank all senior MoH and PORALG staff, but especially the staff at council and facility level, as well as non-government providers and main stakeholders for their input in this review. While we hope this report will be of some use for making the right decisions that will further improve health service delivery towards reaching the HSR and PRSP targets, the RT takes full responsibility for all errors, inaccuracies and all other limitations of the report.

March 28<sup>th</sup> 2003  
The Review Team

## Executive Summary

Below, the main recommendations which the RT considers of higher priority are presented in a table format. Actions that should be taken in 2003-2004 are presented by level (central, regional and district) which facilitates their integration in the National Health Sector Strategic Plan which is presently being developed. The main strategic orientations that would need medium-term actions are also spelled out. In case that specific or additional resources are supposedly required, this is indicated in the last column. References are made to the more detailed recommendations in section 7, and to the relevant sections in the final report.

The full list of recommendations is presented in section 7 of the report. The presentation below does not replace this list but highlights the most important actions to be taken.

The main recommendation from this review is to **focus on service delivery and quality of care** (shifting the focus from too much emphasis on planning and management towards more emphasis on service delivery and quality of care). Improved service delivery requires:

- *a shift of attitude of CHMTs towards service delivery;*
- *a planning, budgeting, reporting process that supports service delivery;*
- *demand-driven, regular and specific technical and managerial support to CHMTs from a skilled regional level;*
- *access for CHMT staff to specific, skills-building oriented, short-term, modular training from Zonal Training Centres;*
- *an environment that is conducive to quality service delivery, including skilled, motivated human resources; appropriate and well maintained infrastructure, staff housing and equipment; sufficient financial resources*
- *greater involvement of and accountability to facility based health staff and communities;*
- *re-focus of performance assessment tools and procedures on quality of service delivery.*

Technical review of health service delivery at district level

Recommendation (reference to full list, section 7)	Reference to section in the technical review report	Objective / Output	Action to be taken	Timing	Level	Responsible	Need for additional or specific resources
1	2.1.1.1		CHMTs to focus CHP on quality service delivery by linking the CHP to departmental action plans	Medium-term	District	CHMT	No
1	2.1.2.4 5.1		RHMTs (and MoH/PORALG) to evaluate CHP and quarterly reports also on service delivery outputs and regular supervision by CHMT to health facilities	Medium-term	Regional Central	RHST/RHMT/RS MoH/PORALG	No
1	2.2.1	<b>Stronger focus on service delivery at district level</b>	MOH to review all policy and disease specific guidelines in a comprehensive way and come up with a coherent set of guidelines	2003	Central	MoH	No
1	3.3.4		PORALG to assess the feasibility of contracting arrangements with health providers at district level (district specific service contracts with public and private providers, linked to an agreed budget)	2003	Central	PORALG	No
1	3.3.4 3.3.5		Perform a district based study on how to improve public-private partnership	2003	Central	MoH / PORALG	<b>Yes</b>
2	2.1.1 2.1.2		Harmonise guidelines for comprehensive health planning, budgeting, reporting and procurement for both government and basket resources. Keep the planning format simple and focus on the use of the plan to achieve better services	2003	Central	MoH / PORALG	No
2	2.2.3		Review the annual priority setting procedures for the CHP (combining MTUHA and BoD data)	2003	Central	MoH, PORALG, MTUHA, NSS, AMMP, TEHIP, NIMR, RHST/MT & CHMT/DC representatives	No
2	2.1.1.1 2.1.1.2	<b>Planning, budgeting and reporting support service delivery</b>	Review and to some extent release the restrictions put on the basket funds and harmonise restrictions for both government and basket funds	2003	Central	MoH / PORALG / partners	No
2	3.1.1		Consider de-linking regional hospital basket from district council basket. Harmonise use of government, cost-recovery and basket funds at regional hospitals.	2003	Central	MoH / PORALG / partners	No
2	4.4		Review auditing procedures of Account n° 6	2003	Central	CAG / MoH / PORALG / MoF	No
2	2.1.2.5 3.1.2		Strengthen the use of IFMS and adapt IFMS to adequately address district health income and expenditure. Address the efficiency/work organisation of LG accountant staff.	Medium-term	Central	PORALG	?

Technical review of health service delivery at district level

3	5.1 5.2		Build capacity of CHMTs step-by-step through regular support from RHST/RHMT/RS and ZTC	Medium-term	Regional Central	RHST/RHMT/RS & ZTC	Yes	
3	5.1	<b>Support from RHST/RHMT and ZTCs focus on management and quality service delivery at district level</b>	PORALG to agree with MoH on role and composition of RHST/RHMT	2003	Central	PORALG & MoH & CSD	No	
3	5.1		Develop the RHST/RHMT capacity within RS	Medium-term	Central	PORALG & MoH	Yes	
3	5.1		Assure appropriate financing of RHST/RHMT function	2003	Central	PORALG & MoH & CSD	No	
3	5.1		Bring together experiences from district health projects that have invested in strengthening RHMTs and make comprehensive analysis of lessons learned from longer term projects	2003	Central	MoH	No	
3	5.2		Set up a full network of ZTCs throughout the country. Develop short-term skills-based learning modules	Medium-term	Central	MoH	Yes	
3	5.2		Assure appropriate financing of ZTC network	2003	Central	MoH & partners	No	
4.1	3.2.1			Asses the implications of the 99/00 standard establishment norms at council level & review with CSD the process for filling posts at council level	2003	Central	MoH & PORALG & CSD	No
4.1	3.2.1	<b>Environment conducive to quality service delivery: 1. Human resources</b>	Do a comprehensive analysis of skills and manpower needs at district level (CHMT + public/private health workers); training needs assessment of district staff	2003	Regional	ZTC & RHST/RHMT	Yes	
4.1	3.2.1		CHMTs develop comprehensive district human resources development and training plans (and tracking tools)	2003	District	CHMT / DC	No	
4.1	5.1		Do a comprehensive training and skills needs assessment at RHMT/RHST	2003	Central	MoH & PORALG & ZTC	Yes	
4.1	3.3.2		Consider introducing performance based incentives linked to service delivery; and allow councils to use government and basket funds to motivate staff through non-financial benefits	2003	Central	MoH & PORALG	No	
4.1	3.2.1		Set the timeframe for decentralising staff matters to council level	Medium-term	Central	PORALG & MoH & CSD	No	
4.2	3.2.6		<b>Environment conducive to quality service delivery: 2. Infrastructure an equipment</b>	PORALG to speed up finalisation capital investment / rehabilitation plan (including staff housing and major equipment)	2003	Central	PORALG & MoF	No
4.2	3.2.6			GOT and partners to agree on resource envelope	2003	Central	PORALG & partners	Yes
4.2	3.2.6	Consider setting a minimum % for annual council health budget allocation for (preventive) maintenance of buildings and equipment		2003	Central	PORALG & MoH & partners	No	

Technical review of health service delivery at district level

4.3	3.1.1		Decide on a single resource allocation formula for both government and basket resources to district councils	2003	Central	PORALG & MoH & MoF & partners	No
4.3	3.2.2 3.2.4	<b>Environment conducive to quality service delivery:</b>	Set timeframe for decentralising transport and drug budgets to council level	Medium-term	Central	PORALG & MoH & partners	No
4.3	3.1.2	<b>3. Financial resources</b>	Develop district guidelines for how to allocate resources equitably between service providers based on agreed service contracts	2003	Central	PORALG & MoH & partners	No
4.3	3.1.2		Assess feasibility of reaching PRSP targets within present resource envelope	Medium-term	Central	PORALG & MoH & partners	?
5	3.3.3		DC/ CHMTs publish annual district health budgets and inform facilities about their annual budgets	2003	District	DC & CHMT	No
5	3.3.3	<b>DC &amp; CHMT more accountable to facility based health staff and local communities</b>	DC/ CHMTs publish annual district health performance data and discuss data with health staff & communities	2003	District	DC & CHMT	No
5	3.3.3		Strengthen planning, management and service delivery capacity of facility health staff in order to involve subsequently communities in planning	Medium-term	District	CHMT	No
5	6		Advocate HSR issues up to community level	Medium-term	District	CHMT supported by RHMT / MoH	No
5	6		Improve communication between MoH and PORALG on pertinent developments in HSR and LGR	Medium-term	Central	MoH & PORALG	No
6	2.2.2 2.2.3 4.2		Review the district health performance assessment tools and procedures, including the NIMR performance monitoring methodology	2003	Central Regional District	MTUHA, NSS, AMMP, TEHIP, NIMR, RHST/MT & CHMT/DC representatives	No
6	2.2.2	<b>Performance assessment more adequate</b>	Refocus and invest in MTUHA minimum information package at district and facility level	2003	Central Regional	MTUHA, ZTC, RHST/RHMT	<b>Yes</b>
6	2.2.2		Strengthen data collection, data management and decision-making at district level	Medium-term	Central Regional	MTUHA, ZTC, RHST/RHMT	<b>Yes</b>
6	4.2		GOT and stakeholders to agree on a final coherent set of national indicators	2003	Central	GOT & partners	No
6	7		Decide on the process and the focus of next year technical and main review	2003	Central	PORALG & MoH & partners	No

# 1 General review of district health services

The technical review has focused on service delivery. In order to deliver the appropriate services continuously, sufficiently and of acceptable quality the health delivery system needs to have the right mix of skills (human resources), drugs, medical and non-medical equipment, facilities (working and living environment), support systems (e.g. planning and management, technical support systems, supportive supervision, monitoring and evaluation, training, quality assurance, transport management, communication systems) and the appropriate corporate culture (attitudes, good governance, transparency, ownership, performance based rewarding) in place at all levels of the system.

The presentation of issues and recommendations follows this logic.

No recent health services data were available to the RT, which would allow some evidence-based evaluation of changes that appeared since the introduction of the reforms. 2002 MTUHA data, NIMR performance assessment data for 2002 Phase I Councils were not yet available at the time of the review. Other reports, such as the State of Health in Tanzania 2001<sup>2</sup>, use data for trend analysis prior to the reforms. It is therefore too early to base this technical review of district health services on evidence-based data, except for the districts visited by the RT. However, where relevant reference will be made to specific changes presented in other documents. Very interesting will be the NIMR 2002 performance assessment as soon as it becomes available<sup>3</sup>.

Based on the limited number of field visits (and previous visits by team members to Phase I and II districts), the RT has the impression that health services delivery at facility level is improving; that most essential resources such as essential drugs, medical supplies, basic equipment, transport, financial resources (and in some districts radio communication systems) are available; that CHMTs are generally well motivated to do a good job but have limited capacity; that quality of plans improve and are more in line with central guidelines; that essential interventions as per EHP, and especially those that address cost-effectively the largest part of the disease burden (IMCI, malaria related activities, STI management, SMI, EDP, EPI, TB DOTS, ...) are reflected in the 2003 council health plan activities (although not always coherently reflected as the main priorities; and not always well translated into coherent prioritised activity plans); that regular supervisory visits are carried out at facility level (varying from monthly to quarterly); that in-service training of facility staff in priority interventions is being carried out. The RT has not had the opportunity to appraise the quality of the interventions, supervision or training. Anecdotal evidence however suggests that some interventions such as EPI coverage have improved as a result of regular on the job supervision. One district with reliable data shows a trend of significant increase in outpatient attendances (from 0.95 to 1.3 per capita), supervised deliveries (+ 30%) and EPI coverage (close to 100%) over a 4-year period.

The PRSP Progress report also identifies some improvement against selected 2002/2003 indicators such as DPT3 coverage increasing from 71 to 78%; HIV/AIDS awareness campaign covering all districts; new malaria control guidelines distributed, trainers trained, drugs ordered.

<sup>2</sup> This report is very relevant in the sense that it provides some useful information that could serve as a baseline. Most data reflect the situation prior to or at the beginning of the introduction of the health reforms. Most health service indicators show a negative (supervised deliveries, antenatal care) to neutral trend (infant and child mortality, malnutrition) over the last decade. If the reforms are successful this trend should be reversed. The report also suggests that some of the PRSP targets are likely to be unachievable (malnutrition, IMR, MMR) or maybe delayed (malaria) unless some important changes happen at strategic level or more focused action takes place. Obviously, most of the above PRSP targets depend also on factors beyond the health sector.

<sup>3</sup> The RT expresses its reservation about the present value of this type of performance assessment as it is mainly based on MTUHA data that are itself largely unreliable. This is explained further in the report.

At a national level, the 2002 PER<sup>4</sup> confirms the trend in expenditure away from 'secondary and tertiary hospitals towards district based health services' and a substantial rise in expenditure on preventive services<sup>5</sup>. This is a remarkable achievement but there are limitations in how much resources can further shift away from hospital care.

The main complaint by CHMTs and DEDs concern shortage of staff; lack of funds for major rehabilitation of facilities and staff houses; some of the restrictions to the use of the district basket funds; delays in the provision of basket funds which interferes with the implementation of planned activities; too many different and sometimes conflicting guidelines; and to a certain extent the workload related to planning, budgeting, reporting systems and processes.

Less important but frequently heard complaints concern the unavailability of some standard equipment at MSD, the composition of the standard drug kits that does not always cover district specific drug needs, the facility based ceiling for drugs in the indent system, the monopoly of MSD.

Different speed of phasing reforms in health, civil service and local government do affect the implementation of the health reforms. The slow speed of the overall decentralisation process slows down or interferes with some aspects of implementation such as timely release of funds for health at council level; limited ownership of the council health plan by non health professionals; incomplete decentralisation process (e.g. the limited authority of district councils on district health staff).

## 2 Planning and budgeting

### 2.1 REQUIREMENTS FOR A WELL PERFORMING PLANNING AND BUDGETING PROCESS

#### 2.1.1 Issues related to planning and budgeting guidelines

##### 2.1.1.1 Planning guidelines

MOH and PORALG have invested a lot of energy in developing coherent planning and budgeting guidelines for council health plans<sup>6</sup>. This has resulted in much more coherent, more comprehensive and better-informed council health plans. Although the workload linked to this planning and budgeting exercise is considerable (between 1 and 2 months full-time CHMT investment per year) and some aspects of the guidelines may require a revision, the RT would advise to continue using basically the same formats and the same processes in the years to come. Changing formats too often only confuses district staff. Therefore, changing formats or processes should be limited to marginal changes with a view to make the work easier rather than more complicated, to make the planning more responsive to the district planning needs and less to central control needs, and to have a single set of coherent guidelines.

#### Issues

<sup>4</sup> MoH, Public Expenditure Review, Health Sector Update for 2002, Final report 2002.

<sup>5</sup> Some of these changes may also be partly due to changes in classification of expenditures and definitions (e.g. what is allocated under preventive health services? Do district based health services exclude 'secondary' hospitals?).

<sup>6</sup> A) Planning Guide for Local Authorities regarding utilisation of the health basket grant. B) Procedures manual for the Joint Disbursement system for Council Health Basket Funds. C) Format of a prototype comprehensive council health plan. D) National planning guidelines for district planning

There are multiple guidelines for planning and budgeting of district basket funds, some of which are contradictory (for example a different and rather unspecified 'negative list' of expenditure items). Verbal guidelines are not always in line with written guidelines, and are confusing. The districts receive multiple instructions from the centre (MOH and PORALG).

