THE UNITED REPUBLIC OF TANZANIA

NATIONAL AUDIT OFFICE (NAO)

A PERFORMANCE AUDIT REPORT ON THE MANAGEMENT OF PRIMARY HEALTH CARE: A CASE STUDY OF HEALTH CENTERS

A REPORT OF THE CONTROLLER AND AUDITOR GENERAL OF THE UNITED REPUBLIC OF TANZANIA

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PREFACE

Pursuant to section 28 of the Public Audit Act No. 11 of 2008, the Controller and Auditor General has been mandated to carry-out Value-for-Money (VFM) or Performance Audit in the Ministries, Departments, and Agencies (MDAs), Regions, Local Authorities and Public Authorities and other Bodies. The purpose is to establish the economy, efficiency and effectiveness of any expenditure or use of resources in the respective audited entity.

I have the honor to submit to the Minister of Health and Social Welfare for presentation to the Parliament of the United Republic of Tanzania my performance audit report on the management of Primary Health Care Services to the citizens of Tanzania Mainland with particular reference to the management of Health Centers' performance.

The report comprises of conclusions and recommendations to the Ministry of Health and Social Welfare, Prime Ministers Office Regional Administration and Local Government, Regional Administrative Secretariats and Councils. The mentioned auditees have been given the opportunity to comment on the final draft report before it will be submitted to the responsible minister. It is a common interest of the auditees and the CAG that the findings of the PHC audit are factually correct and presented in a fair way in the final public version of the report. The authorities have been most helpful in providing vital information, statistics and comments. The audit aims at improving the management of Primary Health Care services to citizens of the United Republic of Tanzania.

My office intends to carry out a follow-up at an appropriate time regarding actions taken by the auditees in relation to the recommendations of this report.

This report has been prepared by Wendy Massoy, Godfrey B. Ngowi and Levina R. Kishimba under the supervision of Gregory G. Teu. I would like to thank my staff and also the auditees for their support and continued finalising cooperation in this report.

Ludovick S.L. Utouh
Controller and Auditor General
Dar es Salaam,
January 2009

Abbreviations and Definition of Terms

BFC	Basket Fund Committee
BoD	Burden of Disease
CAG	Controller and Auditor General
CD	Council Director
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSBs	Council Health Service Boards
CCHPG	Comprehensive Council Health Planning Guideline
Council	Municipal, City and District Council
DMO	District Medical Officer
HC	Health Center
HFC	Health Facility Committee
HMIS	Health Management Information System
HSPS	Health Sector Programme Support
IKAMA	Standard staffing level
LGA	Local Government Authorities
MMO	Municipal Medical Officer
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
NEHP	National Essential Health Package
NHIF	National Health Insurance Fund
OPD	Out patients Department
PAA	Public Audit Act
PER	Public expenditure Review
PHC	Primary Health Care
PMORALG	Prime Minister's Office Regional Administration and Local Government
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Team
RS	Regional Secretariat
RS/RHMT	Regional Secretariat /Regional Health Management Team
RMO	Regional Medical Officer
SWAP	Sector Wide Approach
WHO	World Health Organisation

WPT	Waiting and Processing Time
EPI	Expanded Program of Immunisation
FP	Family Planning
HIV	Human Immuno-deficiency Virus
DC	District Council
MC	Municipal Council
CC	City Council
CCHP	Comprehensive Council Health Plan

Map of Tanzania

Executive Summary

The Primary Health Care (PHC) is regarded as the cornerstone of the country's National Health Policy. PHC is often the first and in many cases the only place of contact regarding prevention and treatment in the community.

The Health Centers (HCs) are managed by Local Government Authorities (LGAs). The Regional secretariat is the linkage between the policy makers and the operating levels. They are responsible for interpreting Government policies and decisions and safeguarding that the available resources in this sector are being effectively distributed and efficiently utilized. Beyond policy and regulation, the Central Government's authorities are also responsible for the way the PHC system is set up and works. However indications suggest that there are problems in the performance of health centers.

The purpose of this audit was to review whether the HCs are managed efficiently and whether their performance is appropriately considered in allocating the available resources. The aim was also to study if adequate actions are taken to improve the situations. The audit has focused on HCs owned and managed by the Government of Tanzania Mainland.

The audit focuses on performance of HCs managed by Local Government Authorities which are responsible for all matters pertaining to PHC services as mandated by the Local Government District Authorities Act No. 7 of 1982 and the Local Government Urban Authorities Act No. 8 of 1982 as amended the Local Government Urban Authorities Act No. 6 of 1999.

Seven regions of various sizes and population and with reasonable accessibility were chosen. The aim was to include regions with different conditions. The regions selected were Dodoma, Iringa, Morogoro, Lindi, Coast, Tanga and Mtwara. In short, the selection covers one third of the regions in Tanzania mainland. According to experts, this ought to be enough for the audit. All these regions were visited by the audit team.

20 councils out of the Tanzania's mainland 133 Councils were selected. Councils were chosen to represent various external conditions, like geographical, statuary, economic and population size.

The audit team consisted of three performance auditors. Data were collected through interviewing concerned actors, reviewing documents and direct observation for measuring waiting processing time and daily workload.

Major findings, conclusions and Recommendations

Audit Findings

The major findings of the audit are as follows:-

We noted that, the HCs are not efficiently managed and are funded without proper consideration of service demands and performance

The Ministry of Health and Social Welfare (MoHSW) has set up standards for the staffing of each HC. Considerations of performance, like workload and customers/ clients waiting- processing time, are not specifically stated in Government documents addressing the Councils' allocation of resources to the HCs.

In reality, the Councils do not fully guarantee that available resources are directed and distributed effectively and thereafter utilized efficiently. For health care services, funds for HCs are allocated from the National to Council level mostly based on demographic criteria. The Councils then may reallocate these resources between their HCs. But this is rarely done. The Council distribute funds to the HCs for running expenses and medical supplies without proper or specific consideration on service demand and performance.

We noted that, few actions have been taken to improve the efficiency and shorten the customers' waiting and processing time in the HCs. Many HCs can not say how much the council is contributing to the health care because they are not aware of their budget since they get no feedback from the Councils on the approval of their budgets. Furthermore HCs lack a comprehensive system for monitoring of their own spending. In addition, the current system of supervision has not been able to detect the HCs that have problems with their performance and suggest remedial action. Also, the conducted supervision by the Council Health Management Team (CHMT) and Regional Health Management Team (RHMT) has not provided the HCs with adequate support to mitigate those problems. Moreover, it is not possible to confirm any certain correlation between the HCs' performance and the conducted supervision.

In spite of certain differences in performance and great potentials for improvements, few actions have been taken by the Government

Even though the workload of HCs in many cases is not that high and the waiting time is likewise seldom extremely long variations in the HCs' performance do exist. For example HCs with the same workload show extended variations in waiting time. HCs with lower workload may even have longer waiting time than HCs with higher workload. The opposite also occurs. These differences in performance seem to be explained mainly by internal factors within the HCs' influence.

The relationship between performance and funding for operating cost at the HCs is weak. Drugs are funded without closer examination of needs. Neither does the number of visitors (users of the HCs services) correspond with allocated staff.

The existing system for regular monitoring does not provide the MoHSW and PMORALG with an adequate overview of up dated and comprehensive information about the problems with performance of the HCs. On the other hand, this kind of qualified information has not been requested by the MoHSW. In addition, few evaluations regarding the link between performance and allocation of resources have been initiated and conducted by the ministry and few actions have been taken by the government authorities to improve this situation.

Recommendations

In order for key actors at District, Regional and National Level to further address problems of efficiency and effectiveness in PHC, we recommend the following for improved conditions for the health center:.

