# Health System Strengthening through Performance-Based Financing in Seven African countries – 2010-2012

# Mid-Term Review
# Country Report Tanzania


**Evaluation team**

MARIA PAALMAN
ERNEST SCHOFFELEN
CLEMENT CHIBANGA



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# Table of Contents



# Abbreviations

| | |
|---|---|
| CHW | Community Health Worker |
| CSSC | Christian Social Services Committee |
| DMO | District Medical Officer |
| FBO | Faith-Based Organisation |
| HMIS | Health Management Information System |
| HQ | Headquarters |
| HR | Human Resources |
| KCMC | Kilimanjaro Christian Medical Centre |
| MoHSW | Ministry of Health and Social Welfare |
| MTR | Mid-Term Review |
| P4P | Pay-for-Performance |
| PBF | Performance-Based Financing |
| PHC | Primary Health Care |
| PMO-RALG | Prime Minister's Office-Regional Administration and Local Government |
| SA | Service Agreement |
| TWG | Technical Working Group |

# 1 Introduction

The churches own and operate many health facilities in Tanzania. Several decennia ago the faith-based organisations (FBO) were praised by friend and foe alike for their high quality health services and the population was willing to pay the requested user fees. Exemptions were granted to the poor at the discretion of the health facilities themselves. Over the years public health services have improved and government staff is now better remunerated than their colleagues in the FBO facilities. During the same period the financial support for the FBOs by European and American churches has gone down substantially. At present the churches in Tanzania have trouble balancing the income and expenditures of most of their health facilities. The Government of Tanzania has a system of supporting church-based health facilities with staff grants, bed grants, joint rehabilitation fund monies, 10-15% of the donor basket fund to be given to FBO hospitals, and inputs in kind for FBO PHC facilities. All of these are provided as input financing. However, according to CSSC, the total subsidies are not enough to balance the budget and disbursements are often late.

The FBO health facilities are organised in the Christian Social Services Commission (CSSC). For many years CSSC and the Government of Tanzania have been talking about formalisation of their relationship in the form of Service Agreements (SA). This intention is part of the health strategy. CSSC was going for full cost recovery on fee-for-service basis of all essential services provided, based on a costing exercise, but Government decided in the end to only make available the basket fund monies to finance the SAs with the hospitals, while continuing the grants as input financing. The SAs mention specific reproductive health and child health services to be provided under the agreement. The FBO facilities have to provide these services for free. Free services increase demand, so more services have to be supplied with less resources, due to loss of income through user fees. All in all, under the SAs more services have to be provided with less resources.

The FBOs are now in a stranglehold. If they do not sign a SA, they will no longer receive their percentage of the basket fund. But if they do sign it, they can no longer ask user fees, which would also reduce their income. In both cases they will not be able to balance their budget and some have calculated they are financially worse off by signing the SA. CSSC, in the meantime, still advises their members to sign a SA with the local government, on the promise that by signing a SA they can benefit from staff secondments.

CSSC is the partner organisation of Cordaid for the 7-country PBF project. Cordaid supported CSSC for many years, but recently decided to phase out this support in the near future due to subsidy cuts by the Dutch government. P4P projects with dioceses in Kagera, Arusha and Sumbawanga, funded by Cordaid's own resources, are still ongoing, but Cordaid's support for these projects will end by December 31st 2011. Norad is funding another P4P pilot in Pwani Region. The project funded by the 7-country PBF project takes place in Rungwe district in Mbeya Region. There is no national programme after a failed attempt to introduce some form of P4P nationwide about two years ago. The problem in Tanzania is that the MoHSW does not favour health facility autonomy. Although the health system is based on devolution down to the district level in practice central government has far reaching influence and directs to a large extent what happens in the districts through detailed guidelines on planning, use of resources, staff establishments etc.