However, guidelines are perceived as essential by CHMTs in order to guide expenditure and to avoid misuse of funds because of pressure from for example councillors, for less essential expenditures.

The planning guidelines are too much oriented towards central requirements (in order to allow assessing compliance with guidelines and budget ceilings; and monitor 'performance') and not enough towards district planning needs. For example, the council health plans focus on activities that need specific funding and leave out activities that do not require extra funding, with the risk that the latter do not happen. For example, supervisory visits by the CHMT to facility level are planned and budgeted for, but activities that would ensure improved quality of the supervision (e.g. development of a checklist for supervision; training in supportive supervision; developing a mechanism for using referral cases during supervisory visits; etc.) are generally not planned for. In that sense, the planning exercise may too much resource-driven. Secondly, planning seems to stop with the council health plan. In some of the districts visited, the RT could not see the link between the overall health plan and the departmental (operational) plans (for example the operational plan of the MCH officer).

Annual priority setting, focused on frequency of health problems, severity, feasibility of case management and population's point of view is questionable (quality of facility based data; disease burden does not change annually, with the exception of some diseases such as the HIV/AIDS epidemic). The exercise seems generally not well understood. One could argue whether it is necessary to set all priorities every year again while at least the 5 main health problems as well as the main cost-effective interventions are known through the Burden of Disease Profile. Moreover, priority setting should also take into account past achievements, present situation and medium-term objectives (based on actual coverage, staff training plans, rehabilitation plans, facility equipment plans, etc.). In the "Format..." a second area for interventions looks at "Structure and Management related problems". For example, lack of medical equipment and supervision will be pointed at. A third area is called "secondary health problems", which looks at nutrition, and water and sanitation. The manual does not stipulate how weighting between these three areas is to be done. One could wonder to what extent the priority setting based on reported diseases could be replaced by the "Burden of Disease Profile" for at least the top 5-8 problems and the top 8 cost-effective interventions.

Planning guidelines miss a medium-term horizon (e.g. 3 to 5 years) and trend analysis (past performance over more than 1 year). Without this information it is impossible to assess whether the council health plans plan are sufficiently coherent, taking into account the present situation and previous achievement.

Comprehensive planning guidelines are still very much understood as basket guidelines (separate planning for basket funds). The basket has become the 'rule of the game'. It will take some time to move away from basket planning towards real comprehensive planning of resources.

According to the CHMTs, there is some conflicting information on which indicators to be used (e.g. Council minimum health standards – performance indicators vs. MTUHA indicators). In the council plans reviewed, some CHMTs were unable to explain the link between performance indicators they are required to calculate and the planned activities or district targets. How much the CHMT was able to influence the value of the indicator through their planned activities was often not clear. See section 4.2 for more discussion on indicators.

In districts where there is only a regional hospital (functioning also as the district hospital) the CHMT had a lot of difficulties in motivating the regional hospital to plan for activities that responded to the district needs. Regional hospitals tend to plan rather for regional hospital requirements as a referral institution. Also, reporting by the regional hospitals is often delayed and incomplete.

In 2002-2003 TACAIDS HIV/AIDS health plan are not included in the comprehensive plan (request to develop the plan came too late as per 11/11/2002).

### 2.1.1.2 Budgeting guidelines

Different planning and budgeting guidelines by sector, multiplies the effort to be invested by LG. Although planning guidelines may be different by sector (for example regarding priority setting), main planning and budgeting formats should be standardised or harmonised between sectors. This would also facilitate the IFMS to be efficiently linked to the planning and budgeting process.

Different guidelines and ceilings for basket and OC funds make planning and budgeting unnecessary cumbersome and less efficient. If CHMTs are requested to come up with comprehensive sector plans, it would make sense for them to use available resources comprehensively and efficiently. A single set of guidelines for use of government and basket resources would help to achieve this objective.

Vertical restrictions<sup>7</sup> on allocation of resources are the same for all districts, independent of the number of facilities and workload at each level. This is especially a problem in municipal councils where the private sector is very much present (e.g. DES).

Restrictions are not always clear (no explicit well defined negative list of items that are excluded from the basket funds) which results in inefficient planning and too much effort going into (regional and central) 'control' function and ex-post correcting of draft plans (with different interpretations in different regions) and critical auditing reports.

Multiple ceiling is affecting prioritisation in budgeting. Some ceilings are not realistic. CHMTs complain especially about the ceiling on training.

Although CHMTs are required to come up with comprehensive plans, they do not know all resources available to them, for example for some vertical programmes such as TB or for capital development.

The information on next year's resources is not timely available as per proposed time schedule. According to central MoH staff this is not a major problem as districts can start to plan for most activities without knowing the overall ceiling (using last years' ceiling). District staff tend to start planning when the information on ceilings is available.

The districts receive multiple instructions from the centre (MoH, MoF and PORALG) sometimes these are delayed and contradictory. For example, in one district the DC had received two different sets of accounting codes one from PORALG and another from the MoF. In another district the DC was informed by PORALG that they can budget for medical equipment only to be told by MOH this is not allowed.

<sup>7</sup> 'Vertical restrictions' means expenditure ceilings by type of provider or level of the health system. 'Horizontal restrictions' means expenditures that are not allowed, by type of expenditure

The TEHIP accounting tool would be an added value to the comprehensive council health plan, because it presents the same budget data in a logic standardised way that allows CHMTs (and also authorities at central level) to analyse comprehensiveness of resource use in function of burden of disease priority interventions. It provides a summary of who is paying for what type of activity and at which level of the system. The programme provides some analytic graphs that facilitate interpretation of data. If budget ceilings would change during the planned review of the basket guidelines, the tool may need some adjustments before being rolled out.

The 'negative lists' of items that cannot be purchased from the district health basket fund is not explicit enough and therefore confusing to CHMTs. For example, a motorbike would fall under 'fixed assets' and is therefore excluded, but a bicycle not. A computer course is given as an example of a capacity building exercise, excluded from the district basket fund, but a training organised by the RHMT on planning and budgeting, which is also a capacity building exercise is acceptable. A clear negative list would avoid a lot of frustration for council health planners.

Double and separate control of the CHP by both the RMO and the RS is likely to be less efficient than an RMO supporting the council health planning exercise and a joint control by RS and RMO.

### **2.1.1.3 Procedures for expenditure and procurement**

Problems with availability of drugs and equipment at MSD are affecting timely procurement by the councils. In one council there has been a delay of one year in procurement of some equipment from the MSD (maternity bed, dental chair).

MSD agrees that there are problems with the 'special procurement', partly due to 'being boxed into procedures' (in order to assure transparency), and partly due to lack of focus or follow-up in this specific area<sup>8</sup>.

For more details on expenditures and procurement, see the PWC report.

## **2.1.2 Issues related to the planning and budgeting process**

### **2.1.2.1 Comprehensive planning and budgeting process**

What does a comprehensive planning and budgeting process at district level mean? The concept of comprehensiveness can encompass different approaches and content of planning for health. Below we list some of them and assess whether the 2003 council health plans for the 5 districts reviewed take into account these concepts or processes:

- a. Involving all providers / stakeholders involved in health related activities
  - i. Involvement varies by district but CHMTs make an effort to include other stakeholders / providers.
  - ii. Involvement is mainly at the planning stage, and most often limited to district basket or project resources only.
  - iii. Transparency on own resources of faith-based and private for profit providers is most often absent.
  - iv. Activity plans of faith-based, private for profit providers and NGOs are most often absent in the CHP.
  - v. No action on how to improve private-public partnership is presented in the CHP.
  - vi. In general, the diversity of clients' needs is not taken into account in the plan (no plan referred to client's perception of needs).

<sup>8</sup> Source: comment from MSD Logistics Adviser on the draft report (dated 20/03/03) .

- b. Pro-poor planning
  - i. Although national poverty reduction strategies are well defined, the planning guidelines do not explicitly refer to poverty reduction targets or activities.
  - ii. District plans reviewed do not explicitly present PRSP targets.
- c. Gender planning or mainstreaming
  - i. Although the priority setting process requires gender disaggregated data for main diseases to be presented in the plan, there is little or no emphasis on gender issues in the plans reviewed.
  - ii. Mainstreaming gender in CHP strategies and activities is not well developed, but it is also doubtful whether CHMTs are sufficiently trained in gender issues.
- d. Bottom-up planning
  - i. Some districts do some bottom-up planning from facility level. This is mostly limited to a needs assessment of non-financial resource requirements (staff, equipment, supplies, furniture, etc.) and of rehabilitation.
  - ii. With the exception of one district, facility based plans are neither activity based nor health problem related.
  - iii. One district was a noticeable exception and has elaborated plans at each facility based on local priority setting linked to health problems. The local health workers are developing sub-district plans with the health committee. Other districts could use this example.
  - iv. Generally, community involvement in the planning process and assessment of community needs is absent in the CHPs reviewed.
- e. Intersectoral planning
  - i. The planning guidelines put very little emphasis on intersectoral planning.
  - ii. The planning process is mostly limited to the health sector.
- f. Medium-term planning
  - i. Only some districts have a medium term council service improvement plan, including health. The link with the annual council health plans is not always clear.
  - ii. The annual council health plan does not refer to medium term objectives and how the planned activities would contribute to achieving them.
- g. Recurrent and investment (capital) planning
  - i. Council health plans do not include information on capital investments.
  - ii. Councils do not know what and when resources for capital development, including rehabilitation, would become available. Some are aware that PORALG is in the process of developing a longer-term rehabilitation plan.
  - iii. The 'Procedures manual for the joint disbursement system for the council health basket funds' however presents a brief notion on the 'development budget', including building works and rehabilitation, capacity building initiatives, non-recurrent programmes, to be financed from the 'central pool'. It does not specify what capacity building initiatives are and why they are to be presented under the development budget.
- h. Evaluating previous performance in order to define or adjust next year's plan
  - i. Last year's performance is evaluated, based on MTUHA data (which are not always reliable) and different sets of indicators (which are not always comprehended by the CHMT). Some districts use sentinel survey population based data for planning and evaluation purposes, which are more relevant (but impossible to be used for evaluation in all districts).
  - ii. Longer-term trend analysis of performance or of service data is often absent.

- i. Incorporating all available resources for health in the council health plan
  - i. CHMTs try to include all health related resources from all stakeholders. Information on central block grants and council resources is present. Information on vertical programmes is not always present. Information on cost sharing is not always included. Information on faith-based organisations is often incomplete (with the exception of DDH). Private for profit resources are largely absent.
  - ii. Expectations on collecting comprehensive information of all providers should be realistic.
  
- j. Ownership of comprehensive council health plan by local government
  - i. Involvement of the DPO in developing the council health plan together with the CHMT varies by district.
  - ii. Expectations on ownership should be realistic in the context where the DED's office has to deal with many sector plans.
  
- k. Full spectrum of needs
  - i. The burden of disease approach and to some extent also the priority setting process tend to underestimate the importance of health problems that do not lead to mortality (such as mental health) or are underlying factors (malnutrition) or are non-disease aspects of health such as gender violence, sexual abuse, etc. Those aspects risk to be underrepresented in the CHP, unless specific attention is given to those problems.

From the above it is clear that comprehensive planning still has a long way to go. Again, this is a step-by-step process and expectations in how soon the process can become fully comprehensive should be realistic. For example, bottom-up planning is likely to become more effective when functional HSB and FHCs are in place. In the short term, this will however complicate rather than simplify the work that goes into planning at district level. In the longer term, plans are likely to be more responsive to the local needs, but stewardship by the CHMT staff will remain crucial. What is possible in one district may still be premature in another district. Therefore, 'growing in planning' should follow the dynamics and the specific situation of a district, backed by relevant technical support at regional level. And specific skills-building courses could be developed and provided by ZTCs to progressively support this 'capacity building'. The RT is however of the opinion that, in the first place, more efforts should go towards ensuring quality of care rather than towards more planning.

Developing the council health plan requires between 1 and 2 months full-time CHMT investment per year. Part of this is due to the review process prior to acceptance of the plans. If CHMTs have to spend more than 1-2 months on planning only, too much emphasis is put on the planning process (or the process is not efficient). Planning and quarterly reporting takes between 2.5 and 3.5 months of CHMT staff time per year in the districts visited.

Ownership of the council health plan by the LG is still limited. Input from the DED's office is mainly at the level of accounting and financing aspects. On the other hand, the district treasurer and accounting staff spent relatively more time on health than on other sectors, mainly because of additional requirements of the district health basket funds. And expectations about ownership should also be realistic as LG staff have to 'own' many different sector plans.

### 2.1.2.2 The role of sub-district structures

To strengthen management structures at facility level requires a well defined managerial and planning capacity at CHMT level. As long as the required level has not been defined and reached not too much should be expected at facility level as to some extent independent

planning and management entities. The RT suggest that supervision by CHMTs should primarily focus on quality of care initially until the defined capacity has been reached at the level of the CHMT. Then capacity in planning and management can be built progressively at facility level. Only thereafter, should further initiatives to involve communities in planning be tested and implemented. If too much effort is invested in planning at different levels in a non coherent way, quality of care which is the core business of staff at facility level may continue to suffer. However, through this step by step approach an incremental change can be expected to be successful.

The above does not mean that districts who have this CHMT capacity can not start the process of decentralising planning and management capacity to facility level (and later also to community level). This will have to be decided on a case by case manner. The RT only draws the attention to the risk of giving too much time and emphasis on planning and too little on quality of care. This has been the experience in other countries that have decentralised service delivery to council level.

Again, this does not mean that facilities and communities should not be fully aware of what resources are available for their area (transparency of budgets allocated to each facility in the district by publishing this information) and how these decisions are taken. Also, health performance for the whole district (as compared to other neighbouring districts) and if possible performance by facility should be made public every year. This is a strong basis for building awareness and initiating informed discussions at facility level with local communities and can be a first step to building local capacity. This may also be a more appropriate way to initiate community and facility staff involvement before investing in building planning skills of facility staff / communities.

Involving communities through HSB and HFCs is discussed in section 3.3.3.

### 2.1.2.3 The case of the private sector

The comprehensive district plans reviewed by the team do involve the private sector, defined as “for profit”, “non profit” VA and other NGOs. The degree of detail in which the various providers are described varies considerably between the government service providers on the one hand (with for example even registration numbers and other details of vehicles) and private service providers (whose number of vehicles are not even indicated) on the other hand. This is not surprising in view of the double role and responsibility the CHMTs are charged with. Besides responsible for the direct provision of government health services the CHMT has the regulatory responsible for the co-ordination and performance of all other providers. It is questionable whether the private providers fully appreciate the regulatory and coordinating role of the CHMT. The RT sees the provision of basket funding for VA hospitals as conducive for better coordination and cooperation. CHMTs’ have repeatedly expressed their concern on the lack of transparency of funding in the private sector. This concern is confirmed in DDH’s and VA hospitals’ annual reports, which limit financial reporting to salaries and patient fees, but do not attach figures to the various donors who are thanked for their contributions in the same reports.