The **MoHSW and PMORALG** should improve the evaluation of the HCs at national as well as regional and council level. It is also of importance with a clarification for the Councils that it is of value for the management of the HCs to consider performance issues, like workload and waiting - processing time.

The **Regional secretariat** should put more emphasis on performance issues in their monitoring and evaluation of PHC at council level. This includes also examinations on how the Councils manage to safeguard effective allocation and efficient utilization of available resources for their PHC services.

For the **Councils** a main issue is an active promotion of efficient spending of available resources for PHC services. This includes a clear budget for the HCs and a regular monitoring of their spending and performance. Most important is also, to make reallocation of resources among the HCs based on their performance.

SCRUTINY OF FACTS

The Prime Minister's Office Regional Administration and Local Government (PMORALG) and the Ministry of Health and Social Welfare (MoHSW) which are directly concerned with this report have been given the opportunity to correct factual errors in the draft report. We wish to put on record that the meetings with each Ministry under the management of primary Health Care performances have been constructive.

Chapter One

Introduction

1.1 Background

Primary Health Care (PHC) is regarded as a crucial element of a national health care delivery system and is believed to stimulate the efforts reaching the Millennium Development Goals and efficient implementation of National Strategies for Growth and Poverty reduction.

The major aim of PHC is to improve the citizens' health and well being in Tanzania. Through the Ministry of Health and Social Welfare (MoHSW) the Government recognizes the PHC as the cornerstone of National Health Policy. PHC is the first place of contact regarding the issue of prevention and treatment in the community through the village health post, dispensaries and Health Centers (HCs). A well functioning PHC is of importance, since it might be the only health care service that is available for a large part of the citizens. In addition, it is also the main link to other and more advanced health care services available in the country.

Through health sector reforms and wide sector approaches the Government of Tanzania has achieved many important milestones in its endeavors to improve health services. Decentralization processes as well as efforts on strategies and different guidelines have focused on better utilization of resources and also on improved quality of health services provided to the citizens.

However, indications suggest that there are problems in the HCs performance. There is a lack of knowledge on how well they perform, and there are reasons to believe that available resources are not always effectively distributed and efficiently utilised. There are also indications of problem in the administrative structure. Preliminary findings indicate significant shortcomings in management and monitoring of the HCs at several administrative levels. This might be viewed in the context of the existing system for funding health care services.

Based on the independent technical review of health service delivery at district level, the review team highlighted client perception regarding long waiting time in health facility.[1] There were also minimal evidences that performance measuring like workload was taken into account for staff deployment.

The Controller and Auditor General (CAG) under section 28 of the Public Audit Act No. 11 of 2008 has the mandate to carry out Performance Audit[2] for the purpose of establishing the economy, efficiency and effectiveness of any public expenditure or program. Performance auditing aims at examining whether the Government

[1] Health Research for Action(HERA), March 2004

[2] Sometimes called Value for Money Audits or shortly VFM Audits

Ministries as well as the Regional, Local authorities and Public Authorities are doing the right thing and doing this in the right and least expensive way.

Based on the above said problems the CAG has decided to conduct a performance audit on whether there is an effective distribution and efficient use of available resources for PHC in the country.

1.2 Purpose of the audit and audit questions

The purpose of the audit is to examine whether HCs are managed efficiently and whether their performance is being measured and appropriately considered in allocating the available resources. The aim is to find room for improving the management and efficiency of the HCs' services to the citizens.

The audit has focused on HCs owned and managed by the Government of Tanzania Mainland. The consideration is on how well the mechanism of measuring and evaluating the performance is linked with the allocation and utilization of the available resources for existing HCs in Tanzania mainland.

This report provides the result from applying the following three audit questions:

1. *Do the Councils manage health centers' performance efficiently; do they use appropriate means to safeguard that available resources are distributed effectively and thereafter utilized efficiently?*

2. *Do the Regional Secretariats efficiently monitor and evaluate health centers' performance at Council level; do they provide the central government with appropriate information and feedback?*

3. *Do the Central government authorities appropriately address mentioned issues*
   – are significant actions taken to improve the situation?

1.3 Audit design

1.3.1 Scope and limitation of the audit

The audit focuses on Local Government Authorities which are responsible for all matters pertaining to PHC services as mandated by the Local Government District Authorities Act of 1982 and the Local Government Urban Authorities Act No. 8 of 1982 as amended the Local Government Urban Authorities Act No. 6 of 1999.

To answer the audit questions a number of sub-questions have been formulated. All major central government authorities with duties linked to PHC have been contacted in order to find out what they are expected to do, what they are doing and how they view the situation. Recipients of services were not interviewed.

The audit team chose a limited number of regions, Councils and health centers (HCs) for closer examination. The selection is not based on random, since the purpose is not to present a scientifically valid general picture but to answer the audit questions above with a reasonable degree of assurance.

Experts in the field have provided valuable information on how to select samples that are small but still allow for reasonable conclusions. One must have in mind, that figures under this study represent a limited number of HCs and that it only provides a picture at a given point in time. However, Experts and stakeholders in the field have to a large extent confirmed that there are huge and yet not fully examined differences in workload among HCs in Tanzania.

Seven regions of various sizes and population and with reasonable accessibility were chosen. The aim was to include regions with different conditions. The regions selected were Dodoma, Iringa, Morogoro, Lindi, Coast, Tanga and Mtwara. In short, the selection covers one third of the regions in Tanzania mainland. According to experts, this ought to be enough for the audit. All these regions were visited by the audit team.

In each of the seven regions, a number of Councils were selected for examination. In few regions all Hcs in selected Councils were chosen to see whether there are differences in management and performance within the same region. Otherwise, only a few Councils from each region were chosen. In total, 20 Councils out of Tanzania's 133 Councils were selected (to match the requirements that the marginal error should be less than 10 %). The Councils were chosen to represent various external conditions, like:

- Geographical: Rural and urban Councils
- Statuary: City Councils, municipal towns and districts
- Economic: Richer and poorer Councils
- Population size: Big and small and various demographic features

The audit team interviewed management in all twenty Councils in order to study how they fulfil their tasks and promote good performance among HCs. Government owned HC's were selected for examination of workload, waiting and processing time (WPT) and some other management aspects. In total, 32 HCs were selected and visited. This means that 40% of the selected Councils were fully covered[3]. The sample size – the 32 HCs – was selected based on similar consideration as above (to find a minimum sample size required for desired analysis). According to the availability of data of workload and WPT, out of the 32 HCs, 30 Hcs were further analysed.

[3] All HCs facilities owned by Government in the said Councils were visited

The selected sample of 32 HCs represent almost 10 % of the (331) HCs in Tanzania Mainland.[4]

Table 1: Summary of sampling of different categories of population chosen in Tanzania Mainland

S/N	Categories	Population	Sample selected	Sample Analysed	% of coverage
1	Regions	21	7	7	33
2	Councils	126	20	20	16
3	HCs	331	32	30	10

1.3.2 Methods and implementation

In undertaking the audit, various methods of data collection were used in order to answer the audit questions. The methods used include the following:

- 73 interviews with representatives of the operating level, the different administrative levels and relevant categories outside the PHC system
- review of various documents related to health sector
- direct observations at the studied HCs and Councils
- data collection of working conditions in terms of workload as well as waiting and processing time at the studied HCs[5].

The audit involved discussions and documents review at national, regional, council and HC levels.[6] The data collection task was done in two phases. The first phase covered Dodoma, Iringa, Morogoro and Tanga regions while the second phase covered Coast, Lindi and Mtwara regions.[7]

Information was collected from various sources and stakeholders in order to take a wide spectrum of perspectives and arguments.[8] At central level various staff concerning financing and administering of health activities were interviewed. At regional and council levels, Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs) were interviewed respectively.