# 2 Effectiveness

The following results as mentioned in the overall logframe are relevant for Tanzania:

- Result 2c: PBF approach is harmonised between Church and State
- Result 3a: An institute, capable of PBF training, exists
- Result 3b: CSSC is capable of independently promoting and expanding PBF in Tanzania
- Result 4a: Client's voice is strengthened

## 2.1 PBF approach is harmonised between Church and State (Result 2c)

During the design of the 7-country project it was assumed that the SAs would provide additional funding for the FBO facilities. The project attempted to use the SAs as a vehicle to introduce PBF in the FBO health facilities in Rungwe. The final decision on how the SAs would be financed came in early 2011. It then became clear that no additional funding would be available to pay PBF subsidies.

Pending these developments a needs assessment among 12 FBO facilities in Rungwe was done (addressing health facility management, HR, infrastructure, HMIS etc., to be used to formulate PBF indicators and targets). A stakeholder workshop was subsequently conducted to identify performance and quality indicators. A technical training of health facility staff took place in September 2010. The PBF coordinator supported the production of business plans. Six out of 12 health facilities now have a business plan and four have costed their health services.

Unfortunately all these preparations have not been used for the SAs in Rungwe. So far only the 2 FBO hospitals in the district have signed a SA with local government, but neither contain specific PBF characteristics. They seem to be the same as the SAs in other areas of the country – outputs are very general and no additional funds are available for incentives, no quantification of services, no targets, no indicators, no verification methods are included in the contract. The visited hospital mentioned that this PBF project had given them a lot of work, without getting something out of it.

Targets and prices calculated by CSSC will be used for billing the MCH indicators in the SAs, pending government's own costing exercise. However, if the hospital does not provide the target amount of MCH services, the DMO still intends to give them the maximum amount agreed in the SA (if not it would be wasted). In case the hospital provides more services they can also not receive more than the agreed amount. In short, this is not PBF, as there are no incentives to produce more and better quality services. Whatever the production, the amount the hospital will receive is fixed.

Moreover, 10 church PHC facilities do not yet have SAs, because the government objects, as it would involve receiving cash and they are not trained on financial management and there is no establishment for an accountant.

At the most we can say that the PBF project has been a catalyst to push government to sign SAs in Rungwe. However, the irony is that SAs now make the FBO health facilities worse off. According to the DMO the SAs could be a small step towards PBF, but the MTR team thinks that the Tanzanian environment is not conducive at the moment for introduction of PBF.

CONCLUSION: RESULT NOT ACHIEVED AND UNLIKELY TO BE ACHIEVED

## 2.2 An institute, capable of PBF training, exists (Result 3a)

Kilimanjaro Christian Medical Centre (KCMC) in Moshi was identified as the national training centre. Unlike in other countries KCMC was contracted as such by Cordaid directly, which makes them the second partner organisation for the 7-country project in Tanzania (on par with CSSC).

During the project time 5 KCMC staff have done the SINA Health course on PBF. In collaboration with CSSC and with technical assistance by Cordaid/ETC Crystal, KCMC has adapted the English SINA Health training modules to the Tanzanian situation and translated them in Kiswahili. Lesson plans and a teaching manual were produced and KCMC has done several training sessions in Rungwe District. Another course is planned for 2012. Each teacher has his/her own expertise and teaches modules accordingly. Unfortunately the same modules are used for different target groups with different levels of general education and different responsibilities.

However, the relevance of training health facility staff and other stakeholders in Rungwe is questionable, as the chances are slight that any form of PBF will be implemented in the near future. Moreover, the MoHSW has not been involved in the adaptation of the training materials and KCMC is not involved in training for the P4P project in Pwani Region. Given the reluctance so far of the MoHSW to adopt the Cordaid PBF methodology, this is understandable, but not opportune. KCMC sent the modules to the MoHSW and is awaiting comments. To get the MoHSW on board would allow KCMC to train stakeholders involved in future PBF/P4P projects or even a national programme.