On the other hand, VA hospitals (and sometimes also HCs) are not regarded as true partners in some districts. This is a tricky problem. In some districts there may be a case of duplicating functions (two hospitals delivering the same services without a need for having two separate hospitals in the same geographical location) and thus a case for not spending scarce public resources to subsidise non-essential services. In other districts, a VA hospital is performing an essential function complementary to the district hospital (e.g. delivering the EHP in an isolated area or far from the district hospital; or providing some more specialised services such as surgery, ophthalmic care) and should have access to a reasonable budget. In that case the CHMT (or DHB) should decide, based on volume of services, type of services and responsibility of both hospitals, how the hospital budget (government and basket funds) should be divided between both hospitals, based on principles of equity, transparency and accountability (this type of agreement can best be translated into specific service contracts with both hospitals). In order to guarantee fair allocation of resources it would be rational that the Council Health Services Board would have a fair representation of all type of health providers (government and non-government).

Real coordination and optimal use of basket funds by providers can only be achieved if there is full financial transparency of all financial flows for health in the district. This is further elaborated on in sections 2.1.2.2, 3.3.4 and 3.3.5.

### 2.1.2.4 The role of the RS and RHMT

For reasons of economy of scale and efficiency, the RS is the appropriate level where Council Health Plans and health performance should be assessed on behalf of the Central Government, as 117 districts can never be correctly assessed at central level, both for reasons of its high number and the lack of knowledge of the central level about the specific district conditions. The RS is close enough to the Council level, to know the specific local context and to provide proper technical back-stopping.

The role of the RS and the RHMT vis-à-vis planning, budgeting and reporting at district level is discussed in section 5.1 where the role of the RHMT and RS is discussed in a comprehensive way.

### 2.1.2.5 Budgeting process

Information on next year's resources is not timely available as per proposed time schedule in the planning and budgeting guidelines..

Some funds are still not decentralised: vertical programmes<sup>9</sup> (e.g. TB/leprosy at regional level); the budget line at MSD limits the authority of the district to buy drugs outside of MSD and de facto confirms the MSD monopoly.

Transparency on resource allocation could be strengthened. In none of the visited districts annual health budgets are being published. Publishing budget information would inform both providers (health facilities) and communities on how resources are allocated in the district.

A single set of comprehensive guidelines for budgeting government and basket resources would allow for more coherent resource allocation and prepare the way to budget support in the medium term. This would enhance sustainability of support provided from external resources.

The RT was informed that new guidelines on planning and budgeting are being developed (or exist already?) in the framework of the MTEF. The RT has not seen those guidelines and does not know in how much these guidelines are different from or conflicting with present guidelines. As MoH and PORALG are planning to review the health planning and budgeting guidelines soon, it will have to take into account those new guidelines.

The number of LG accountant staff is limited. As timing for budgeting and reporting work is likely to become the same for all sectors, it will only become even more cumbersome for accounting staff to deal with all sector requirements at the same time. This may lead to unnecessary delays, unless accountant staff is sufficient in numbers and skills to deal with the workload. Although PORALG is not in favour of 'decentralising' LG accountant staff to specific sectors, it may be good management to allocate specific sectors to specific LG accountants. On the other hand, many CHMTs may not see the need to co-opt a LG accountant in the CHMT. This should be clarified with PORALG and maybe there is a need that core and co-opted CHMT members need to be more clearly defined and job descriptions written.

### 2.1.3 Skills for planning and budgeting

Planning and budgeting skills of CHMTs have considerably improved, especially at Phase I districts.

There is often a pronounced skills gap between the DMO (especially when trained in public health) and other CHMT staff. Although in other districts where no trained DMO is present, other CHMT staff such as the DNO tends to take the lead. Some CHMTs still have problems to comprehend all aspects of the planning guidelines. Especially skills to interpret quantitative data, trends analysis and indicators are strikingly limited. These skills are likely to be better in districts where donor project type of support focuses on building planning and management skills (e.g. TEHIP, GTZ, ...).

Capacity building of CHMT staff in planning and budgeting requires regular on-the-job support, complementary to the CHMT training in planning and management. This support should be a major component of the role of the Regional Health Support team (RHST/RHMT). This should be seen as a stepwise incremental approach to capacity building over several years.

<sup>9</sup> Judging from the draft Health Sector Strategic Plan, the vertical program funds would still constitute 25% of the health budget.

There is a need for a skills assessment of CHMT staff in planning, budgeting and management of service delivery. ZTCs should develop specific skills-building oriented modular short-term training courses.

## 2.2 INFORMATION REQUIREMENTS FOR DEVELOPING AN APPROPRIATE COMPREHENSIVE COUNCIL HEALTH PLAN AND BUDGET

### 2.2.1 Up-to-date and coherent national policies and guidelines

Besides the planning and budgeting guidelines discussed in chapter 2.1.1 several other policy and disease specific control guidelines exist. It is estimated that at least 30 different guidelines apply to the delivery of district health services. These guidelines range from HMIS guidelines, Supervision guidelines, Inventory of Health Facility standards to TB treatment and HIV/AIDS District intervention guidelines. Since these documents have been written over a considerable period of time by various different departments and organisations, coherence between the documents is difficult to see. Several documents, especially the more general ones seem to be overlapping, while it is not clear whether a more recent document has replaced an older one. An attempt has been made to translate this range of manuals into one practical tool. This tool, "Quality Standards & Criteria for District Health Services" does not add yet another manual to the series, but stipulates level by level which general standards apply. This is a commendable effort, but when using this manual reference to the original sources will be necessary. During the RT visit to 5 CHMTs it became clear that very few of the guidelines mentioned in the "Quality Standards..." tool are actually readily available. It became also clear that the CHMT members know only few of the guidelines. In none of the visited offices, neither at district nor at regional level, guidelines were systematically kept together, despite the existence of library in the offices. The RT could only get hold of some of the guidelines listed in the "Quality Standards..." tool. Several other guidelines, known to the mission, like the Essential Drugs List or the District HIV/AIDS Interventions (by TANESA) were not available in the visited CHMT and RMO offices. At the visited health facilities only very few and in one case a very irrelevant guideline were available.

On utilisation of guidelines the RT got the impression that CHMTs do not optimally use the various guidelines during the formulation and implementation of comprehensive district health plans. This is likely to be caused by the unfamiliarity of some RMOs with these guidelines, the uncertainty about which of the various documents apply and the unavailability of many of the guidelines at various levels.

The RT recommends that the list of guidelines is critically reviewed and that a selection of documents relevant to the different levels is made. The list of these relevant documents and the documents themselves should be made available to the CHMTs and through these to the health facilities. By doing this the MoH will perform its core task, setting and disseminating national standards. During support supervision by the RS the list and documents available can be regularly updated.

The RT was specifically asked to look at HIV/AIDS intervention guidelines. In some of the visited districts counselling guidelines were available, but the TANESA's District HIV/AIDS Interventions guidelines were conspicuously absent in all districts visited. The planned health sector HIV/AIDS activities in these districts were limited in terms of depth and variety, mainly limited to STI case management and conventional IEC.

## 2.2.2 Availability and analysis of valid local data

All districts have MTUHA data available. The planning guidelines refer mainly to MTUHA data for planning and for evaluation of performance.

However aggregated data at district level are often unreliable and can therefore only be used for planning purposes with some reservation. The RT did not have the time to analyse whether the issue is mainly the quality of the information at facility level or the quality of the aggregation at district level. However the problem has been well described in the Review of the HMIS (2000).<sup>10 11</sup> Logistical shortfall, such as MTUHA books being unavailable for months, also affect data completeness.

Analytic skills at district level are generally limited. As said earlier, comprehensiveness of trend analysis, interpretation of indicators and of quantitative data is generally weak. This limits the appropriateness of the planning exercise, based on activity and coverage data collected through the MTUHA and on performance measured by indicators, again mainly based on MTUHA.

The unreliability of MTUHA data at district level also undermines the relevance of the national NIMR performance assessment largely based on standard quantitative indicators calculated from reported facility based data (see section 4.2 on monitoring).

In line with the recommendations of the 2000 HMIS Review, that proposed to limit the MTUHA primarily to a minimum package of information needed for and to be used for decision-making by the district level, the RT recommends to refocus or re-design the MTUHA in order to function as a facility-based information system. This minimum information package would focus on activities carried out, interventions covered (e.g. develop relevant coverage information for other interventions than EPI only) and resources available/used (drug stock management; training database; human resource database; facility database; etc.). While workload related to and scope of the present MTUHA would be reduced, its use would increase by collecting only information that is useful for district planning, management and evaluation. This recommendation is not new. A lot has been invested in evaluation of HMIS, in agreeing on its operational plan, but based on the districts visited little has happened to streamline and increase output and efficiency of HMIS and its use at district level. Action on this issue cannot be taken by the MoH HMIS department, in isolation of other actors dealing with district data such as the NSS, AMMP, TEHIP, NIMR and CHMT and RHMT representatives.

AMMP, NSS<sup>12</sup> and SDS<sup>13</sup> data are population based and therefore much more relevant for planning of essential health interventions based on reliable disease burden data. However, this type of data collection cannot and should not be implemented in all districts. If data collection areas are well selected to reflect the country's diversity, this information can be useful to measure changes in disease burden allowing the central level to adjust policies and strategies; and the district level to plan accordingly (using burden of disease data of a similar district profile that is part of the NSS).

As discussed in the 2000 HMIS review, the main limitation of AMMP is that the data it produces are in principle only useful at the level of the four project areas (district level). The total sample is not fully representative of the national picture as sample populations are

<sup>10</sup> HERA, Review of the Health Management Information System (HMIS/MTUHA), March 2000, Volumes I and II

<sup>11</sup> This problem is also highlighted for national aggregated MTUHA data, in 'The State of Health in Tanzania, 2001' (Prof. E. Muhondwa, Draft Report, March 2002).

<sup>12</sup> MOH. National Sentinel Surveillance System, Adult Morbidity and Mortality project, National Mortality Burden Estimates for 2001.

<sup>13</sup> MOH. TEHIP, Burden of Disease profile 2001.

geographically limited and do not sufficiently reflect health status, poverty and burden of disease variations in the country. Although the total sample size may be large enough to be statistically representative for the nation and overall mortality data probably give a reasonable picture of the average situation in the country, variations between regions or different areas in Tanzania can not be sufficiently provided by the present sampling. This limits the usefulness of AMMP and NSS data for planning and monitoring performance at regional and district level (apart from the project sites / regions) under its present format.

However, as AMMP and SDSS data are potentially very useful for district planning and priority setting, the feasibility of a new sampling strategy has to be carefully addressed in order to make it a true national sample for assessing nationwide burden of disease and to make it more useful at district level. This was already advised in the 2000 HMIS report. Some progress has been made by pooling sentinel surveillance data under the NSS and come up with broad national estimates of the Tanzania' disease burden (based on Hai, Morogoro, Ilala and Temeke). There is a great opportunity in Tanzania to come up with one of the first population based sentinel surveillance systems in Africa, that is representative for different regions in the country, by further incorporating other already existing district DSS including Rufiji (TEHIP), Kilombero and Ulanga (Ifakara Research Centre), Magu (Tanesa), etc. This could be achieved at little extra cost.

The added value of the DSS sites is that they collect regular quantitative information across a range of social sectors, useful to monitor PRSP and HIPC. This information should not be limited to use by the health sector but be shared through active engagement with the Bureau of Statistics and the Prime Minister's office. Intersectoral population based information would also be very useful in monitoring the HIV/AIDS national policy.

### 2.2.3 Local priority setting

The "Format of a Prototype Comprehensive Council Health Plan" prescribes a method of ranking health problems. This is based on reported frequency of a diagnosis, its severity, feasibility of case management and populations' point of view. For each diagnosis these aspects are weighted and a ranking is made. A weakness of this process is that existing serious underreporting of certain diseases can lead to an unjustified low ranking. The notorious underreporting of maternal mortality (in one of the visited districts claimed as a total of 3 per year, while only 25% of the expected number of caesarean sections were done) could lead to a falsely claimed success and a downgrading of MCH initiatives.

As discussed under section 2.1.3, one could argue whether it is necessary to set all priorities every year again at district level while at least the 5 to 8 main issues and cost-effective interventions are known through the Burden of Disease Profile.

The link between priority setting (as per guidelines) and planned activities is not always clear. Do we do the right thing? How do we tackle the priorities through appropriate actions? The RT is of the opinion that the priority setting process could benefit considerably from close guidance by the RS-Health Support Team.

Given that the priority setting process is not sufficiently understood in some districts, that HMIS data quality and availability varies a lot at district level, that seemingly good quality population based data exist through the National Sentinel Surveillance System (although the present selection of sentinel sites does not yet cover the full range of the country's diversity), the RT would recommend that priority setting for essential health interventions to be delivered by public health facilities, should be based primarily on the Burden of Disease Profile. This information should be adapted for diseases that are specific for the district, but not (adequately) reflected in the overall or regional Burden of Disease Profile (e.g. onchocerciasis). Diseases that are presently likely to be underestimated by the mortality based

burden of disease profile (such as mental health or underlying factors such as malnutrition) and non disease specific health problems should also be taken into account when planning priority interventions. MTUHA facility-based data should be used specifically to provide additional key activity data, coverage data and specific management and resource data (e.g. drug stock management, staff training).

### 3 Implementation of the council health services

#### 3.1 ISSUES RELATED TO FUNDING

##### 3.1.1 Resource allocation formula

The RT is in favour of a demand-based approach (limited by actual resource availability) as a basis for allocating resources for health to Councils, rather than the norm-based, input-oriented approach based on National Minimum Standards. The PORALG consultant report<sup>14</sup> provides the right arguments to move into this direction. Regarding the health sector, the top 3 factors would be population, poverty and land area. The new census would provide updated population information and the relevant information for small area analysis of poverty, valid at council level. Land area is known, but some would prefer mileage, as land area does not always reflect correctly the resources needed for supervision, supplies and patient referral. On the other hand land area in combination with population is an indicator for sparseness of population (which again is a proxy for the cost of organising service delivery). A simulation of introducing both alternatives (land area or mileage) would help making the decision which criteria to retain in the formula.

The main other health (and poverty) related factor is infant or under-five mortality. According to the Burden of Disease profile under-five mortality takes up more than 75% of total years of life lost<sup>15</sup>. The RT is of the opinion that Child Mortality (under-five mortality) can be used as a proxy for disease burden at district level if the census 2001 provides reliable council-specific information. Child mortality may reflect poverty better than infant mortality as it will take into account more poverty related malnutrition (while infant mortality is likely to overemphasise perinatal death). Also, lowering child mortality should not lead to immediate reduction in resources, as this may be the result of continuous effective investments in essential health interventions that need to be sustained<sup>16</sup>.

Whether distance from Dar is a factor to include or not should be assessed cross-sectoral (for example present system of MSD not passing delivery costs on to a specific district may change in the future). The decision should not be based on present organisational behaviour of MSD only. But if distance from Dar proves to be a marginal cost factor cross-sectoral, the RT would advise to drop the factor in order to keep the formula as simple as possible.