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[4] The selection of 32 HCs based on the listed 331 HCs mentioned in the Annual Health Statistical Abstract of April 2006

[5] See Appendix 20 and 21

[6] See reference list for documents reviewed.

[7] The second phase came after stakeholders meeting where by the team was told to increase the scope so as to add more information and more HCs in order to get a comprehensive and balanced picture.

[8] See list of persons being interviewed.

External experts and research scientists as well as managers and staff and representatives from the field and some NGOs were interviewed. Managers of HC's or their representatives were also interviewed, by telephone or through visits. It has often – but not always – been possible to verify orally provided Information and statements.

This broad approach helped us in obtaining vital information and provided a number of opportunities to exchange views and arguments. It also helped interpreting data and analyzing things from different perspectives.

Both official and unofficial documents from different sources were studied. It has not always been possible to check the quality of the information in details. If there were reasons to believe that the quality was not what it ought to be, the information has not been used. Alternatively, comments on the quality are provided.

Another method used in gathering information is direct observation. Information on waiting-processing time (WPT) and workload was collected by this method.[9] The method was time-consuming, but necessary to be able to get reliable and independent data. However, the presence of the observer of WPT was known to the staff of the HCs during observation. This was unavoidable due to the nature of the exercise. Also there was a less separation of duties between management and operating staff of the HC. The data gathered provide a picture of working conditions and service delivered to the visitors[10] at the HC at a given point in time. The data is sufficient in answering the audit questions, but it does not allow for conclusive statements for all HCs.

The MoHSW is responsible for developing human resources policies and strategy for training. However the shortage of health staff is critical in terms of qualification and mix. According to the Human Resources for Health strategic plan, the shortage of professional staff in the HCs for the year 2006 was 59%. The audit team focused on the use of available staff in the visited health facility i.e 41%[11].

During the audit, experts and stakeholders in the field were able to discuss the methods used and findings at meetings with a focus group. These meetings provided valuable information to the audit team. A draft report was examined by an independent external reviewer. Before finalizing the report, it has been sent to all major auditees (PMO-RALG and MOHSW) for facts clearance process.

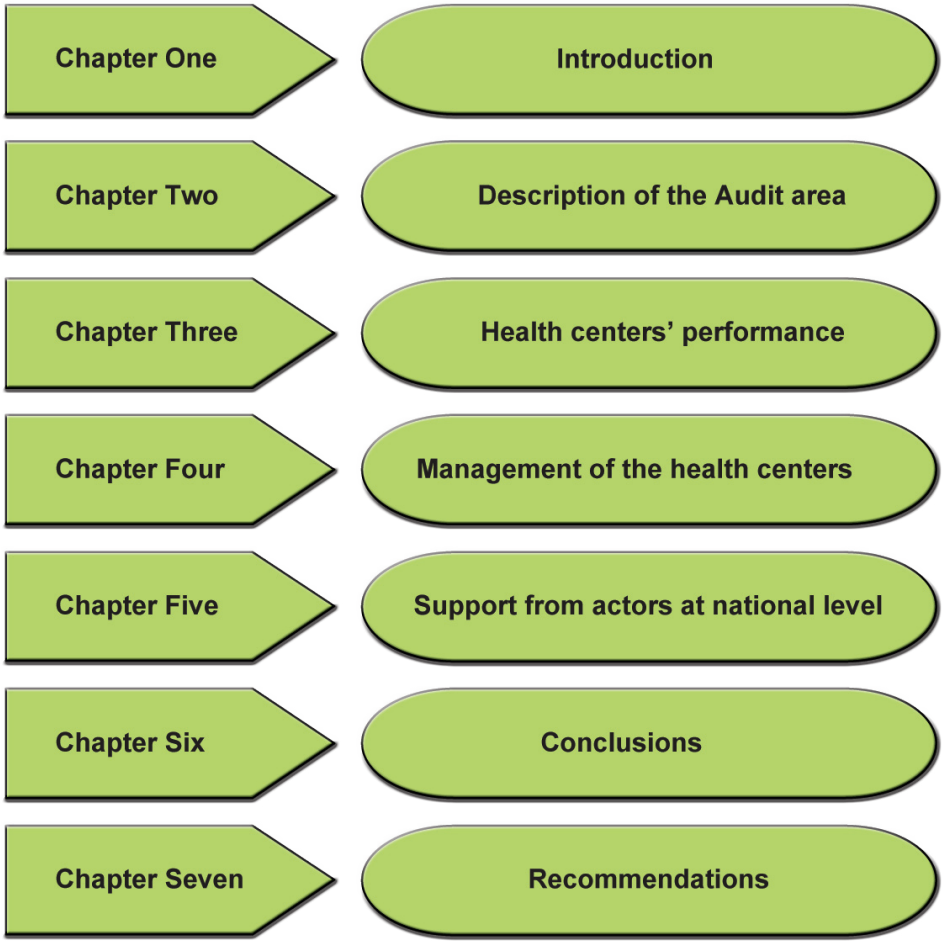
[9] WPT refers to the total time spent by a visitor at HC from arrival to exit, and workload refers to the average number of visitors at HC per day per fulltime working medical staff. For more detailed information see Appendix 20.

[10] Visitors refers to the clients/patients looking for health service to the HCs

[11] MoHSW Human Resource for Health Strategic Plan 2008 – 2013 issued January 2008

1.4 Structure of the audit

The report is divided into seven Chapters. These are as follows:



Abbreviations are explained the first time they are used in the text. A list with all used abbreviations is available after the preface.

Chapter Two

Description of the Audit area

The concept of PHC was officially launched in 1978 in the Alma – Ata Conference (WHO, 1978) as the key strategy for achieving the WHO's goal of 'health for all'. PHC and decentralised district based health system were part of the strategy to address issues of equity and accessibility of health care services in developing countries.[12] Tanzania had already started implementing the goal of health for all after the Arusha declaration of 1967. In 1983, the Ministry of Health issued guidelines on the implementation of PHC in the country.

Primary Health Care services form the basement of the pyramidal structure of health care services. This is provided by a number of dispensaries, HCs and District hospitals at the district level.

The basic requirements of PHC are as follows:

- Community Involvement
- Cooperation with other sectors
- Decentralisation

2.1 The health care policy

The National Health Policy aims at implementing both national and international commitments. The vision is to have a healthy community that can contribute effectively to individual development and to the country as a whole. The mission is to facilitate the provision of basic health services which are proportional, equitable, of high quality, affordable, sustainable and gender-sensitive.[13]

Goals and objectives

The goals of the policy are to safeguard and improve the health and well-being of all the people, with a focus on those at risk and to put in place a health system that will meet people's needs and contribute to increase life expectancy. These aims are assumed to be achieved through PHC. Good health i.e., physical mental and social well being is seen as a major resource for economic development.[14]

The Tanzanian government took deliberate efforts during the two decades of post independence to alleviate some historically inherited inequities, introducing, for example, free health services. The process of free provision of health services,

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[12] Kimaro C. & Sahay S. An institutional perspective on the process of decentralization of health information systems: A case study from Tanzania. WHO, 1994; Braa & Hedberg, 2002; Sandiford et al., 1992)

[13] Tanzania Service Provision Assessment,2006

[14] Primary Health Care Strategy, 1992

however, suffered, during the early 1980's due to many issues. Consequently, the country adopted new socio-economic policies such as the World Bank's structural adjustment programme and introduced the public sector reforms.

The health sector reform programmes, which started in 1994, focused mainly on decentralization of health services by taking on board both managerial and financial reforms. One of the objectives is to improve access, quality and efficiency of primary health services at district level.