CONCLUSION: RESULT SATISFACTORY

## 2.3 CSSC is capable of independently promoting and expanding PBF experience in Tanzania (Result 3b)

Three people from CSSC did the SINA Health PBF course, two from CSSC headquarters in Dar es Salaam and the CSSC 7-country PBF coordinator in Rungwe. One of the two CSSC HQ trained staff is presently working on another project, the contract of the other person will end 31 Dec 2011. Although other staff within CSSC is informed about PBF, as from next year a critical mass of PBF experts is clearly lacking within the organisation.

In the context of the 7-country PBF project CSSC organised advocacy events, such as the National PBF Forum, and in 2012 CSSC will organise an international PBF meeting for government s and donors in Dar es Salaam. There is a public/private *district* PBF forum, functioning as the mandatory PPP forum, but CSSC representation in the *national* TWG on health financing is presently weak.

Some information materials on PBF have been made. Although sharing of PBF information has resulted in a small group of MoHSW staff in favour of PBF (they have also done the SINA Health PBF course), these staff are not high profile enough to make a difference as to decision-making on key issues related to PBF. The non-conducive environment in Tanzania makes it difficult to advocate for PBF. Moreover, the tense relationship between CSSC and the Churches in general on the one hand and the MoHSW/PMO-RALG on the other hand, makes it unlikely that CSSC can exert a big influence on expanding the PBF experience in Tanzania.

CONCLUSION: RESULT NOT ACHIEVED AND UNLIKELY TO BE ACHIEVED

## 2.4 Client's voice is strengthened (Result 4a)

For many years Health Facility Governing Committees have been mandatory in Tanzania. Community members are on these committees. However, in health facilities run by the churches they are frequently not very active. Due to the project 7 of the 10 Committees in FBO PHC facilities in Rungwe are now actively meeting. Hospital Boards of FBO health facilities, however, are appointed by the Bishops, without election of community members.

The project introduced suggestion boxes in the health facilities, but very little or no use is made of them by the population. There was a plan for an ombudsman, but there are no funds available to remunerate this person.

Because no PBF pilot could be set up in Rungwe, satisfaction surveys and community verification could also not be done.

CONCLUSION: RESULT PARTLY ACHIEVED

# 3 Efficiency

## 3.1 Staffing

The Rungwe PBF Coordinator is contracted by CSSC on a full-time basis for the duration of the project. The project also employs a part-time accountant in the Rungwe Office. Because there is no PBF project in Rungwe, despite many advocacy activities and negotiations for more PBF characteristics in the SA, the need for a full-time PBF coordinator in Rungwe is questionable. CSSC could consider to use him part-time in Dar es Salaam to support the organisation of the international meeting, planned for February 2012. He could also be the right person to represent CSSC in the TWG on health financing.

At CSSC HQ the coordinator of the Cordaid funded P4P projects also oversees the 7-country PBF project, although she is not funded by it. When she will leave this position by the end of 2011, it is not yet clear who will be the official liaison with Cordaid.

The salaries of the KCMC staff are not funded out of the project.

## 3.2 Reporting

Every 6 months CSSC makes a narrative progress report and financial report against the EU reporting format and sends them to the Project Coordinator at Cordaid the Hague. They do receive feedback on both narrative and financial reports from Cordaid.

## 3.3 Finances

When reporting is satisfactory disbursements are made by Cordaid directly to CSSC and KCMC. Disbursements by CORDAID are usually timely.

The budget for Tanzania for the 7-country project was € 387,015. At the mid-term €137,551 had been spent. The expenditure rate therefore was 35,5%. As is the case with most other countries, the budget allocated for travel has been underestimated and this needs to be re-programmed.

Cordaid might have had its own reasons to choose KCMC as the training Institute (historical ties), but the distance from Moshi to Rungwe could hardly have been further, which is inefficient, due to 4 days of travel involved for every visit. This raises costs for transport and per diem. Flying is possible, but prohibitively expensive.

## 3.4 Synergy

The intended synergy between the already existing SAs and the PBF model did not occur. No other synergies were reported.