Regarding referral services, the RT would advise to finance regional and tertiary hospitals outside of the council health grants. Alternatively, the referral or tertiary care function could be financed separately, while the secondary care offered by the regional hospital to specific districts could be part of the council health budget (whether or not the council has a district hospital). Councils would then buy secondary care services from regional hospitals. The same could also apply for referral cases, where councils buy these services from regional hospitals. The latter is the system operating in Zambia. This would also solve the problem of allocating resources to councils without taking into account different workload of district hospitals (e.g. Ifakara hospital or a district hospital serving populations of more than one district).

<sup>14</sup> PORALG, Georgia State University, developing a System of Intergovernmental Grants in Tanzania, Draft, December 2002.

<sup>15</sup> See NSSS, National Mortality Burden estimates for 2001 and TEHIP, Burden of Disease Profile 2001. Analysis pointy in the same direction in both reports (although data sources are different).

<sup>16</sup> According to MoH, the infant or child mortality indicators are no longer sufficient to measure (or reflect) the BoD, mainly due to the HIV/AIDS epidemic; MoH suggests to update the (national) BoD regularly through surveillance data.

District designated hospitals should be considered the same as government district hospitals and therefore treated the same way regarding resource allocation. Other mission and voluntary agency facilities in the district could be treated as government health facilities, at the discretion of the Council. However, if services are being duplicated Councils could decide to exclude some non-government facilities or only subsidise certain services.

Disease specific criteria would only complicate the allocation formula. If extra resources would be needed for a specific district because of the presence of a costly specific disease or because of certain services only being delivered there (e.g. regional hospitals providing HAART) or because of its location (e.g. border districts facing an Ebola outbreak), this should be financed separately.

Given the most likely very different situation of capital development per district (need for major rehabilitation and new construction may vary considerably), the RT advises to keep the capital development budget outside of the resource allocation formula; and base allocations for capital development based on the actual district specific needs and a specific long-term capital development plan (as being developed under PORALG).

Given the above discussion, the RT would advise a resource allocation formula based on the criteria of population, poverty, land area (or mileage)<sup>17</sup> and under-five mortality<sup>18</sup> as the main criteria. Eventually, one could decide to add the percentage of under-five population (as a proxy for higher need of resources required to tackle the largest part of the disease burden; as a proxy for increased demand for reproductive health, safe motherhood and under-five health services; and as a pro-poor factor); the 2001 census will indicate whether variation is sufficiently significant to include this factor or not. Adding again total fertility rate as a factor may be double counting with the weight of the under-five population, and therefore only complicate the formula.

Even with the above 'rational' formula some issues will need ex-post correction (which needs a specific assessment and may require resources beyond the council allocation):

- The formula does not take into account different volumes of services being delivered (see above for discussion and proposed solution for balancing resources between district hospitals and / or regional hospitals);
- Capital development should be tackled outside of the formula.

Lastly, the formula does not take into account performance. The RT understands that it is a rational choice to allocate main resources based on needs rather than on performance. Performance could be taken into account outside of the resource allocation formula through other mechanisms such as SASE or performance based incentives for health and LG staff (see further).

As a basic principle, the RT advises to use the same formula, once it is agreed, for both government and health basket resources.

### 3.1.2 Level of funds and cash flow

<sup>17</sup> As said earlier a simulation could be helpful in deciding whether mileage or land area is the better choice. MoH indicates that 1/3 of Tanzanian land is occupied by National Parks and Game reserves and another 1/3 by water and that therefore land area does not reflect the true picture of resource requirement. On the other hand distances from one point to another are linked to vehicle, fuel, supervision and allowances costs. Therefore the MoH is in favour of the mileage as a criteria based on the well established routes under the EPI programme (or from CTU). The Rt would still recommend to do a simulation exercise using both criteria in order to decide which criteria is more appropriate. It should be noted that costs of delivering health services go beyond transport and supervision costs.

<sup>18</sup> The MoH comment of the appropriateness of the under-five mortality as a reflection of BoD should be assessed.

In the districts visited all DED's and CHMTs confirmed that government and basket funds are generally sufficient to cover planned service delivery, with the exception of rehabilitation, capital development and human resources (which are at present not under the direct control of the council). This is an important observation and reflects also the present absorptive capacity of most districts<sup>19</sup>. This is likely to evolve in the future, but probably not so fast in districts with limited LG and CHMT capacity. Therefore, increasing funds for service delivery beyond the 0.5 USD per capita (or even including both government and basket funds) may have to be decided on a case by case basis, based on good track record of managing resources. It is however the opinion of the RT that achieving some of the ambitious PRSP health related targets within the limitations of the present resource envelope will be impossible; similarly, it is not because the resource envelope would increase that the targets will be achieved if no well focused and concerted actions take place in all districts.

The viewpoint of the DED's and CHMTs may not be the same of other health providers. For example, in general VAs complain that they lack sufficient resources to deliver quality services and that they have insufficient access to both government and basket funds. Also, the present resource envelope of about 6USD per capita for health in Tanzania is low compared to other countries in the region (and much less than what is estimated as the basic requirement by the Commission on Macroeconomics and Health or even the WB – 1993 report). The MoH aims at increasing the resource envelope to about 9 USD. The RT agrees that there is a need for more resources especially in the area of infrastructure, rehabilitation, maintenance (buildings and equipment), human resources and some non-government providers. Also, the HIV epidemic will require additional resources for the health sector. It should be noted that both the HIPC initiative and the Global Health Fund will/do result in an increased resource envelope over the coming years. These additional resources may however not cover some of the specific needs mentioned above. It is the opinion of the RT that additional resources should be allocated with great care and in a selective way. While some can be allocated to all councils, based on needs (e.g. rehabilitation), others should only be allocated based on a good track record of efficient decentralised management of resources. Some argue that Tanzania does not have the means to follow-up on track records of councils. It is the opinion of the RT that this again should be the role of the RS / RHMT on behalf of the central government.

Delays in release of funds from the central level to the councils affect implementation of activities. There is an average delay of one quarter in all the councils visited. Delays can be due to late reporting although this should not be directly linked (late reception of quarterly reports should not affect the release of funds of the next quarter but rather the second next quarter).

Delays in disbursement between the District Council and the DMO's office occurred in some districts visited. This was caused by the bureaucratic procedures involved at the LA. For example according to LA's Accounting Manual any expenditure amounting to Shs 2 million needs the finance committee's approval. This finance committee meets monthly. In some districts this finance committee does not meet due to lack of funds (read sitting allowances). This means delays in processing payments, but this can be resolved locally (it again shows how linking allowances to normal work duties can negatively affect output). Similar 'within-council' delays are discussed in the PER 2002.

Platinum (the IFMS software) is not being used effectively to process expenditures in some of the councils. Staff needs to be further trained and supported on the use of Platinum. This problem is recognised in a recent evaluation of the implementation of the Platinum system<sup>20</sup>.

<sup>19</sup> Note that total (reported) budget for health per capita varied between 2 and 3.6 USD in the 5 districts visited.

<sup>20</sup> PORALG, Progress of the implementation of the PLATINUM system in LGs, April 2002.

### 3.1.3 Procedures and ceilings

The issue of both vertical and horizontal ceilings for basket funds have been discussed under section 2.1.1.2 and recommendations on how to change the ceiling approach are made in annex 1.

See the PWC report for details on procedures.

### 3.1.4 Expenditures

Expenditures are influenced by delays in providing funds.

Platinum (IFMS software) is not being used effectively to process expenditures in some of the councils. LG staff need to be further trained and supported on the use of platinum.

Appendix 3, schedule A of the Budgeting guidelines (the health sector recurrent accounting return) is a headache for some districts. Data provided seem often not to reflect the reality.

The PER 2002 raises the issue whether some funds allocated to health are not spent on the sector (in 2000 average expenditure was 886 Tshs, while per capita income to the health sector was 1,016 Tshs). Whether this is partly due to mistakes in accounting for expenditures should be further clarified.

See the PWC report for more details.

### 3.1.5 Accountability

Account no 6 is a joint account. It receives different types of revenues such as block grants, cost sharing revenues, district own contributions and receipts in kind (e.g. drugs). However the basket restrictions on expenditure necessitate separate accounting of funds to meet the audit requirements. Most councils, especially those operating manual accounting systems are unable to account and report the basket expenditures separately to adhere to restrictions and meet audit requirements. This is because the capacity to code the expenditures and keeping separate documentation is lacking in the councils. This causes delays and errors in reporting.

Platinum / IFMS districts can produce the required financial information but not in the BF formats. Thus the CT staff extracts the information manually and then processes by aggregating and summarising manually or using other computer applications such as excel. There is a risk of errors and delays. The current IFMS as it operates does need further modifications to more adequately address district health income and expenditure, which should not be a major problem.

The PER 2002 highlights that more accurate and comprehensive record keeping is required at local council level. The PER team had many difficulties in obtaining a coherent picture of health income and expenditure at district hospital and council level.

For more details, consult the PWC report.

<b>3.2 ISSUES RELATED TO NON-FINANCIAL RESOURCES</b>
--

### 3.2.1 Human resources and skills

Lack of skilled human resources is the problem number one mentioned by all CHMT visited.

The RT looked at human resources both in terms of quality and quantity. The number of staff in the CHMT and the RMO's office seemed to be adequate. The number of staff working in the health facilities was not according to approved staffing levels. Big differences in success in filling posts between districts were seen. Last year Morogoro Rural saw about 80 out of 130 requested vacancies approved by the Civil Service Department while Kondoia had a much lower success rate of 21 filled posted out of over 100 requested vacancies. Apparently some districts are able to present their case more successfully to the CSD than others. Of course availability of staff differs. More isolated regions have more difficulties attracting skilled staff, but in the above case, both districts confirmed having no problems in finding interested and unemployed qualified staff.

Government establishment patterns<sup>21</sup> are rigidly adhered to by the CHMT, not taking the possible very different patient loads in different health facilities into account. This can lead to relatively overstaffing in one health centre or dispensary at the expense of health workers in another health facility.

Considerable training efforts have been going on in many districts in recent years. These training initiatives were often based on locally perceived but not well-described needs. The visited Districts could not provide coherent training plans or overview of what training had been completed last year as training is part of several different components of the comprehensive health plan. This mission could not assess the appropriateness and effectiveness of these training efforts. The RT recommends that CHMTs compile their planned annual training into one multi-annual overview, so that coherence and magnitude of this important investment in health services can be made clear. Furthermore, the RT recommends that this investment be based on a comprehensive training needs assessment done with support of the RMO and in consultation with the MoH's HRD department. For some training efforts it might be more cost effective to combine districts', to make better use of the Zonal Training Centres.

At CHMT and Regional level, very few vacancies were reported to the RT. The capacity at these levels varies considerably, often associated with previous and ongoing CHMT and RMO capacity building projects. Several detailed task analysis of the CHMT and its members exist. However, no assessment of the currently existing capacity to carry out these increasing tasks has been carried out. A training needs assessment can only be based on a measured discrepancy between the available and the required capacity. This discrepancy would also serve to trim down to more realistic levels the ever-increasing expectations put on the CHMTs by policy makers and other stakeholders. The RT recommends that a training needs assessment will be carried out at district level.

Irrespective of the outcome of the policy discussion on the number of health staff in the RS, a similar training needs assessment needs to be done at Regional level. In addition a careful appraisal needs to be done to assess the RMO's 'willingness to change'. Some of them may not be interested in the new job profile ('inspiring public health management facilitator and supporter') and prefer to continue doing mainly clinical work. In some cases 'retrainability' towards the new profile may be problematic.

A recent study on HR for health in Tanzania<sup>22</sup> critically looked at the availability of staff and future projections of HR needs in view of demographic change and the expected burden of

<sup>21</sup> Latest MoH guidelines on facility based staffing norms date from 1999/2000. It was not clear to the RT whether districts adhere to these norms or to previous establishments set by CSD.

<sup>22</sup> Human Resources for Health: Requirements and Availability in the Context of Scaling-up Priority Interventions in Low Income Countries, case Studies from Tanzania, C Kurowski et al, January 2003

disease. The report concludes that significant increases in staff productivity can be made. Despite these productivity increases, the number of staff needed is estimated to double in 2007 and triple by 2015<sup>23</sup>. HIV/AIDS related interventions are expected to take 40% of health workers' time in 2015. These projections confirm the paramount role of HR in the health sector.

Lastly, Councils' authority on staff matters is still very limited. There is no incentive for Councils to manage human resources efficiently, as savings made (e.g. running a service with less but more competent staff) are still kept centrally.

### 3.2.2 Transport

Neither in documents, nor in discussions with the CHMTs transport was mentioned as an issue (with the exception of DES, where two supervisory vehicles was said to be too limited, especially when the CHMT is also responsible for monitoring quality of private sector providers<sup>24</sup>). The provision for fuel in the Basket Funding was mentioned as adequate (and funds requested was often significantly below the 15% ceiling).

The RT did not have the time to assess the transport issue in more detail. There may be problems of local maintenance, fleet management or sustainability of present modalities that have not been mentioned during the visits. Differences in numbers of vehicles that were available were however striking. One district had about 14 vehicles (some of which stationed at HC level for cascade supervision and patient referral), while others had only 3 to 4. Some districts have an operational ambulance system in place linked to a two-way radio-communication system. Other districts seem to have problems acquiring ambulances (although this problem has not been mentioned in the 4 rural districts visited).

Motorbikes seem strikingly absent in health service management in Tanzania. This has been introduced with a lot of success in other Sub-Saharan countries (e.g. Ghana, Zimbabwe, Zambia, South-Africa) and has proven to be a very cost-effective transport modality if well managed (preventive maintenance, driving skills building courses, replacement costs as part of kilometre cost, etc.). Riders for Health<sup>25</sup> has introduced this formula successfully in a number of countries.

The RT has neither reviewed the new Transport Policy, nor discussed with the Central Transport Unit about future plans. Therefore, some of the information presented here may need some update or correction. However, the RT has been informed that the CTU still defines CHMT supervision requirements on the basis of laid down route maps with mileages and fuel estimates. While this approach may have been essential in order to determine local needs in the reform districts and to avoid misuse of funds, time may have come again to decentralise decision-making on transport issues to council level, especially to those councils that have a good track record in managing resources. This would again strengthen decentralisation. It is obvious that decentralised management of vehicles will require other control/accountability mechanisms in order to avoid the use of health cars for other purposes.

### 3.2.3 Equipment

<sup>23</sup> It should be noted that these figures on staff need and workload quoted from the Kurowski study assume that the CMH ambitious service delivery targets are reached, which is not realistic given the financial envelope needed (more than 30 USD per capita).

<sup>24</sup> The RT was told that allocation of supervisory vehicles is done by the central Transport Unit, based on a formula that takes into account the number of government and faith-based facilities that are regularly being supervised and the distances to be covered. This to the disadvantage of for example a Municipality CHMT where a large number of private for profit providers are present but not taken into account in the formula.

<sup>25</sup> A useful document is "A study to determine the key components of a cost-effective transport system to support the delivery of PHC services", Abt Associates in collaboration with Riders for Health, August 2001.