Health Sector Strategic Plan
The present, second, Health Sector Strategic Plan (HSSP) covering the period July 2003 – June 2008 focuses on provision of equitable quality health services and client satisfaction.[15] This can, according to the Strategic Plan, be realized through

- Improved management of district health services and services delivery using the Essential Health Package (EHP).
- Improved availability and utilization of resources i.e. personnel, drugs supplies and equipments.
- Improved communication and transport between different levels of the health services pyramid.
- Introducing performance based incentives and staff benefits linked to service delivery.

2.2 Roles and responsibilities

There are a number of key players who facilitate the whole process of providing health services to the citizens. The roles of the health sector are executed at the national, regional and council level, which also is the operating level.

2.2.1 Central government authorities – regulators and supervisors
The actors at the national level have influence on the HCs performance both as actors from national level and as system supervisors. Their roles among other things are policy making, developing standards and guidelines, coordination and supervision.

The Ministry of Health and Social Welfare (MoHSW) is responsible for developing policies and standards for PHC. The ministry has developed and decided on the Local Government and Health sector reforms. The National Health Policy has also been reviewed and a number of collaborative forums have been conducted.[16]

[15]Comprehensive Council Health Planning Guideline, February 2007.

[16]Collaborative forums includes Basket Financing Committee, Sector Wide Approach (SWAP), Technical and Annual Health Joint Technical Review meetings carried out by the PMORALG and MoHSW aiming at improving health services.

These reforms include formation of Health Sector Management structures at different levels as well as monitoring and evaluation tools. These tools include assessment criteria for – among other things – progress reports and guidelines for supervision.

The MoHSW allocate drugs (pharmaceuticals and medical supplies). Drugs and medical equipments are distributed through the Medical Stores Department (MSD) which is under the MoHSW. The ministry also facilitates the PHC services with technical advice, support and with monitoring of, among other things, disease patterns and the quality of health services.

The Prime Minister's Office – Regional Administration and Local Government (PMO-RALG) – deals with the implementation of the health policies. This task includes monitoring of the use of funds and also administration of human resources at the regional and council levels. The PMO-RALG also has a coordinating role by linking all Regional Administrative Secretaries (RAS) and Local Government (Councils) in Tanzania Mainland.

2.2.2 Regional authorities – evaluators and supervisors

At the Regional level, the Regional Secretariats (RS) is an extended arm of the MoHSW and the PMO-RALG at the central level. Among other things the RS plays the role of:

- Supporting the health service delivery through the Regional Health Management Teams (RHMT)
- Assessing Council Health Plans as well as its implementation reports (technical and financial reports)
- Monitoring and supervising the Council Health Management Teams i.e. CHMT and advice them accordingly.
- Provides the central level with information for decision making.

2.2.3 Local authorities – operational managers and service providers

PHC services operate under Local Government Authority whose mandates are derived under the Local Government Urban Authorities Act No. 8 of 1982[17] and the Local Government District Authorities Act. The functions of both the City and Municipal Councils are provided for in Section 7A of Act No. 8 of 1982[18]. One of their functions is to improve and maintain quality health service for the residents. According to the above function, the Councils' are responsible for managing all government owned HCs in their respective area.

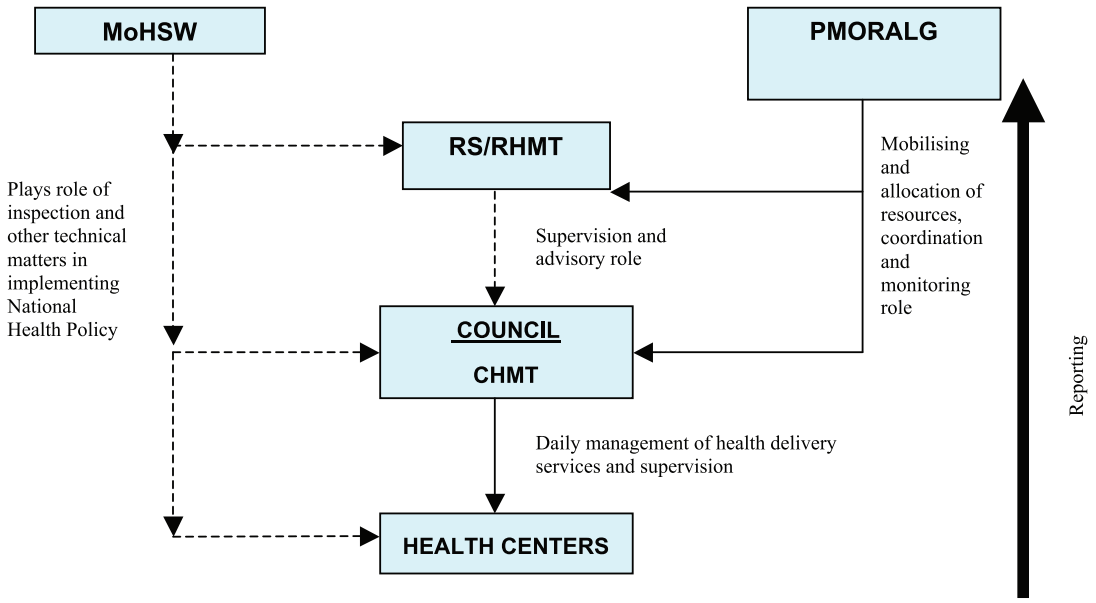
The Councils manage the HCs through the operating team, Council Health Management Team (CHMT), headed by the Municipal- or District Medical Officer

[17]Amended with Local Government Urban Authorities Act No. 6 of 1999.

[18]Amended to Section 69A of Act No. 6 of 1999

(DMO). At council level the Health Management Information System (HMIS) requires each HC to report quarterly and annually to the DMO. See Figure 1 below.

Figure 1: Health System in Tanzania



Source: Interviews and document review

Each council is responsible for monitoring and evaluation of performance of its HCs. Information from HMIS and supportive supervision are the major tools in assisting the Councils with monitoring and evaluation of HCs' performance.

The HMIS is a system used for collecting data from health facilities relating with activities of various health programmes and health care services. These data are also reported to higher, administrative levels[19]. Apart from these various categories of data collection, the system also includes schedules which require the health staff at the HCs to report workload to the Councils. This reporting of workload implies the total number of visitors of various categories divided with the employed number of health staffs at the HC.[20]

Supportive supervision is done by the CHMT in order to assess performance of the HCs. This supervision is also carried out with the aim of guiding, supporting

[19]Data collected relates with Community outreaches, drugs and medical supplies, Outpatient Department, Antenatal, Child, Family planning, Diarrhea Treatment Corner (DTC), Dental, Laboratory and measles immunization.

[20]The HMIS book 2 page 9 schedules 7 require the computation of workload per day. The objective is one health staff to serve 30 – 50 patients per day. There is no big difference between employed and present staff at HCs visited

and assisting health providers in carrying out their assigned tasks. The purpose of supportive supervision is to focus on problem solving as an approach in order to improve quality and to meet client needs. The aim is also to strengthen health workers' performance in relation to quality and standards and to identify gaps and to address them. According to the MoHSW, the aim is also to promote quality outcomes. This is done by strengthening communications, facilitating team work and supporting health providers in implementing, monitoring and improving their own performance. The Supervision Guidelines requires the CHMT to conduct at least one visit per quarter in each health facility.

2.2.4 Council Health Service Boards (CHSBs),

This is an executive organ of the council for supervising and controlling all health activities and resources. The Board is also responsible for implementing all policies given by the Ministry of Health to improve the working environment and remuneration of health workers. The board is expected to build good relationship with other sectors and development partners in the health sector to pool resources in a sustainable manner[21].

CHSBs including the Medical Officer, a CHMT representative, community and NGO representatives, and private hospital representatives, provide a multi-stakeholder forum promoting local participation and dialogue; CHSBs assist the CHMT with the preparation of comprehensive council health plans.