## 3.5 Support by HDP

CSSC knows what the role and tasks of HDP in the 7-country project are and the Rungwe project coordinator is in regular contact with HDP, albeit not frequently. The contacts are mostly general, relating to announcements etc. Specific contacts were frequent during the preparations for the national PBF Forum, for which HDP provided inputs on the content of the meeting. HDP visited the project three times: the first time for an orientation visit together with the Cordaid Project Coordinator, the second time for training, and the third time HDP gave a presentation during the National PBF Forum. CSSC is satisfied with the support by HDP, but would like HDP to come twice a year.

There is a problem, that progress reports are not sent to HDP. They are sent directly to Cordaid. This means that HDP is not automatically aware of progress and problems, which hampers their coordination role. CSSC seconds the suggestion of CHAZ in Zambia to first send the progress reports to HDP, who then forwards them with their comments to Cordaid.

The Rungwe Project Coordinator does actively use the project website. He made an account and regularly downloads resources. He also has a blog. However, he complains that other people are much less active, they do not react. Technical improvements are necessary to make the site more user-friendly. Then much more use can be made of the website's possibilities. The evaluation team agrees with him on these comments.

He did seek direct contact with other countries once, but got no reply. Still he finds the network useful, in particular the face-to-face contacts during the international meetings. Two people from CSSC also went on a study visit to Rwanda.

## 3.6 Support by Cordaid

The present 7-country project was the follow-up of earlier P4P projects in Tanzania funded by Cordaid. CSSC staff was involved in the initiation, planning and designing of the PBF 7-country project. A Cordaid consultant from ETC Crystal supported CSSC with this. The same consultant also supported training in 2010, the National PBF Forum and the adaptations of the PBF curriculum by KCMC. They are quite satisfied with his support.

CSSC has regular contacts with the project coordinator at Cordaid and the financial department of Cordaid, mostly related to clarifications of issues.

## 3.7 Visibility of EU and Cordaid

CSSC has made promotional materials (for example caps and t-shirts) and a brochure on the PBF project, which all prominently carry the EU logo. Also the sign on the street in front of the project office carries the EU logo.

# 4 Recommendations

1. CSSC should organise an exchange visit to CHAZ in Zambia, including key MoHSW officials, to discuss Church/State partnership at the highest possible level of government and churches.
2. KCMC/CSSC should discuss the training modules with MOHSW in an effort to extend their training capacity to serve other potential PBF/P$P projects.
3. KCMC should adapt the modules to different level target groups, for example a specific training course for CHMTs, one for purchasing agencies, and one for health facility staff.
4. CSSC should ensure that a qualified person represents the organisation in the TWG on health financing
5. CSSC should organise exchange between Rungwe and Sumbawanga, where 12 faith-based PHC centres do have SAs and are paid in cash, without having an accountant.

## Annex 1 People met and organizations visited Tanzania

| | |
|---|---|
| Madina Paul | PBF coordinator CSSC |
| Siegfried Knauer Runge | Head Competence Centre CSSC |
| Father Lucas | Zonal Director CSSC Southern Zone |
| Theophil Michael Sule | Zonal PBF Coordinator CSSC (Rungwe) |
| Israel Peter Mwakyolile | Bishop Rungwe Diocese |
| Carina Dinkel | MD/Surgeon Itete Hospital Rungwe |
| Sungwa Ndagabwene | DMO Rungwe |

# Annex 2 Presentation Feedback workshop

## MTR 7-country PBF project Tanzania

Feedback workshop
24 Nov 2011, Kigali

## Team composition

- Maria Paalman, independent consultant
- Ernest Schoffelen, PC Cordaid HQ
- Clement Chibanga, PC Zambia



## Recent Changes/Info – 1

- GoT has a complicated system of supporting church-based HF with several grants and 10-15% of the donor basket fund for faith-based hospitals + inputs in kind for faith-based PHC HFs= input financing
- Formalisation of relationship between govt and faith-based health services in the form of Service Agreements (SA) is part of the health strategy. CSSC was going for full cost recovery on fee-for-service basis, but govt decided to only replace input financing of basket fund monies by output financing on basis of billing. However, the budget is by far not enough to provide all services mentioned in the contract.
- No SA, no basket funds!