Some major equipment were said to be not available at MSD (e.g. dental chairs, maternity beds). This resulted in more than 1-year delays. Some districts state that MSD keeps the money that was budgeted in the council health plan until MSD will be able to deliver at a later date. As the expenditure was budgeted under the MSD budget line, councils cannot purchase the same item outside of MSD during the same budget year. However, councils can in the following year include the same item under 'other expenditure' to get permission to buy it outside of MSD. This procedure looks very cumbersome and inevitably results in unnecessary delays in acquiring basic equipment.

Two districts complained of MSD sometimes delivering equipment of poor quality. According to MSD this problem has now been rectified<sup>26</sup>.

### 3.2.4 Drugs, medical supplies and diagnostics

As mentioned earlier, no major problems were mentioned regarding drug availability. All districts confirm that drug availability has been relatively ok over the past years. The main problems encountered at district level concern oversupply of some essential drugs and undersupply of others, which is mainly due to the standardised composition of the drug kits; and more importantly the limitation for councils to use health basket funds to buy drugs outside of MSD. While most councils understand that public facilities have to buy essential drugs at a reliable, low-cost and efficient provider, they request the authority to buy drugs outside of MSD in case of emergency or out-of-stock at MSD. Some councils also question the logic of the monopoly position of MSD and doubt whether monopoly leads to better performance.

Regarding the indent system, the feedback was positive although the facility ceiling for drugs was said to be sometimes insufficient. The RT did not have the time to assess performance of the indent system.

MSD points at the risks of decentralised drug budget management if councils can buy outside of MSD. Misuse of funds may occur and procurement of drugs may be biased by kick-backs from the suppliers<sup>27</sup>.

Even if the Government of Tanzania decides for the time being to continue the monopoly position of MSD (mainly for reasons of efficiency and economy of scale), the RT would advise to allow councils to buy essential drugs outside of MSD in case of out-of-stock at MSD or in case of emergency. It is somehow against the spirit of decentralisation to keep the district drug budget entirely at MSD, out of the control of the councils. But also this can be interpreted as a temporary measure that could change over time, especially when districts have proven to have the local management capacity to properly manage financial resources. As MSD rightly points out, pros and cons should be carefully balanced. MSD would also gain if they were no longer a monopoly. In a competitive environment it would be easier to cut-out not profitable activities and some personnel and concentrate on core business<sup>28</sup>.

The PER 2002 noted that it was impossible to account for drugs and medical supplies separately, neither in the MoH nor in the MSD accounts<sup>29</sup>. Breakdown by account holder and item also seem to be problematic. This will need to be looked into

### 3.2.5 Communication

<sup>26</sup> Source: comment on the draft report by the MSD Logistics Adviser.

<sup>27</sup> Source: ibidem. According to MSD more than 1/3 of MSD's turnover is from customers who can buy outside of MSD but prefer MSD for reasons of value for money and good governance (no kick-backs)

<sup>28</sup> Source: ibidem.

<sup>29</sup> According to MSD separate statistics on drugs and medical supplies are available at MSD.

Two-way radio communication between peripheral health facilities and the district centre were particularly mentioned as very useful. It is being used for patient care, referrals and administrative communication. Staff at peripheral health facilities in particular appreciates this link as it reduces the sense of isolation. Misuse of this equipment is almost impossible, although placing the district centre radio in the DED's office instead of the district hospital, as is the case in one district, seriously undermines its usefulness.

The cascade supervision system as well as the ambulance referral system largely depend on this two-way radio communication system. If the cascade system and or ambulance referral system is proven to be cost-effective, there may be a need to roll out this experience to other districts nationwide. However, as some believe that these systems have not proven to be cost-effective in other Sub-Saharan countries (but experiences vary considerably), it would be wise to first critically analyse cost-effectiveness of these systems (including maintenance and sustainability), before rolling out. Also, if it is being decided to roll out the radio communication system, some additional work may be required on national frequency requirements for the radios, plus agreement on the vehicles, management training for the health centre staff in charge of supervision, and work on the content and the approach of supportive supervision (see further).

### 3.2.6 Capital development

Councils have no capital development and maintenance plan (health facilities, staff housing, infrastructure, equipment, furniture). Some councils have assessed their needs for building new and rehabilitating existing facilities and submitted the information to central level. They have however no information on how and when these needs would be addressed.

The RT has been informed that PORALG is working on a nation-wide rehabilitation plan of district health facilities. Also MoH is developing a ten-year development plan for hospital services. Progress has been documented in the 2001 and 2002 Joint Health Review Reports. The RT has no update on these developments.

The 2002 PER confirms that over 80% of total expenditure concern recurrent expenditure, moving away from development. Over the period reviewed, expenditure on development always falls way below the stated target.

A recent review of maintenance of facilities in 9 district hospitals in Kagera confirms the lack of infrastructure and maintenance, the absence of standardised equipment (e.g. 15 different nationalities of suppliers of hospital equipment). Some argue therefore for a fixed minimum percentage from the council health budget to be allocated to maintenance (including preventive maintenance).

## 3.3 ISSUES RELATED TO SYSTEMS DEVELOPMENT

### 3.3.1 Referral system

The RT found that only few patients are formally referred from dispensaries and health centres to district and regional hospitals. Formally means that the health worker sends the patient with a letter to the next level (and feedback exists from the higher level). A referral system with communication between health workers at different levels about referred patients is not in place in most districts.

Radio communication systems and availability of an ambulance at district level (sometimes even at HC level) improves the timely referral of critical patients. This was obvious in two districts visited. However records are only maintained on the cost-sharing aspects of patients referred by ambulance. Other aspects, such as using the experience of referred cases in teaching and supervision is absent.

### 3.3.2 Motivation of staff

SASE type of increasing salaries (which is roughly more than doubling the basic salary) is only limited to senior management staff and although supposed to be performance related it seems to be paid out bi-annually without proper performance assessment. SASE is only limited to some senior staff, which is likely to create some difficulties with other staff.

There is no structured performance based reward system for facility staff. However, there are some isolated initiatives such as a reward system for best supervision in the cascade system in Morogoro, and extra duty allowances in DES (said to be based on 'performance').

Allowances may benefit again mainly senior staff that already gets incentives such as SASE. Other aspects of staff motivation such as recognition for the good work, helping staff to perform better, cascade system of supervision and support, motorbikes, radio-system, training, improving the working environment, etc are used to some extent in some districts, but often without any comprehensive strategic approach. Funds do not allow for rehabilitation of housing, facilities, topping up salaries, etc..

Some experiences, especially those from Cambodia<sup>30</sup> and Egypt<sup>31</sup> on performance based incentives for health staff at facility level could be useful for Tanzania. Both systems are based on performance based incentives linked to the health facility team performance in service delivery, based on a transparent simple contract, a 'minimum standard approach' for facilities to be enrolled in the incentive system ('accreditation') and an independent regular assessment whether the services and criteria stipulated in the contract is adhered to (quality assurance function).

Linking allowances to routine activities that are part of a job description (e.g. meeting of the Finance Committee; annual planning; supervision; etc.) may provide the wrong incentives. Allowances should be linked to extra costs that are borne by staff out-of-their station (e.g. staying overnight during supervision; attending a seminar outside of the facility; etc.) or to performance (doing the right job right).

Some would argue that allowances are a hidden topping up of salaries and is considered a right and therefore difficult to change. The RT would advise to deal transparently with salary issues. If salaries are too low for staff to do their job right, this is a cross-sectoral issue that is best dealt with through fundamental civil service reforms. If this cannot be achieved in the short run and stakeholders are willing to top up salaries of health staff, it would be more efficient to link topping up (in whatever format, such as allowances) to performance.

### 3.3.3 Building community involvement

<sup>30</sup> Relevant literature from Cambodia is MSF Cambodia, The New Deal in Cambodia: the second year. Confirmed results, confirmed challenges. July 2002.

<sup>31</sup> Relevant literature from Egypt is MoHP, PHC Accreditation programme, Policies and Procedures Manual, 2002 and the Family Health Facility Implementation Manual, 2002.

Few districts have developed health services boards (HSB) and facility based health committees (Health Centre Committee –HCC- or Dispensary Committee –DC-). The Kinondoni experience (which is limited to an urban setting) seems to be positive and has led to communities being more involved in priority setting and bottom-up planning. Also these structures are used to pass on HSR messages and regularly discuss health related issues. Sense of ownership of health facilities by the HSB seems to have increased considerably. The RT has not had the opportunity to address the usefulness of these structures in any detail, but the CHMT recommended these structures to be rolled out in all districts.

The demarcation of roles and responsibilities of the Council Standing committee responsible for health (consisting of elected councillors) on the one hand and the not democratically appointed HSB is an area of concern to the RT. This needs to be addressed. The claimed added value of Boards needs to be made clear and evidence-based, since experiences in other countries indicate that Boards could consume considerable funds for meeting and travel allowances, becoming economies of their own, without adding much to quantity and quality of care.

On the other hand, if the government and stakeholders want communities to be more involved in local priority setting and taking responsibility for health, local health committee structures may be the way forward. The RT would advise against setting up multiple sectoral parallel structures de-linked of the LG structures. Therefore, if the Facility Health Committees is the choice already made, their link with the Ward Health Committee and the Ward Development Committee (and the Village Health Committee?) should be clear<sup>32</sup>.

In section 2.1.2.2 the issue of involving communities in planning has been discussed. While the RT is in favour of involving communities, it proposes a step-by-step approach whereby most emphasis is in the first place put on core business of health providers: quality of care.

### 3.3.4 Involving all stakeholders

Involving all stakeholders in the Council Health Plan remains a difficult process, which success varies by district and is often based on trust and individuals, rather than on systems development.

However, there are ways to ensure better involvement of stakeholders by building partnerships based on professional mutual arrangements. In Zambia for example the CHMT would contract NGOs, VAs and government health facilities based on a well defined service contract. The contract spells out which services a facility or organisation is supposed to provide and what resource envelope is provided. The advantage for both parties is that the engagement of each partner is clear and documented. It does not create false hopes (of unlimited resources being available) and gives each partner the right to claim what has been agreed (for example, avoiding that a DDH would get much less than the 35% of the basket fund). It also allows the CHMT to better manage service delivery provided by government and non-government providers and ensure that less duplication of services is done (e.g. a mission hospital close to a government district hospital providing the same services could not or only partially be subsidised or contracted)<sup>33</sup>.

<sup>32</sup> The Government Notice N° 224, published on 7/6/2002, under the LG (District Authorities) Act, 1982, provides the details of the establishment of the Council Health Service Board and Facility Boards in Shinyanga district Council. The responsibilities given to each of those committees is considerable. While the underlying idea may be laudable, the RT is not convinced that local communities can properly carry this full responsibility.

<sup>33</sup> ELCT is much in favour of these type of contractual arrangements or service contracts.

### 3.3.5 Public-private mix

The RT was informed that it is common that government health workers own or manage private health facilities like pharmacies and clinics. The potential conflict between the public and private interest of individual health workers was illustrated by anecdotal records of hospital staff delaying the availability of public medicines as this would reduce profits from their privately owned pharmacies. The RT was not able to review the legal and regulatory issues related to private for profit initiatives of government staff. If not yet done, the MoH should take up this issue as it may seriously undermine the effectiveness and credibility of government services.

In order to avoid potential conflicts and increase transparency, it may be wise to allow government doctors doing private work within the public health infrastructure during certain hours, after his or her government duty. Premises and equipment could be hired by the medical staff for private practice under a well-defined contractual agreement. This would increase public hospital revenue, while ensuring that private practice is more complementary to public duties. It is also a way to enhance private-public collaboration in health service delivery and allows for better quality assurance of private practice. Again, it would make it easier to include private-for-profit providers in the council health plan.

The RT is aware of the sensitivity of this topic and the need to carefully test contractual arrangements. Some countries do implement this type of public-private arrangement and claim it works better than previous arrangements where government doctors have private practice outside of the public facilities.

Another problem concerns illegal, not registered practitioners and pharmacies. According to ELCT these practices provide dangerous treatment alternatives. This underscores the need for proper and effective sector regulation<sup>34</sup>.

## 3.4 ISSUES RELATED TO SERVICE DELIVERY

### 3.4.1 Quality of services

In the visited districts and RMO-offices the above-mentioned “Quality Standards...” tool were not available, neither were other explicit Quality Assurance (QA) mechanisms. Districts reported to have been visited in recent years by MoH staff for the purpose of QA, but these were perceived as inspection by junior or inappropriate staff. A report of these visits by the MoH gives an overview of services in place, but does not provide information on quality of services measured against standards and clients’ perspective. Discussions with some senior staff of VA hospitals and DDHs, and a review of hospital annual reports indicate that there are no QA systems in place. It was indicated that at a national level, the crudest system of QA, based on clients’ complaints against medical personnel’s professional conduct, was not yet functional. The very few cases of staff suspended or sanctioned for malpractice should therefore not be seen as an indication of quality.

Reports from GTZ supported districts in Tanga Region, in which context the “Quality Standards...” tool was developed show that it is relevant and possible to introduce a QA system for district health services. This system does not only look at the availability of services, but also at its effectiveness and other crucial aspects. This experience shows that QA is a logical and necessary step to improve the effectiveness of health services. It cannot be

<sup>34</sup> Source: comments on the draft report by ELCT.

overemphasised that health services can contribute to reduction of poverty, only if the services are effective and cost effective. Poor quality health services, for which scarce household resources are spent at the expense of food and education, contribute to the cyclic relation between illness and poverty.

Since many resources are now in place in the district health facilities it is appropriate that QA becomes an integral part of health services. The QA experiences in Tanga Region will be very valuable in this process. Experiences in other countries, like in Ghana, where QA has been introduced nation wide will be highly relevant to Tanzania.

### 3.4.2 District hospital

The RT has not had the time to assess district hospital service delivery nor its quality.

The few district hospitals visited by the RT seem to function relatively well. Although this is obviously not a representative observation, the team members' knowledge of Tanzania's health service allowed to conclude that government district hospital services have improved in terms of available and used services in a number of districts. But there is still considerable scope to improve quality and cost-effectiveness of hospital service delivery.

As discussed in other sections in this report, quality of care and quality assurance are the core business that should receive more emphasis now.

Last year's technical review did also not cover district hospitals. This is probably an area that need a specific review next year.

### 3.4.3 Regional Hospital

The 2002 joint review concluded that the Regional hospitals are seriously under-funded and under-resourced and do not necessarily function as a realistic referral level for district hospitals. The 2002 joint review's recommendation to effectively consider the Regional hospitals as district hospitals as long as necessary resources cannot be provided is not realistic. However, the current situation is that Regional hospitals very often function as district hospitals, but at a probably very high cost. The current RT noticed that in Districts where the Regional hospitals doubles as District hospital, there is a much weaker link between the hospital and the CHMT and lower level facilities. This is an area to look into.