2.2.5 Health Facility Committees (HFC)

HFC provide a consultative forum aimed at ensuring community participation in the management of individual facilities. The roles of HFC among other things include overseeing the general operations and management of the health facility and facilitating a feedback process to the community pertaining to the operations and management of the health facility.

2.3 Funding

PHC is financed mainly by the government and the donors through block grants and health basket funds (HBF) respectively.[22] Other sources of finance include cost sharing, community health funds and National Health Insurance.

- The block grants from the government are mainly used to finance salaries for all full time health staff employed by the Councils and Other Charges.

[21]RS/RHMT Training Modules in support of Council Health Management Team – Module One: Health Sector Reforms and Planning

[22]The Comprehensive Council Health Plan Guideline provide direction on how the resources at the council are managed as well as the guidance on formulating budget based on NEHP and assessment of executed planned activities performance.

- Health Basket funds from development partners (donors) are the major sources for financing the operating activities concerning the provision of health services to citizens.

- Funds for Drugs are money from both the Government and the donors (Block Grant and HBF). These resources are allocated from the MoHSW to the Medical Stores Department (MSD) for financing procurement of medicines, medical equipment and supplies at the HCs.

Disbursement mechanism for both health block and basket fund follows government procedure. However, condition for disbursement of HBF is different from health block grant. Below is an outline of the fund allocation.

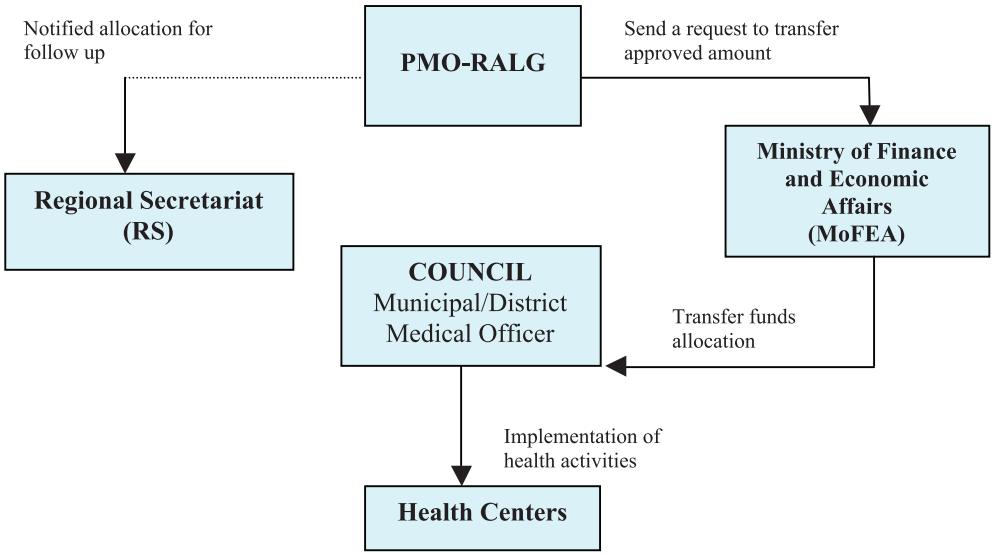
2.3.1 Allocation of Health Block grant (HBG)

Block Grants are directly released to the Local Government's Authorities (LGA) by the Ministry of Finance and Economic affairs (MoFEA). The allocation of HBG follows the normal government procedure whereby the approved budget is allocated to the council as requested by PMORALG from MoFEA. The PMORALG notifies the RS for follow up.

The allocation to the council is based on a formula in which the following factors are considered:

- Population (70%)
- Poverty count (10%)
- District Medical vehicle route (10%)
- Under-five mortality (10%).

Figure 3: Disbursement of Block Grant



Source: Interviews and document review.

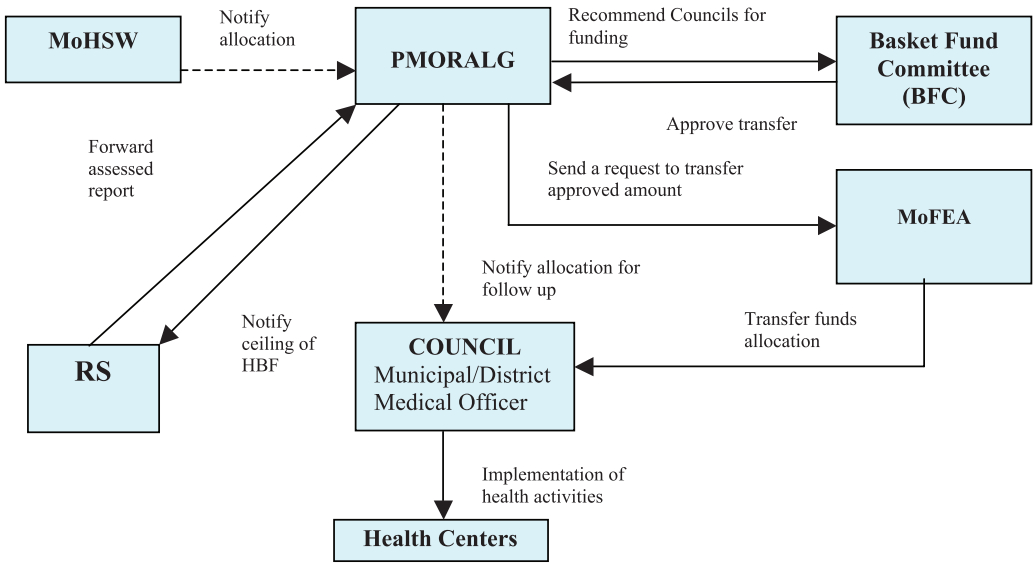
Council's staff are paid their salaries from the block grant (personal emolument). The Councils have mandate to employ health staffs using the Block Grant after getting permission from the President's Office-Public Service Management. For each HC there is a Staff Establishment, the so called IKAMA[23] issued by the MoHSW and PO-PSM with a proper mix of 29 health staff per each HC. The Councils then have the power to allocate and reallocate the available staff between the HCs within their area.

2.3.2 Allocation of Health Basket Funds (HBF)

HBFs are disbursed by the MoFEA after an approval of the Basket Fund Committee. Allocation is based on the formula of Population (70%), Poverty count (10%), District Medical vehicle route (10%) and Under-five mortality (10%). RS review progress reports and submit assessment report to the PMORALG. PMORALG recommends to the BFC, councils to be funded and give reasons for those not to be funded either for non submission of CCHPs and/or progress reports or shortfalls discovered there from.

At Council level HBF is allocated in a range of percentage per cost center. There are six cost centers in the CCHP Guideline[24]. One of them is serving the HCs which are supposed to get 15-20% of the total Council's HBF budget allocated for the Council's implementation of activities at this level. The DMO provides the HCs with goods and services (technical support) while the HCs provide health service to the citizens. These resources are directed for the HCs' services as seen in Figure 2 and 3.Figure 2 shows a system graph for the disbursement of funds.