## Recent Changes/Info – 2

- MCH, HIV, TB, STD etc. services have to be provided for free – resulting in decrease in income for church facilities, while number of services increases – no financial compensation
- There is no national PBF programme, but several pilots have been done or are on-going (Cordaid in 5 dioceses + Norad in Coastal Region)
- Problem: MoHSW does not favour HF autonomy – system very centralised
- Problem: MoHSW sees FBOs as competitors, not cooperative



## Results Tanzania

- 2c) PBF approach is harmonised between state and church
- 3a) PBF training institute exists
- 3b) Partner capable of independently promoting and expanding PBF
- 4a) Client's voice is strengthened



## 2c) PBF approach is harmonised between state and church

- A needs assessment among 12 church HFs on HF management, HR, infrastructure, HMIS etc. was done, to be used to formulate PBF indicators and targets
- A workshop was done to identify performance and quality indicators
- 5/12 HFs now have a business plan, based on costing exercise
- But, all these preparations have not been used for the SAs in Rungwe, which do not contain specific PBF characteristics–they seem to be the same as the SAs in other areas of the country – outputs are very general and no additional funds are available for incentives, no quantification of services, no targets, no indicators, no verification
- An informal agreement with DMO is that for a number of MCH indicators the targets and prices calculated by CSSC will be used

## 2c) PBF approach is harmonised between state and church

- In Rungwe district only 2 church hospitals now have a SA, 10 church PHC facilities not yet (MoH objects, because it would involve receiving cash and they are not trained on fin. management and there is no establishment for an accountant)
- PBF has been a catalyst to push govt to sign SAs in Rungwe. However, the SAs now make the church-based health facilities worse off.
- The SA could be a small step towards PBF, but the Tanzanian environment is not conducive at the moment
- CONCLUSION: RESULT NOT ACHIEVED



## 3a) PBF training institute exists

- Kilimanjaro Catholic Medical Centre (KCMC) in Moshi was identified as the national training centre
- 5 staff have done the SINA Health course
- KCMC has done several training sessions in Rungwe
- Refresher courses are planned, but lack budget
- In collaboration with CSSC and w/TA by Cordaid, KCMC has adapted the English SINA Health training modules to Tanzanian situation – translated in Kiswahili; lesson plans and teaching manual were produced
- However, MoHSW has not been involved
- CONCLUSION: RESULT SATISFACTORY



## 3b) Partner capable of independently promoting and expanding PBF

- 3 people from CSSC did the SINA Health course
- CSSC organised PBF/SA advocacy events, such as the National PBF Forum, and in 2012 CSSC will organise the international meeting for govts and donors in DSM
- There is a public/private *district* PBF forum, but CSSC representation in *national* TWG on health financing is weak
- Some information materials on PBF have been made; constant sharing of PBF information has resulted in group of MoHSW staff in favour of PBF (have also done the SINA course), but these staff are not high profile enough to make a difference
- The non-conducive environment in Tanzania makes it difficult to advocate for PBF
- CONCLUSION: RESULT NOT YET ACHIEVED



## 4a) Client's voice is strengthened

- Health Facility Committees are mandatory in Tanzania. Community members are on it.
- 7 of the 10 HFC in faith-based HFs in Rungwe are actively meeting
- Satisfaction surveys are not done in Rungwe
- Hospital Boards of faith-based HFs are appointed by the Bishops, without election of community members.
- CONCLUSION: RESULT NOT ACHIEVED



## Recommendations

- CSSC is advised to organise a study tour to CHAZ Zambia, including key MoHSW officials
- KCMC/CSSC should present final modules to MOHSW for approval, and seek accreditation from National Council for Training
- CSSC should ensure that a qualified person represents the organisation in the TWG/HF
- CSSC should develop a PBF advocacy strategy (request TA from Cordaid?)
- Organise exchange between Rungwe and Sumbawanga, where 12 faith-based PHC do have SAs and are paid in cash, even without having accountant