## 4 Supportive supervision, monitoring, reporting and auditing

### 4.1 SUPPORTIVE SUPERVISION

Supervision has increased dramatically with the provision of basket funds. The quality of supervision remains an issue of concern. In the districts visited by the RT supervision plans were in place, in some cases as schedules on the walls in the health facilities. Reports of supervisory visits were available in some, but not all visited districts. These reports were said to be send back to the facilities after the visit. The reports were not filed per facility, i.e. there was not a separate file for each facility, where the issues, follow up etc for that facility was

easily accessible. The concept of supportive supervision was known to several CHMT members and RMOs, but guidelines on supportive supervision were not available in their offices. The RT is aware of appropriate supportive supervision mechanisms in other Regions and Districts in the country, using simple but essential tools. These tools consist of one file per facility in the supervising office which can be consulted prior to a visit, and a standard form which indicates the reason for the supervisory visit, the specific areas, the observations, the action to be taken, by whom and when and signatures of supervisor and supervised staff. These “triplicate write through forms” are filled and signed at the end of visit. One copy is left at the facility, one copy is kept at the CHMT office and one is sent to the RMO. The value of these forms is that they indicate the commitment to take action by the various levels.

As mentioned earlier, supportive supervision can be strengthened through cascade supervisory systems, but this requires proper training of health centre staff in supportive supervision (a capacity that is still weak at CHMT level in many districts) and, based on the Morogoro experience, additional financial and other resource inputs.

## 4.2 MONITORING AND INDICATORS

The RT has been informed that LG is rolling out a Monitoring and Evaluation System to all districts. The system would cover all sectors at the local level and aim at assisting councils to plan more effectively and at providing relevant information to regional and Central level. The RT has had no access to this new tool and is therefore unable to comment on it or appraise its complementarity with (or potentially replacing) ongoing monitoring systems in health<sup>35</sup>.

There is a difference between indicators that are useful at national level for monitoring the implementation of the health sector reforms, poverty reduction strategies and SWAp instruments; and indicators that are useful for measuring district-based performance. Some indicators can serve both purposes. In the following discussion we look at both sets of indicators separately.

**District health services performance** is measured through district specific annual MTUHA data and through an ad-hoc (not yet institutionalised) NIMR performance assessment that is largely based on information provided by MTUHA but locally crosschecked. In some districts, impact on health indicators can be measured more accurately through population-based sentinel demographic survey systems.

As indicated earlier, quality of MTUHA data is poor and therefore indicators based on poor data are also likely to be incorrect. The initial ranking of districts based on the 2002 NIMR performance assessment did not always correctly reflect district performance as assessed during this review. This is not surprising given the poor quality of MTUHA data in most of the 5 districts reviewed. Without a major and focused intervention to re-orient the scope and the use of MTUHA at district level, performance measurement using MTUHA makes only sense in districts where data are reliable<sup>36</sup>.

Therefore, regarding monitoring district health service performance, the RT would advise the following:

- Re-focus the MTUHA to provide the minimum package of information required to manage district health services (see higher), complementary to other essential data

<sup>35</sup> The only report reviewed by the RT is LGRP, National Orientation workshop on Routine Data Systems, Paper presented on Monitoring and Evaluation, November 2002. This document is not very explicit about what type of data are to be collected and about the proposed procedures.

<sup>36</sup> The RT noticed also that in some districts MTUHA data do include regional hospital data, in other districts not. Sometimes it even varies between years in the same district.

provision systems (further developing the NSS). As stated before this should not be done by the HMIS department alone, but together with NSS, AMMP, TEHIP, NIMR and representatives of CHMT, RHST/RHMT and LG.

- Invest in training of health staff at council and facility level in the use of this information for decision-making. This requires additional investment.
- Critically review the list of NIMR indicators based on the above re-focus exercise.<sup>37</sup>
- Replace some of the less relevant indicators by some relevant quality assurance indicators that better reflect whether councils are implementing the right actions in the right way. Use the "Quality Standards & Criteria for District Health Services for the selection of QA indicators.
- Move away from health impact indicators (such as child mortality) that are based on facility reported data. These type of indicators can be much more accurately measured through SDS systems and are more relevant beyond the district level.
- Institutionalise the NIMR exercise as an annual performance review to be carried out by the Regional Health Support Teams on behalf of the Central Government. NIMR could support RHSTs initiating this new job and collecting district data for national comparison (which still could be done by NIMR). Timing of performance assessment should be linked to the planning cycle.

Regarding indicators, useful at national level there is need for more coherence and harmonisation of different sets of indicators proposed for the Public Health Sector Performance<sup>38</sup>, the proposed indicator list for PRS/PRBS/PRSC performance assessment<sup>39</sup>, PORALG proposed indicators, etc. It is inefficient to have different sets of indicators measuring more or less the same issues but using different specific data or indicators (e.g. definition of indicators on HIV, TB, family planning in the different sets of indicators) or having health related poverty indicators that are not reflected in the Public health sector performance profile.

There is obviously a need for government and stakeholders to agree on a final coherent set of national indicators and harmonise between different sets of indicators. This would require MoH, PORALG, main stakeholders and the ad-hoc PRSP Indicator Taskforce to sit together to agree on those indicators that are more or less but not exactly the same in the different indicators sets. As the PRSP indicators are still being discussed, this is the right time to agree.

### 4.3 TECHNICAL AND FINANCIAL REPORTING

Councils and CHMT complain that too many different reporting systems exist, both quarterly and annually. Apart from the technical and financial quarterly report (including the health basket fund which is still reported on separately in a so-called 'comprehensive' format; up to 2 weeks CHMT time per quarter), there is the quarterly MTUHA report (up to 1 week CHMT time per quarter) and the quarterly LG Reform report (1 day quarterly). In addition there are annual reporting requirements such as on PHC performance, poverty eradication (?), reproductive health and sometimes donor-specific reports.

Most of these reports have their specific format and even when duplicating reporting, information has to be provided on different time-consuming formats. Some formats are not clear: for example some districts do not know whether they should report only on activities

<sup>37</sup> In its August 2000 report on 'Performance Target setting in 37 first phase reform districts, NIMR rightly states that each indicator should be valid, objective, sensitive and specific. The RT would advise NIMR to critically review the present set of indicators in that light. In addition it would be necessary to review how much we can trust the underlying data, the relevance of each indicator vis-à-vis the main reforms, EHP and poverty reduction, and advise the users on how much these indicators can be influenced by health related and by non-health related factors.

<sup>38</sup> Public Health sector Performance Indicator Profile – indicator Table 2001.

<sup>39</sup> Indicators for Performance assessment in the context of the Tanzania Poverty Reduction Strategy, Proposal for discussion, 31 January 2003.

implemented during the previous quarter or cumulative for all activities implemented since January the 1<sup>st</sup>.

There is obviously a need for harmonising different reporting requirements and agree on a single comprehensive format for the health sector. In addition, reporting formats would have to be harmonised across sectors by PORALG.

Issues related with accounting records are dealt with in section 3.1.5.

Some councils are experiencing delays to submit their technical and financial reports on time because the regional hospitals that are entitled to 35% of the district budget (where the hospital is located) delay or fail to account for the funds. There is an obvious problem that regional hospitals are not sufficiently motivated to provide the district council with the relevant information on expenditures made, especially for the council health basket fund. This seems to be mainly a question of authority (and probably lack of interest of regional hospital staff in district activities) and may require the need to separate regional hospital basket funds from the council health budget. This has been discussed more in detail in section 3.1.1.

Other delays are due to the separate technical and financial reporting process, as the CHMT has no accountant. Workload of LG accountants that need to provide quarterly financial data on multiple sectors may increase considerably when other sectors will come 'on stream'. While there will be a need for PORALG to harmonise quarterly reporting requirements for all sectors, there may be a need to increase accountant staff in some districts and make specific accountants responsible for specific sectors.

#### 4.4 TECHNICAL AND FINANCIAL AUDITING

There is duplication of the auditing process. The BF (credited on account n°6) is audited by PWC on behalf of the CAG (now called the National Audit Office) who formally approves the audit report. Government funds (also on account n°6) are audited by the CAG. This is inefficient use of auditors as both audit the Account n°6, but only partially<sup>40</sup>. There is a need of streamlining the process in the form of joint audit exercises.

The current Terms of Reference for auditors is not based on a holistic and comprehensive approach of the basket fund to the districts. The Terms of Reference requires the verification of separate basket funds within the mixed account No. 6. There is a need to review the Terms of Reference of Auditors of the basket funds if a holistic approach of basket funds is expected.

The financial auditing process as described above conventionally focuses on the questions whether funds have been spent according to approved procedures and whether acceptable unit costs have been used. Cost effectiveness of expenditure is usually not looked at. Several QA systems nowadays add a cost effectiveness component to the regular auditing exercise. This will be highly relevant for the CHMTs as their autonomy to purchase increases, while their technical expertise might lag behind in some cases. A cost effectiveness audit would provide valuable information to the CHMTs, the RS, PORALG and the MoH to improve or maintain cost effectiveness. Such an "add on" to the regular audit exercise could be considered for a limited period of time for a limited number of districts as a learning exercise. The regional level could progressively take up the technical component of the audit, as part of a joint exercise with the financial auditors.

<sup>40</sup> Two separate accounting exercises of part of the expenditures made from the N°6 Account (government versus basket funds) inevitably introduces the possibility of errors, as reported expenditures can eventually shift from one to the other type of expenditure, depending on the 'best fit' for that particular auditing exercise.

## 5 Support structures

### 5.1 THE ROLE OF THE RS AND THE RHMT

The 2002 Joint Health Sector Review concluded that the Regional level has been largely bypassed in the efforts to develop decentralised health services. Bypassing the Regional level might be understandable as most emphasis was initially put on LG and thus CHMTs' role and capacity. This review team is, like the previous review team, of the opinion that not much progress in management of district health service delivery can be expected if the CHMTs are not closely supervised and supported. The RS and in particular the RMO<sup>41</sup>, being the extended arm of central government ministries, are the obvious authority or agency to provide this support. Some different job descriptions for RMOs are circulating, but the most recent one<sup>42</sup> stipulates various tasks, which merely concentrate on supporting the planning and management tasks of the CHMTs. This job description is based on the principle of a demand driven assistance in which the LG indicates what support is needed and when. The RT strongly supports this explicit job description and its demand driven principle. And considers this supporting role as crucial for future district health development. However, the RT has observed that many RMOs are not aware of their newly expected role and that several are certainly not equipped for it. This is for example illustrated by several RMOs who still see clinical duties for individual patient care as part of their work.

According to the above job description the health support role of the RS will encompass at least the following tasks (based on an average of six Councils/CHMTs per region) per year:

- supporting 6 planning sessions with CHMTs of 2 weeks each
- 24 quarterly CHMT reporting sessions of 1 day each
- advocate and monitor the implementation of central government policies by CHMTs in the field of health promotion, prevention, medical care, nursing care, pharmaceuticals, laboratory diagnostics and other fields
- coordinate all health activities and interventions which go beyond LG level or cross district boundaries, like public health and environmental activities, epidemic control, training and continuing education, Voluntary Agency hospital care, health services research and projects
- identify and mobilise complementary financial and other resources for LG health activities
- coordinate with other sectors where the main determinants of health are located (agriculture for nutritional status, education for sexual and reproductive health, water and sanitation for under five mortality)
- prepare RS's sectoral quarterly, half yearly and annual progress reports

The RT would propose to add the following tasks:

- quarterly or bi-annual district peer review meetings where CHMTs present activity and performance data and discuss how performance can be improved
- compile and analyse district performance data, and feedback to district council
- support CHMTs in specific technical areas (new policies, new techniques, new modalities) in order to keep CHMTs up to date with evolving modalities and technology of health care
- do quality assurance of district health services on behalf of the central government

<sup>41</sup> The term RMO is used for this position although different job titles are used in different policy documents

<sup>42</sup> In "Restructuring Regional Administration, Job Descriptions for Staff in Regional Secretariats, PORALG, January 2003

- asses (together with the RS) and approve CHPs on behalf of the central government
- participate in the annual technical and financial audit, for the technical part

Conventional knowledge of the health sector leads to the conclusion that about three senior health professionals are needed to carry out these tasks in a satisfactory manner<sup>43</sup>. This conclusion contrasts sharply with the currently proposed number of only **one** “Medical Officer (Public Health)” as member of the RS. The RT noted with surprise that the education sector will have three RS members, while the health sector is much more complex in terms of rapidly changing technology, human resources, diversity of actors and sources of funds. The RT is fully aware of the need to keep the RS as small as practical, to avoid the creation of central ministry duplications. However, not being able to carry out above minimal tasks will seriously compromise RS’ role and thus CHMTs’ performance. It might also necessitate the central MoH to provide technical assistance on a regular basis which contravenes the principles of decentralisation and has proven to be not cost-effective (e.g. follow-up of implementation of IFMS (platinum<sup>44</sup>) at district level). The RT therefore strongly recommends to reconsider the number of public health professionals in the RS. The professional backgrounds needed to cover these tasks will include a Medical Officer with public health specialisation, a senior Nursing Officer and a senior Environmental Health officer. These professionals must have a proven interest and a track record in planning and monitoring health interventions and in providing support supervision<sup>45</sup>. The RT proposes to change the concept of Regional Health Management team (RHMT) into a Regional Health Support Team (RHST) as part of the RS, as the main task of this team is to provide demand-driven support to CHMTs and not to manage services. The MoH however prefers to keep the wording of RHMT<sup>46</sup>.

The RMO’s job description list as one of its main activities the identification and mobilisation of additional technical support to assist the CHMTs. For this purpose, and if the RHST/RHMT has not the technical competence in-house, short term assistance could be provided by the Regional Hospital, for example by the hospital pharmacist or the chief laboratory technologist. For training needs expressed by the CHMTs which cannot be met by locally available capacity, training institutes like the Zonal Training Centres can be called in.

Some district health development projects have for several years focused on strengthening RMOs and their teams<sup>47</sup>. These experiences are very valuable and should be used in further strengthening efforts. The coverage of these interventions is currently limited to 4 out of the 20 Regions. The RT recommends that an intervention will be developed with the objective to improve the capacity of those RSs that are not covered. This intervention should obviously be based on above experiences.

In order to correctly take up this new role, the future staff of the RHSTs will need a different profile and attitude as compared to their previous roles. They will have to be de-linked from the regional hospital, be a full-time technical support team without clinical obligations<sup>48</sup>, no longer be ‘controllers’ but ‘supporters’, ‘back-stoppers’ and ‘skills-builders’. The basic principle will be that demand for their services should originate from the CHMTs. On the other hand, RHSTs also have a responsibility that goes beyond district borders and a job to do on behalf of the Central Government. Therefore, RHSTs will also have to be pro-active regarding some of these central assignments and to be good ‘sales(wo)men’ selling their services at CHMTs.

<sup>43</sup> Some argue that 3 professionals may even not be sufficient as regional staff are often occupied with seminars and workshops and therefore not full-time available for their core-business.

<sup>44</sup> Source: PORALG, Progress of the implementation of the PLATINUM system in LGs, April 2002

<sup>45</sup> The RT is of the opinion that HMIS data management does not require a full-time post within the RHST/RHMT. Data compilation and management within the RS can be organised cross-sectoral. Analysing data is the job of the health professionals of the Regional Health Support Team.