Figure 2: Disbursement of Health Basket Fund system graph



Source: Interviews and document reviews

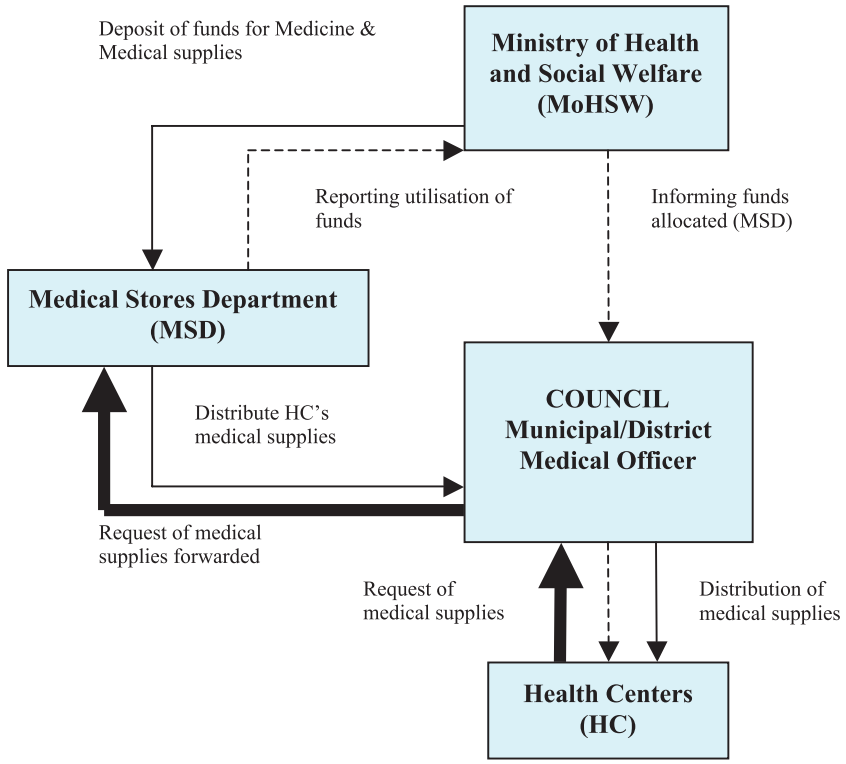
[23]Standard staffing level

[24]Other cost centers include Office of DMO, Council Hospital, Voluntary Agency Hospitals, Dispensary and Communities.

2.3.3 Allocation of Funds for drugs and Medical Supplies

The Funds for Drugs are allocated annually from the MoHSW to the Medical Stores Department (MSD) based on analysis for each HC. The MSD then plays the role of procuring, storage and distribution of the required and approved drugs as per HCs, request.[25] This is illustrated in Figure 4.

Figure 4: Allocation of funds for Medicine and Medical Supplies to HCs



Source: Interviews and document reviews

[25] Most of HCs visited order their drugs from MSD on quarterly basis through ordering system which known as Integrated Logistic system (ILS).

Chapter Three

Health centers' performance

The main issue in this audit is whether the HCs are managed efficiently and whether the HCs' performance is being measured and appropriately considered in allocating the available resources.

This chapter concerns the aspects of efficiency and effectiveness of the HCs' performance as well as information related with the causes and explanations of the output of this performance. The examination is based on studies of the performance at the HCs in terms of workload and waiting and processing time.[26] The examination is also based on interviews at the Councils level and the HCs as well as reports issued by the Councils and the HCs.

This chapter deals with two main issues.

- One issue concerns funding and workload at the HCs.
- The other issue concerns aspects of efficiency and effectiveness of the HCs' performance.

3.1 Funding and workload

The audit team has studied 30 HCs with respect to funding, workload and waiting and processing time. The first step was to study funding and workload.

3.1.1 The workload varies but is mostly not so high

Workload is used to describe relations between demand for health care services and ability to meet those demands. It could be measured in different ways. In this study it's measured by the number of unscheduled visits (visitors) to the HCs in relation to the human resources. More precisely, it refers to the average number of visitors at the HC per day and per full time working medical staff. By measuring workload one gets a picture of the relation between the extents of the activities at the HCs in relation to the amount of human resources allocated for these activities. According to HMIS standard[27] set, the average workload range from 20 – 50 visitors per day.

The workload has in this case been measured by direct observation, during two regular working days and some by interview and review of documents[28]. It provides a picture of the workload in that given time.

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[26] For further information see section 1.3.

[27] The standard need to be reviewed as the HMIS is also outdated

[28] 32 HCs were visited and 30 HCS were analyzed (Refer appendix 15)

Photo 1: Congestion of visitors in one of the health facilities

According to the study, the workload varies significantly among the HCs. In this study it varies from 1 to 23 visitors per day and full time working staff among the studied HCs. As shown in Table 2 below, a great majority of the HCs (80 %) had less than ten visitors, and only two HCs had a workload of 13 visitors or more.

Table 2 raises the question on the allocation of resources. Few HCs seem to have more work, while others have a rather low workload.

Table 2: Number and percentage of HCs with their respective workload

Workload (Number of visitors per day per staff)	**Number of HC**	
	Number	**%**
1 – 3	8	27
4 – 6	10	33
7 – 9	6	20
10 – 12	4	14
13 – 15	1	3
16 +	1	3
Total	**30**	**100**

Sources: Auditor's Physical observation, interviews and document reviews

The above findings suggest that the demand for services – the number of visitors – is not proportional to the allocation of human resources. The majority 80% of the

HCs have 1-9 visitors per day per staff, i.e. a low workload while the remaining few (6) have to struggle with a higher workload.

3.1.2 The resources for Drugs are basically the same at all HCs

Ideally, resources for drugs should correspond to the needs or somehow reflect the number of visitors (given fairly similar external conditions and demands). Even so, it's difficult to deny the fact that resources for Drugs are basically the same for all HCs. Our data indicates HC with the largest numbers of visitors had fewer resources for drugs, than those with few visitors (compare for instance the HC in Kilimarondo, with 18 visitors per day, and the HC in Makorora, with more than twenty times as many visitors per day). This is shown in Table 3 below.

Table 3: Visitors, workload and funds for drugs at HCs – a comparison

Name of HC	Average number of visitors per day at the HC	Workload (Average visitors per day per staff)	Funds for Drugs allocation per Quarter (TSH)
Ngome	40	1	2,000,000
Kilimarondo	18	3	2,000,000
Makorora	380	8	1,755,000
Chihangu	67	8	2,000,000
Mandawa	100	14	2,000,000
Chalinze	231	23	2,000,000

Sources: Data collected through observation, interviews and document reviews

The MoHSW uses a formula for the allocation of funds (deposited at MSD) for the different levels. This formula has several arbitrary aspects and does not take the actual workload or performance of each health facility into account, nor local Burden of Disease (BoD) or poverty indicators. This formula does not explain the variations noted in the PER.

3.2 Workload and time for waiting and processing

Waiting and Processing Time (WPT) refers to the total time spent by the HCs' visitors from their arrival to their exit from the HC including time for treatment. An examination of WPT provides a picture of the HCs' performance. One criterion of service delivery efficiency is high workload combined with quick service delivery. However, the MoHSW has not yet established visitor expected waiting times. Other country like Malta had published Quality Service Charters (QSC) for HCs. The Floriana HC in the said country had issued QSC in 1999 with visitors expected waiting time of 30 minutes to be seen by General Practitioner (GP) while Qormi HC had in the year 2000 published QSC with expected waiting time of up to one hour[29].

[29]Auditor General of Malta, performance audit report on primary health care (the General Practitioners functions within Health Centers), 2001.

Photo 2: Visitors waiting for the services at the health facilities

3.2.1 Waiting and processing time varies among HCs

Ideally, the waiting time should not vary much among HCs (unless there are policies saying that citizens do not have the right to equal level of service). In our study, however, the differences are significant, even though the proportion of HCs with a high average WPT, is small. On a scale from 1 to 181 minutes or more of WPT most of the HCs are on the lower part of this scale. A visit at a HC doesn't last more than one hour for half of the examined HCs and less than 40 minutes for almost one third of them as seen in Table 4 below).

Table 4: Number and percentage of HCs with their respective waiting time

Waiting and processing time (Minutes)	Number of HCs	
	Number	%
1 – 20	4	13
21 – 40	5	17
41 – 60	6	20
61 – 80	6	20
81 – 100	3	10
101 – 120	2	7
121 – 140	1	3
141 – 160	1	3
161 – 180	1	3
181 –	1	3

Source: Auditor's physical observation

3.2.2 Variation in efficiency among HCs

Efficiency can be measured in different ways. In this study, we found relevant to measure efficiency by comparing workload with WPT. Units with similar conditions in terms of similar service and equal workload are expected to have the same WPT. If that is not the case, it's common to seek explanation amongst "internal factors" such as management, competence, organization etc.

According to this investigation, the HCs' performance varies significantly. WPT varies significantly even when the workload is the same. And differences in workload are not always reflected in WPT, even if there is an overall link between them. It's hard to believe – even by experienced analyst consulted – that external factors (or factors related to the design of the study) may explain more than some of these differences.

Long time for service delivery is not only due to high workload, and high workload does not exclude a short WPT. This is illustrated in the Table 5 below.

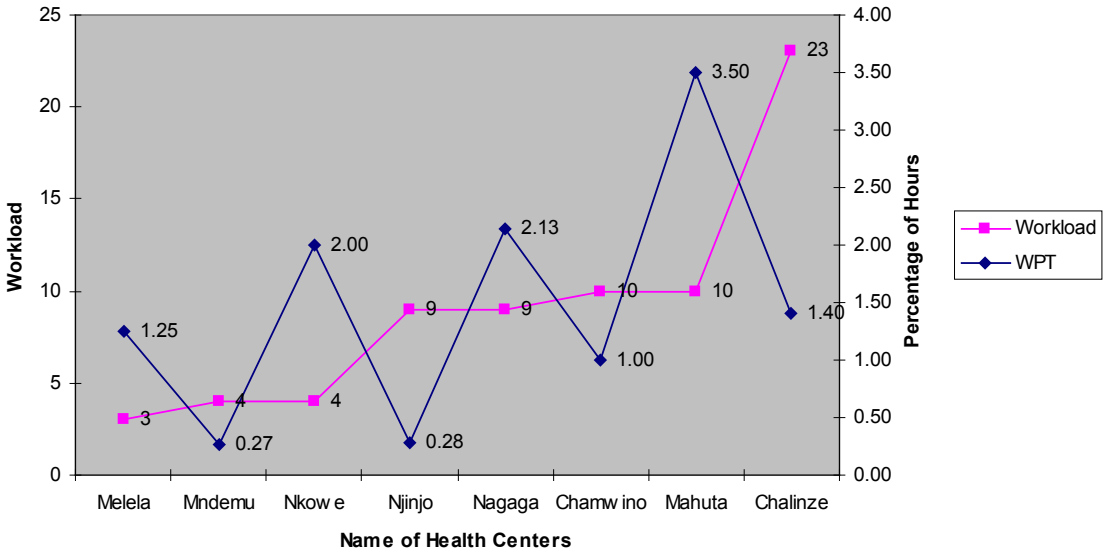
Table 5: Workload compared with waiting and processing time

Name of HC	Workload (Average number of visitors per day per staff)	Waiting and processing time (WPT) (Minutes)
Melela	3	75
Mndemu	4	16
Nkowe	4	120
Njinjo	9	17
Nagaga	9	128
Chamwino	10	60
Mahuta	10	210
Chalinze	23	84

Source: Auditor's physical observation, interviews and document reviews

This can be visualised as below:

Chart 1: Workload compared with waiting and processing time



The chart above illustrates great differences in performance among the studied HCs.

- It clearly seems that the HC in Nagaga has much longer WPT than the HC in Njinjo although it has the same workload.

- In comparison with the HC in Mndemu, it also seems that Njinjo is the better performing HC of the two. The workload at the HC in Njinjo is more than twice as high as that at the HC in Mndemu, but the WPT is about the same. In other words: Njinjo is able to keep the WPT short, in spite of a high workload.

- The HC in Mndemu is, on the other hand, more efficient than the HC in Nkowe.

- Moreover, even though the workload is close to 8 times higher in the Chalinze HC compared to the HC in Melela, WPT is not that much longer.

3.2.3 No influence on efficiency by external factors

Different issues might cause or explain the varying efficiency in performance at the HCs. These issues are important to define in order to find solutions for improvement of less efficient working systems. The issues might be internal, i.e. part of the operating and management system of PHC on different levels. The issues might as well be external, i.e. issues outside the PHC system as different environmental conditions linked to different living areas, like rural or urban, richer or poorer districts areas

The external issues have been considered at the choice of the HCs to be visited in this audit. The choice covers partly complete council areas with all HCs belonging to one council. In order to examine the influence of environmental issues an examination has been conducted on WPT and fulltime working medical staff for the HCs within the same Councils' area. The result of this examination is shown in the Table 6 below.

Table 6: Waiting and processing time in larger and smaller HCs within the same council

Name of Council	Name of HC	Average WPT (minutes)	Size of the HC (Average number of medical staff)
Mkuranga DC	Kisiju	101	11
	Mkamba	29	8
Iringa MC	Ngome	15	27
	Ipogoro	44	30
Bagamoyo DC	Chalinze	84	10
	Lugoba	48	18
Kilwa Masoko DC	Masoko	65	16
	Njinjo	17	7

Source: Auditor's physical observations, interviews and document reviews

The result of the examination of HCs within the same Councils' area shows similar variations of efficiency as for HCs from different Councils' areas. This result indicates that varying living conditions may not have to be the major explanations of variations in the HCs' efficiency[30].

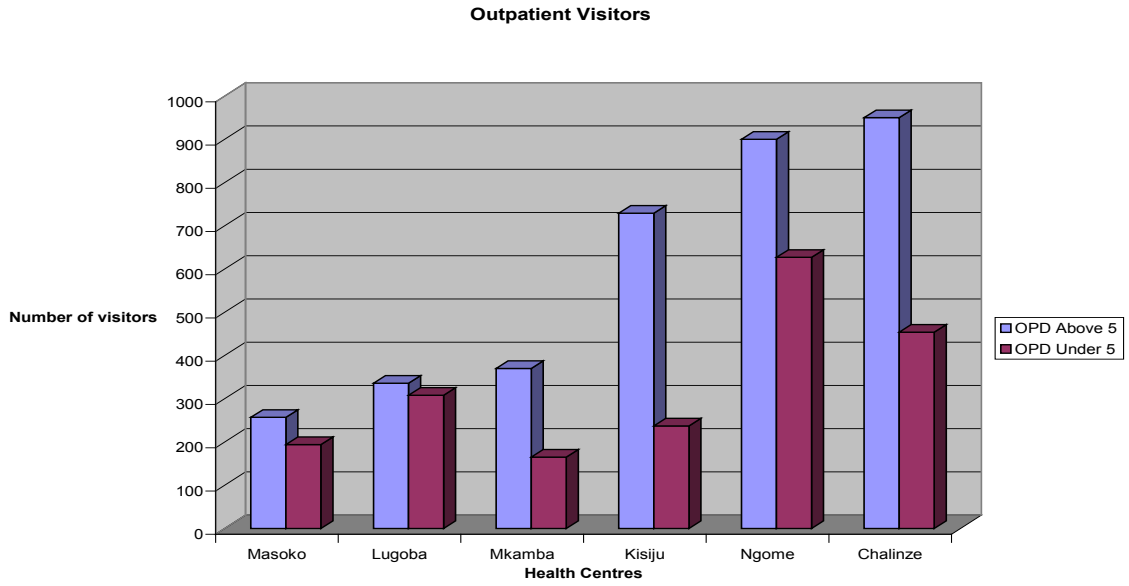
Another observation at the above examination is that bigger HCs do not show any advantage in terms of efficient utilization of resources. Rather it is the other way around. The smaller HCs show a more efficient utilization of resources.