<sup>46</sup> The MoH argues that “supportive” is used for non-professional, not technical staff. Moreover, all legal documents refer to the RHMT. Therefore the text has been corrected throughout the report and the concept RHST has been replaced by RHST/RHMT.

<sup>47</sup> Like TEHIP and the Tanga, Mbeya and Kagera district health projects

<sup>48</sup> The same viewpoint is expressed in the debriefing note (21<sup>st</sup> February 003): Feasibility Study for the Development and management Plan for Kagera regional Hospital.

## 5.2 THE ROLE OF THE ZONAL TRAINING CENTRES

The four Zonal Training Centres (ZTC) in the country have traditionally been responsible for continuing education for various cadres of health staff. Although most courses were focused on clinical skills, some ZTCs have developed a broader range of courses, including health services management courses. Iringa and Arusha ZTC have been instrumental in training CHMTs and LG staff in utilising the new District Health Management guidelines. These two ZTCs have received considerable support from donors over several years, but most importantly the leadership in these institutions has shown vision and initiative. The experiences show that the ZTCs can play an important role in training and continuing education of all cadres of health staff, especially when new skills and roles are being introduced. The experiences also show that the ZTC can only play an effective role if there is leadership and sufficient funding. It is obvious that those two features are related as leadership is often seen as a precondition for investment.

It should be noted that capacity and leadership of ZTCs varies considerably and capacity building needs will therefore vary between schools and need to be addressed on a case-by-case basis.

The RT was informed that one development partner is considering to invest in the ZTCs. This is a laudable initiative, but the MoH, who is formally responsible for the ZTCs, should ensure the necessary level of leadership to make these investments fruitful. Lack of concerted coordination and use of these (too few) centres is well recognised at the MoH. **According to the RT capacity of RHSTs, CHMTs and LG staff in health planning and management will only improve considerably if continuous support is provided by RHSTs and if ZTCs offer the necessary short-term skills-building training modules in planning, management and quality of care.** ZTCs have a major role to play in continuous education and probably in the whole area of health worker training.

## 6 Advocacy of the reforms

The RT has been informed that health sector reform advocacy materials are being developed by the MoH and distributed up to district level. Other means such as radio and TV messages have been developed and are regularly broadcasted. The RT has not had the opportunity to assess the quality of the materials or appraise media messages.

During the field visit, the RT has not come across any ongoing or reported activity on health sector reform advocacy. In the districts visited, advocacy materials were not readily available. Even if available, information on the HSR is not getting down beyond the district headquarter level. Awareness materials are not distributed below district level. Staff are not trained in how to do advocacy and use the materials.

The only reform messages (exceptionally) observed at facility level concern cost-sharing (these posters were even present in facilities that do not apply cost-sharing). It is not surprising that communities equal reforms to cost-sharing, as reported in the PER 2002. According to the health staff and CHMTs interviewed, many facility based health workers equal health sector reforms mainly with retrenchment.

The RT has been informed that collaboration on LGR and HSR messages between PORALG and MOH was more effective in the first wave of phase I councils, but has cooled down now.

There is obviously a need to re-think how advocacy of the reforms can effectively reach both the providers and the clients. LG structures such as Ward and Village Health committees are underused in getting HSR messages across. District health staff should be trained in how to pass HSR messages in stead of only receiving leaflets from the center. And media campaigns could probably be made more attractive to the target public (soap operas; Rap songs, etc.). Maybe some lessons can be learned from the private sector publicity companies.

Some argue that it would be me more appropriate to wait with broader advocacy of the reforms until service quality has sufficiently improved, in order not to create false expectations at community level. While this may be one rational approach, it basically confirms that health reforms are perceived as mainly a technical & managerial reform without much involvement of the community. A different approach could be to make the community partly responsible in implementing the reforms successfully by holding the health staff accountable to the community. The latter approach would of course need a well informed community.

## 7 Main recommendations

Let us keep our ambitions and expectations of rapid changes in health status and health service delivery at a realistic and modest level. But let us use the positive experiences to move forward. And let us build on what we have achieved so far. **How can we move forward?**

The main recommendation from this review is to **focus on service delivery and quality of care** (shifting the focus from too much emphasis on planning and management towards more emphasis on service delivery and quality of care). Improved service delivery requires:

- *a shift of attitude of CHMTs towards service delivery;*
- *a planning, budgeting, reporting process that supports service delivery;*
- *demand-driven, regular and specific technical and managerial support to CHMTs from a skilled regional level;*
- *access for CHMT staff to specific, skills-building oriented, short-term, modular training from Zonal Training Centres;*
- *an environment that is conducive to quality service delivery, including skilled, motivated human resources; appropriate and well maintained infrastructure, staff housing and equipment; sufficient financial resources*
- *greater involvement of and accountability to facility based health staff and communities;*
- *re-focus of performance assessment tools and procedures on quality of service delivery.*

### 1. Focus on service delivery

- Focus on the core business of health providers, which is quality service delivery (promotive, preventive and curative care based on the EHP). The time invested in planning, budgeting, reporting, supervision, training, data collection for HMIS, meetings, involving communities, etc. should primarily support service provision. LGs and CHMTs should in the first place ensure that health services of good quality are delivered in the district.
- Use the effort invested in planning and reporting to move towards coherent prioritised activity plans that improve service delivery. Move progressively from theory (mainly planning to get financial resources) to practice (planning for better health and better health services accessible to all). Link the CHP to departmental activity plans (e.g. the activity plan of the officer responsible for reproductive health). Move from a district plan, mainly developed for central level information requirements and for acquiring funds, to a district plan that is useful at district level (see section 2.1.1.1 for details). Do not spend more time on planning and reporting (rather reduce than increase time invested), but use the invested time more effectively in order that the core business of health providers (delivering services of good quality) is sufficiently addressed by the CHP.
- Review all policy guidelines in a comprehensive way and come up with one coherent set of policy guidelines, translated into a user friendly, easily updateable format for use at facility level. The list of guidelines should be critically reviewed and a selection of up-to-date documents relevant to the different levels should be made. The list of these relevant documents and the documents themselves should be made available to the CHMTs and through these to the health facilities. By doing this the MoH will perform its

core task, setting and disseminating national standards. During support supervision by the RHST/RHMT the list and documents available can be regularly updated (see section 2.2.1 for details).

- In line with the above recommendation (and although not directly linked with improving service delivery) there may be a need for the MoH to create a communication section at central level (e.g. by expanding and strengthening the present MoH library). This unit could assemble and catalogue all MoH publications, reports, guidelines, etc. It would keep records of all updates and reviews of existing guidelines and reports. It could coordinate the website and act as a clearing house for all policy related materials.
  - Measure achievements and quality in service delivery (see performance assessment below). Develop quality assurance tools (use the Quality Standards & Criteria for District Health Services, 1999 as the main basis as well as GTZ experience). See section 3.4.1 and 4.2 for more details.
  - Develop more creative ways of public-private partnership through contracting arrangements and allowing private practice to take place in public facilities. These ideas are further developed in section 3.3.5 and 3.3.4.
2. *Make planning, budgeting, reporting guidelines and processes more supportive to district service delivery*
- Review planning and budgeting guidelines to come up with a harmonised set of guidelines for comprehensive health planning, budgeting, reporting and procurement for all resources, both government and basket funds (if possible harmonised planning guidelines and reporting formats for all sectors through PORALG – an initiative PORALG is working on already for budgeting and disbursement guidelines).
  - From a pragmatic point of view, and not to further confuse CHMTs, the RT would refrain from fundamentally reviewing or changing again the **planning format**. If changes need to be made to the format they are marginal and would rather have to simplify the format than making it more complex. Rather, the **planning process and the use of the plan** should be looked into, in order to make this a more useful instrument to CHMTs.
  - Strengthen the planning and budgeting process in order to become a real comprehensive and integrated exercise, useful to the CHMT and PORALG. This requires ongoing effort, regular support to CHMT and LG through RHST/RHMT and RS, and will take time. See section 2.1.2.1 for details about what comprehensive planning entails.
  - Review the annual priority setting procedures for the CHP. Combine a minimum set of MTUHA data with Burden of Disease data to decide on what priority health problems need to be tackled through which cost-effective interventions. This priority setting does not need to be repeated every year at district level. See section 2.2.3 for how priority setting in CHPs could be improved.
  - Review and to some extent release the restrictions put on the use of the basket funds and develop a coherent set of guidelines for use of both government and basket funds. Allow the funds to be used for essential and pro-poor activities or expenditures. Allow district councils to defend their case if restrictions are not adhered to in their plans. See

section 2.1.1.1 and 2.1.1.2 for details. The RT's advise on how to change the ceiling approach is explained in annexe 1.

- De-link regional hospital basket from district council basket. This recommendation requires careful consideration. The rationale and possible alternative approaches to solve this issue are discussed in section 3.1.1. If the contractual approach is retained as the future option (CHMTs contracting providers), the regional hospital budget could remain within the council health basket.
- Initiate comprehensive joint auditing of Account n° 6 by CAG and external auditors (see section 4.4).
- Consider moving away from a purely financial auditing to combining technical and financial auditing with a focus on cost-effectiveness (see section 4.4).
- Consider using the TEHIP accounting tool in all CHPs (see section 2.1.1.2).
- Consider co-opting responsible LG accountant staff in the CHMT during planning, budgeting and reporting exercises. Develop appropriate job description.
- Strengthen use of IFMS / Platinum and adapt IFMS to adequately address district health income and expenditure. Invest in accurate record keeping at Council level.
- Consider introducing contractual arrangements between CHMT and service providers (see section 3.3.4).

3. *Support the districts and CHMT in achieving change through more effective regional support by the RHST/RHMT and through skills-building by the ZTCs*
- Take a longer-term view on step-by-step capacity building, taking into account the limited capacity at district level.
  - Build capacity at CHMT through a) regular support from RHST/RHMT and RS; and b) through short term modular skills based training from the ZTCs.
  - There is a need for both demand-driven and pro-active continuous support from regional level: integrate the Regional Health Support Team (RHST/RHMT) as part of RS. The RT therefore strongly recommends reconsidering the number of public health professionals in the RS. The professional backgrounds needed to cover these tasks would include a Medical Officer with public health specialisation, a senior Nursing Officer and a senior Environmental Health officer. These professionals must have a proven interest and a track record in planning and monitoring health interventions and in providing support supervision. Major investment in skills building of, support to and change of capacity and attitude of present RHMT staff will be required. Possible job description of the RHST/RHMT is proposed in section 5.1. Developing the RHST/RHMT capacity as part of the RS will require additional investment.
  - Some district health development projects (e.g. Tanga, Kagera, Mbeya) have for several years focused on strengthening RMOs and their teams. These experiences are very valuable and should be used in further strengthening efforts. An intervention should be developed with the objective to improve the capacity of those RSs which are not covered. This intervention should obviously be based on above experiences.
  - Set up a full network of ZTCs throughout the country. Build the capacity of the existing ZTCs to be able to provide short-term skills-building courses especially for CHMT and RHST/RHMT, but also for the ZTCs to become the main schools for continuous education and health worker training. Canada is willing to support a MoH led consultancy to assess the feasibility and the needs for such a network. More investment will be needed to build the right capacity at each of the ZTCs. This issue is briefly discussed in section 5.2.
  - Make comprehensive analysis of lessons learned from longer term 'projects' (TEHIP, Kagera, Tanga, ...), roll out positive experiences making use of ZTC modular training courses, district peer reviews organised by regional level (examples are the cascade supervision system, quality assurance model, the radio call systems, etc.).
  - Strengthen supportive supervision and roll out existing supervisory tools (see section 4.1).
  - Clarify the role of the LGRT in supporting HSR. Neither RMOs nor CHMTs understand clearly the role of the LGRTs.

4. *Invest in a conducive environment for quality service delivery*

➤ 4.1 Invest in the main resource of the health sector: human capital

- Assess the implications of the 1999/2000 standard establishment norms (and their application) at council level. Review whether the norms need to be readjusted in function of workload at facility level and of skills needed. The Civil Service Department should grant permission to fill the posts in an equitable manner (and not only based on how well the case is defended by the district council).
- Consider introducing performance-based incentives linked to service delivery. Consider de-linking allowances from routine planning, management, supervisory and teaching activities that are part of senior staff job description (especially for staff already getting SASE benefits). If stakeholders are willing to pay allowances, it would be more efficient to use these incentives to improve performance. Some international experiences of performance-based incentives are briefly described in section 3.3.2. The RT is aware that new policies on incentives may require cross-sectoral decisions. This should not stop PORALG and MoH from testing its feasibility and appropriateness in one sector, in order to develop the experience for other sectors.
- Allow councils to use government and basket funds to motivate staff through non-financial benefits (staff housing; two-way radio; rehabilitated facility; transport means; capacity building training, etc.).
- Consider decentralising authority on staff matters to district councils. If too early in the reform process, introduce measures to motivate councils to manage health staff efficiently.
- Do a comprehensive analysis of skills and manpower needs at district level (both at CHMT and for health workers). This training should be based on a comprehensive training needs assessment done with support of the RS – RHST/RHMT Team and in consultation with the MoH's HRD department. Districts should develop staff development and training plans. See section 3.2.1.
- Irrespective of the outcome of the policy discussion on the number of health staff in the RS, a similar training needs assessment needs to be done at Regional level. In addition a careful appraisal needs to be done to assess the capacity, skills and motivation of RMOs and other regional health staff.

➤ 4.2 Invest in appropriate infrastructure and equipment

- PORALG to speed up the development of the capital investment / rehabilitation plan. See section 3.2.6.
- Government and stakeholders to agree on the future resource envelope and the mechanisms to finance the plan .
- The capital investment plan should include major equipment and staff housing.
- Consider setting a minimum percentage for annual council health resource allocation (government and basket funds) for (preventive) maintenance of buildings and equipment.

➤ 4.3 Provide sufficient financial resources versus the expected outputs

- Allocate resources in an equitable manner (both government and basket funds) through a single resource allocation formula. See section 3.1.1 for comments on the resource allocation formula.
- Consider additional government and basket funds for rehabilitation of facilities and staff housing (and if agreed, also major equipment such as two-way communication systems). See section 3.2.6 and 3.2.5 for the rationale.
- Consider whether and when budgets for drugs and transport could be decentralised to district level. This would mainly require a shift from the central basket to the district basket fund; and the development of strict guidelines and control mechanisms. The rationale is explained in section 3.2.2 and 3.2.4.
- Do a study on how resources should be allocated by the CHMT between different government and non-government facilities. Review the criteria and set guidelines for councils to develop service contracts with providers. See section 3.1.2.
- Assess whether the PRSP targets are achievable within the present resource envelope and decide on whether additional financial and other resource inputs are necessary and feasible in the medium-term and/or whether some of the targets should be reviewed. See section 3.1.2.

5. *Involve facility health staff and the community more and in a structured way*

- Increase transparency on resource use by publishing district health budgets and informing facilities (and communities) about their financial resources.
- Increase accountability to health staff and communities by publishing annual district health performance data. Use this mechanism to have informed discussions with health staff at and communities, and by doing so build local capacity step-by-step (rather than by involving communities too quickly in planning and priority setting).
- Involve the community step-by-step in local planning of health services based on locally perceived needs and make communities step-by-step more responsible for their health through the planned HSB, HFCs linked to the LG Committees. Ensure that local health staff have the capacity to plan and manage health services well, before communities are given too much responsibility. And ensure that local health staff focus on quality of care in the first place. See section 3.3.3.
- Reinforce the advocacy of the reforms up to community level. See section 6.
- Improve regular communication between PORALG and MoH on pertinent developments in respectively LGR and HSR. This could become a permanent agenda item for basket meetings.

6. *Review performance assessment tools and processes*

- Review the health performance assessment procedures. Re-focus MTUHA to provide a minimum package of information relevant to district managers. Invest in quality of data collection and use at district level. The MTUHA department together with other

interested partners (NSS, AMMP, TEHIP, NIMR, RHST/RHMT and CHMT/LG representatives, etc.) should review what minimum information should be provided by MTUHA and what complementary information could be provided through an extended NSS (making use of all existing DSS). Rationale and approach are explained in section 2.2.2 and 2.2.3.

- Review the NIMR performance monitoring methodology. Combine relevant indicators built on reliable data with quality assurance data. Consider the use of quality assurance of services implemented as performance measurement as long as quantitative data collection is not sufficiently reliable. Institutionalise annual council health performance assessment and quality assurance through the RHSTs, as this structure is the closest to the district council level. This is further explained in section 4.2.
- Integrate the consumer's perspective in evaluating health services. This should be part of the quality assurance tools.
- Government and stakeholders will have to agree on a final coherent set of national indicators and harmonise between different sets of indicators (e.g. 26 indicators of the Public Health Sector Performance, the proposed indicator list for PRS/PRBS/PRSC performance assessment and PORALG proposed indicators at council level). This is discussed in section 4.2.
- Invest in data collection, management and decision-making at all levels, but primarily at facility and district levels. This should be a major task of the future RHSTs.
- Regarding the annual technical and main review process, the RT would advise that during the main review, government and partners decide which topics would need more detailed technical analysis before the next main review. The agenda and TORs should be decided immediately after the main review in order to allow for sufficient time during the following year to address these issues in-depth. For example the review of district health services performance of 2003 would have benefited from more time and a larger sample of districts to come up with sufficiently informed recommendations. As mentioned in the introduction of this report, the RT has not had sufficient time to deal in-depth with some major issues that affect quality of service delivery at district level (e.g. human resources, community involvement). These aspects would require a more in-depth analysis. Therefore the RT would recommend to have the technical review organised in a somewhat different way: in-depth, well-focused and well-resourced studies or evaluations carried out during the year preceding the main review that would inform the main review.

And lastly, the RT would recommend the MoH, PORALG and stakeholders to make use of the present momentum. Take some important decisions and set relevant milestones during this main review, in order to set the agenda for improving service delivery and quality of care. Ensure that decisions made are translated into appropriate strategies and action in the National Health Strategic Plan (2003-2006).

It is the opinion of the RT that some of the recommendations made at the end of this report would have to become conditional for continuous partners' support to the sector. This may be the only way avoiding that a number of critical actions that have been proposed and agreed upon, are repeated again every year.

The Review Team  
March 2003

**Annex 1. Proposals for adapting the procedures regarding the use of council health basket funds.**

Reduce the number of restrictions linked to the basket funds and consider using the same guidelines for both government funds (OC and basket funds, including or not internal revenue).

Consider having a separate district basket fund for rehabilitation, capital development (or allocate a specific budget from the central basket fund). This can be the same fund and the same funding channel. For example, the district basket funds is increased up to 1,00 USD per capita of which 0.5 USD is for service delivery and 0.5 USD is for capital development (major rehabilitation). Guidelines would have to be developed for both types of expenditure.

**Guidelines for the health service part of the district basket plus government health service funds (OC):**

**Guidelines for expenditure by level of the health system:**

- Resources should be spent at all levels of the system (spell out the same levels as before).
- Do not spend more than 10% at the level of the CHMT.
- Do not spend more than 35% at the district hospital level.
- If more than one hospital in the district, do not spend more than 40% on all hospital services (decide locally on the repartition key between both hospitals; in principle, the resource envelope available to each hospital, the role of each hospital and the workload should guide the decision on how to allocate the resources).
- Spend at least 55 % (50 % if two hospitals are available) at all levels below the district hospital (include all levels: HC, dispensary, community).
- Spend at least 5% at community level.
- If you want to spend more than 35% (or 40% if two hospitals) for hospital services or more than 10% at CHMT level, you have to defend your case.

**Guidelines for expenditure by type of expenditure:**

- Government and council health basket funds can be used for all health services related expenditures that aim at improving service delivery, with the exception of:
  - o Salaries, wages, and other payroll benefits.
  - o Capital development (this item would preferably be financed from a specific rehabilitation fund; explain the concept and state clearly what type of expenditures they cover).
  - o Major rehabilitation (this item would preferably be financed from a specific rehabilitation fund; explain the concept and state clearly what type of expenditures they cover).
- Government and council health basket funds can be used for all health services related expenditures that aim at improving service delivery, including the following items, but only upon specific agreement:
  - o Longer term training (e.g. computer training); this is called 'capacity building initiatives' in the previous guidelines
  - o Fixed assets such as motorbikes (provide a specific list of items for which specific agreement is required; or a unit cost ceiling –e.g. 2,000 USD- above which a specific agreement is required).
- Government and council health basket funds can be used for all health services related expenditures that aim at improving service delivery, including the following:
  - o Provide a positive list.

Develop specific guidelines for the capital development fund.



## Annex 2. List of literature

### MoH

- Procedures Manual for the Joint Disbursement System for Council Health Basket Funds, February 2000
- Format of a Prototype of a Comprehensive Council Health Plan, March 2001
- Planning guide for Local authorities regarding utilisation of Health Basket Grant, August 2000
- Ministry of Health Vote 52, Medium Term Expenditure Framework 2002/2003-2004/2005, July 2002
- Tanzania Joint Health Review, Main Report, March 2002
- Tanzania Joint Health Review, Technical Report, March 2002
- Technical report of the Joint MOH/Partners annual review of the health sector, March 2001
- Main Report of the Joint MOH/Partners health sector review, March 2000
- Main Report of the Joint MoH/Partners of implementation progress of health sector plan of action 1999/2000 and appraisal of the proposed health sector plan of action, 2000/1
- Situation analysis ( three reports, one for each phase)
- Monitoring and Evaluation Indicators for the Health sector prepared jointly by MoH/Partners 2001
- Comprehensive Annual Health Plans, phase I & II (sample)
- Progress reports from councils (sample)
- Planning of District HIV/AIDS Programmes (Tanesa / NACP)
- National Mortality Burden Estimates for 2001 (NSSS, AMMP)
- The State of Health in Tanzania, 2001 (Institute of Public Health)
- Burden of Disease Profile 2000, Coastal Zone (TEHIP)
- Burden of Disease Profile 2001, Coastal Zone (TEHIP)
- Performance Target setting in the 37 first phase reform districts, August 2000 (NIMR)
- Situation Analysis of 45 districts under phase II of the Joint Health Sector / Local Government Reform, March 2001 (NIMR)
- Situation Analysis of 31 Councils under Phase III of the Joint Health Sector / Local Government Reform, June 2002 (NIMR)
- Quality Assurance Supervisory visit report in 20 regions of Tanzania Mainland, March 2001
- Quality Standards & Criteria for District Health Services, February 1999 (GTZ)
- District Health Accounts Tool, Instruction Manual, June 2003 (TEHIP)
- Review of the Health Management Information System, March 2000 (HERA)
- Evaluation of the cost sharing programme implementation (health services user fee) in the public hospitals in Tanzania, April 1999

### PORALG

- Developing a system of intergovernmental grants in Tanzania (Block grant study), January 2003 (George State University)
- Draft revised LG restructuring manual, Jan. 2003
- RS planning and management guide, Nov. 2000
- Framework for participatory district planning and budgeting, 2001
- Public service act, July, 2002
- LGRP-study on implications of Public Service act on LG staff, November 2002
- LGRP MTP 2002-2005
- LGRP work plan 2002-03
- Decentralisation in Tanzania, WB, March 2002
- Fiscal decentralisation in Tanzania, IMF, October 2001
- Local Government (District Authorities) Act 1982, Government Notice N° 224, published on 7/6/2002n The Shinyanga district Council (Council Health Services Board establishment) Instrument, 2001

- LGRP, National Orientation workshop on Routine Data Systems, Paper presented on Monitoring and Evaluation, November 2002.
- RS institutional strengthening programme, September 2002
- Local Government Act. August 2000
- Progress of the implementation of the PLATINUM system in LGs, April 2002
- RS planning and management guide, nov. 2000
- Framework for participatory district planning and budgeting, 2001
- Public service act, July, 2002
- Review of the LG service regulations 2000 and the draft public service regulations, December 2002
- LGRP MTP 2002-2005
- LGRP Work plan 2002-03
- Decentralisation in Tanzania, WB, March 2002 (softcopy only)
- Appraisal study of the organisational development needs of the RS, June 2001
- RS, Restructuring regional administration, Job descriptions for RS staff, June 2000
- PORALG PER April 2002

### **Other sources**

- Discussion paper on move from health sector basket funding to budget support (not dated).
- Some thoughts on resource allocation to councils for health. A commentary on "Developing a System of Inter-Governmental Grants in Tanzania", (not dated).
- Indicators for performance assessment in the context of the Tanzania Poverty Reduction Strategy, January 2003
- Human resource Studies in Health for Poor and Transitional Countries, draft conceptual paper, January 2003 (Charles Hongoro et al)
- Human resources for Health: Requirements and Availability in the context of scaling up priority interventions in low-income countries (Christoph Krowski et al)
- A study to determine the key components of a cost-effective transport system to support the delivery of PHC services (Abt Associates & Riders for Health)
- The New Deal in Cambodia. Confirmed results, confirmed challenges, July 2002 (MSF Cambodia).
- The Family Health Implementation Manual, 2002, MOHP Egypt.

### Annex 3.

## TOR for Technical Review of Health service delivery at district level.

### Background

As in input to the Annual Joint Health Sector Review it has been decided to conduct an independent technical review of the district health services.

### Objective

- To review the health service delivery at district level with a focus on major overall achievements, weaknesses, challenges and opportunities as well as last year's performance.
- To assist in preparing the Main Review Report

### Scope of work

The Technical Review should have the perspective of the managers of the system at district level and below, in terms of constraints and usefulness of policies and guidelines and focus on opportunities and constraints for creating an enabling management environment including improving the incentive structure for staff and institutions. The Team needs to consider not only health specific guidelines etc. but in the context of decentralisation and public sector reform also guidelines from other ministries particularly PORALG.

The Review should also take into consideration the perspective of the consumer in terms of felt need and health seeking behaviour.

In addition the Team Leader will assist during the main review with the preparation of the Main Review Report. In this matter he will report directly to the responsible officer from GOT.

The is a diagnostic review and not intended to be an in depth review. The main scope is:

- In general to identify major achievements, weaknesses, constraints and opportunities in relation to district health services, preventive as well as curative. In this context the Team should indicate a way forward to deal with the major problems identified and to exploit the opportunities.
- Specifically to outline a way forward in terms of improved health policy, technical guidelines, planning & budgeting guidelines, tools for monitoring and supervision and changed management modalities. The recommendations will provide inputs to New Strategic Health Plan 2003/2006.

Based on an initial briefing with MOH, PORALG and Partners the Review Team will prioritise and further focus the work.

This may include recommendations on further technical work to be carried out.

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

1. Assess, mainly based on existing documentation, the trend in performance of the Districts in terms of outputs and outcomes.
2. Assess appropriateness of current general guidelines and policies for improving quality of services at district level in terms of content of individual guidelines, number of guidelines and consistency between them. This does not include an in depth assessment of the medical technical content but should focus on the guidelines as management tools.

3. Specifically review the appropriateness of planning and budgeting guidelines both regarding basket funds and general GOT funds for improving quality of services at district level, this work will be supplemented by the planned assessment of the Basket disbursement mechanism, cf overall TOR for the annual review. The Team leader will in addition provide comments for this separate review report on Basket disbursement mechanism.
4. Assess problems with and potential benefits from improving data gathering and processing, including current HMIS, in terms of managers needs and in order to improve service quality at district level. This should include an assessment of the possibility of utilising the TEHIP and AMMP experiences/ systems in a non-project setting and the planned countrywide roll out of the TEHIP "accounting" tool.
5. Assess the appropriateness of monitoring and supervision in terms of responding to the needs of district level managers and improving quality of services. This should be done with a particular view to the role and function of the Regional level and include recommendations on practical short and medium term steps to strengthen this function.
6. Assess the potential for increased involvement of the Sub-district health structures in management, e.g. planning, budgeting and monitoring.
7. Assess the collaboration with private sector, both in terms of the current status as well as future potential for improved efficiency of the whole health sector and recommend practical short term and medium measures to improve the collaboration.
8. Assess constraints in terms of size of funds and cash flow in implementing activities. Contribute to the current considerations of resource allocation criteria for GOT as well as Basket Funds to the districts.
9. Contribute to the current considerations of resource allocation criteria for GOT as well as Basket Funds to the districts.
10. Assess general capacity as well as specific constraints (number, quality, accessibility) in terms of other resources particularly human, transport, drugs, medical supplies and diagnostics. Specifically the Team will assess how far the Councils are beginning to fill vacant posts.
11. Assess the motivation of staff, factors that influence this and outline the way forward in terms of improving the incentive structure for staff and institutions.
12. Assess the functioning of the referral system.
13. Assess the management and function of the District Hospital, both in terms of the general performance of the district health services as well as more specifically the referral system.
14. Review specifically the guidelines for and the implementation of HIV/AIDS related district health services.

### **Methodology**

The Team will build on existing documentation, including last years review of district services, which will be forwarded in reasonable time prior to the Team's arrival in Tanzania. It will only to a very limited extent gather independent data.

The main part of the Review will take part in the field, focusing on a number (at least 4) of districts in two regions, out of which one region should be a poor region (as identified in the Household Budget Survey). The districts will be from Phase I or II Councils, with a balance between good and bad performers, as identified through the quality assessment of the Council Health Plans submitted and Performance Indicator Assessment of 37 Phase I councils currently undertaken by NMRI. The Team may choose to split up in order to cover more districts.

The Team will work closely with the relevant officers in MOH, PORALG, RS and district Councils.

### **Team and Timing**

Leo Devillé, MD - Health Systems Specialist – *Team Leader*

Thomas van der Heijden, MD - Public Health Specialist

Victoria Kipende, MD – Regional Medical Officer

3<sup>rd</sup> to 17<sup>th</sup> February 2003.

Team Leader will Attend Main Health Review 17-20 March 2003

**Output**

- A Debriefing Note on 17 February 2003
- 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 27<sup>th</sup> February (deadline for commenting 7<sup>th</sup> March), final report issued 11 March 2003.
- A presentation at the Main Sector Review Meeting – medio March 2003.

22-01-03