This examination reveals certain variations in efficiency at the HCs' performance even within the same Councils' area. In order to further check possible influence from other external issues these have been examined also in another way.

The influence on HCs with good and less good performance have been studied when it comes to different kinds of population as well as different conditions of health and illness in the area. The analysis shows that, the number of visitors categorized as under five and above five does not differ much by comparing different HCs. See Chart 1.

[30]Varying living conditions refers to rural and urban economic conditions

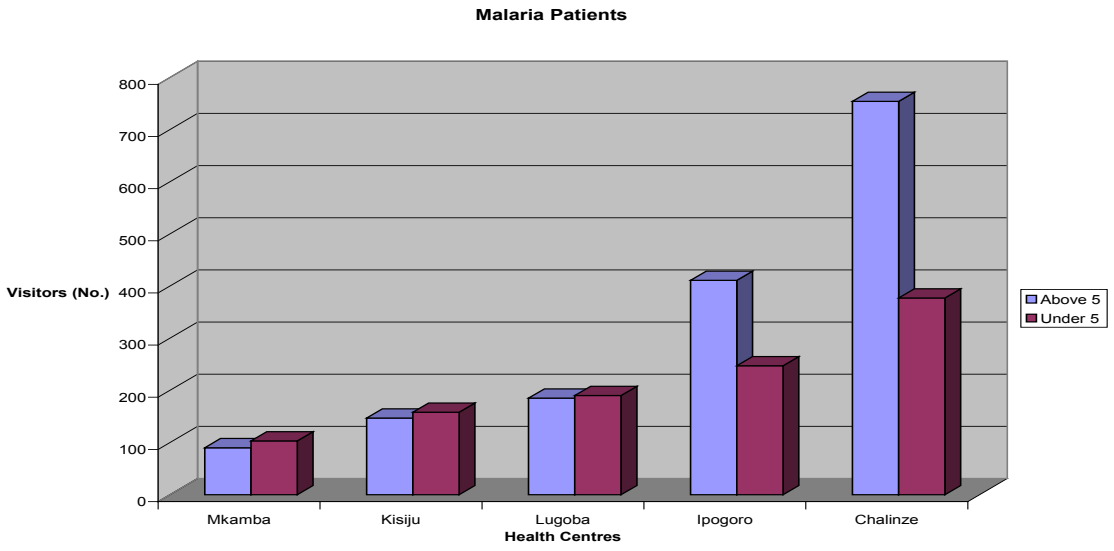
Chart 2: Average Outpatient visitors per month



Source: HMIS Report 2007

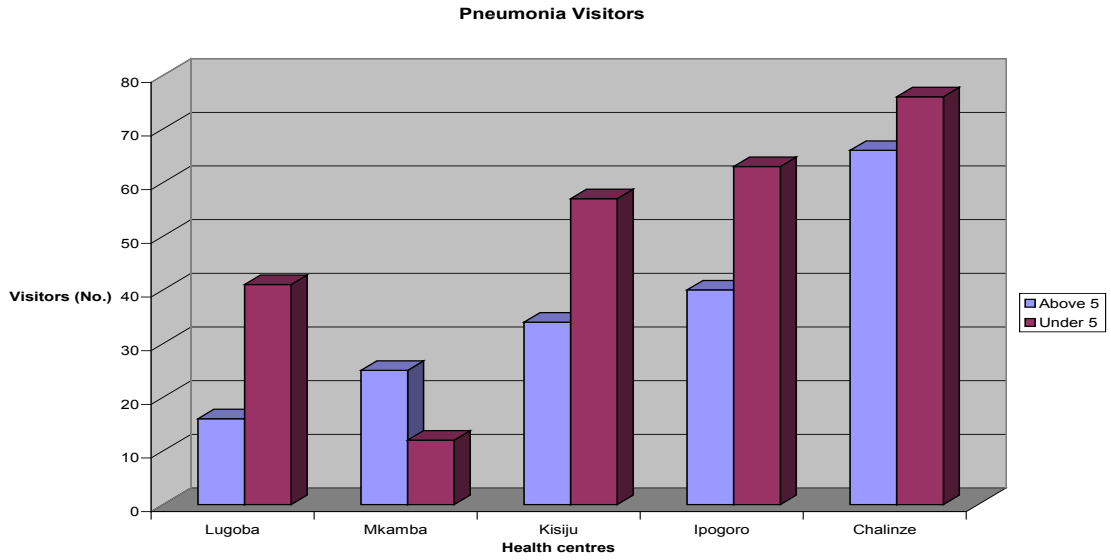
Furthermore, the selection of three diseases (Malaria, Pneumonia and Diarrhoea) out of the top ten diseases shows that average number of visitors is more or less equal. See Chart 2 and Chart 3.

Chart 3: Average Malaria case visitors per month



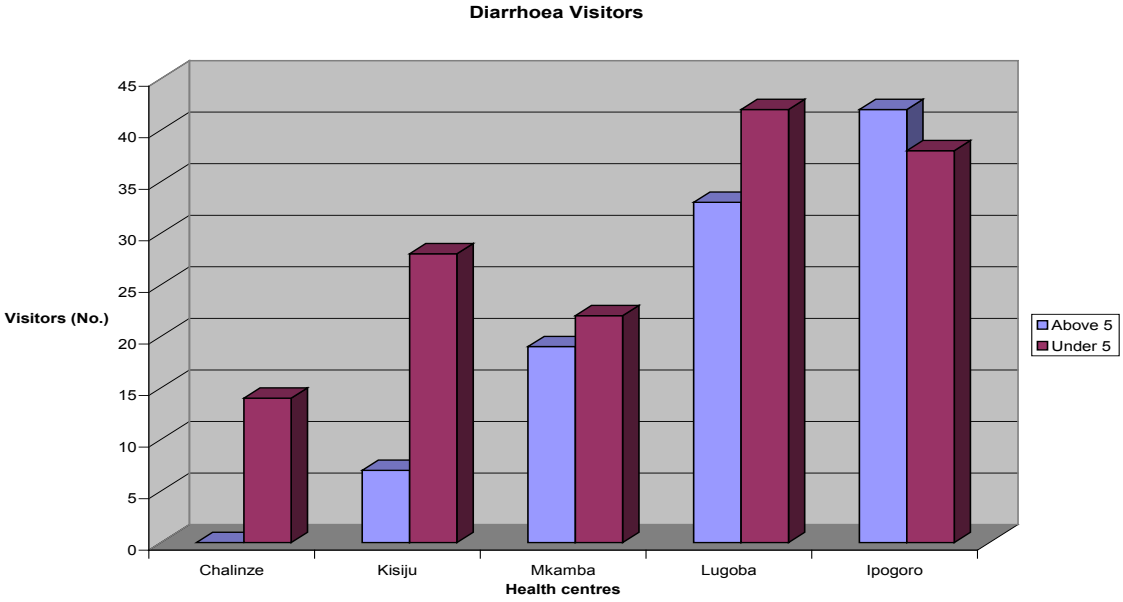
Source: **HMIS Report 2007**

Chart 4: Average Pneumonia case visitors per month



Source: HMIS Report 2007

Chart 5: Average Diarrhoea case visitors per month



Source: HMIS Report 2007

Moreover, the above charts show differences in the HCs performance are to a little extent influenced by patterns of population and illnesses.

The results above indicate internal rather than external causes to these variations.

3.3 Other findings

3.3.1 Little incentives to join CHF

The Community Health Fund originate from the community where by household is faced with two options to pay their medical bills, either pay an annual amount to join the Community Health Fund (CHF) for services at public health facilities in that year, or to pay Tshs 1,000/- for every episode of illness attended to at a public health facility. The CHF is one of the options of reducing the financing gap in the health services. The CHF is a potential means ensuring greater security of access to health care, empowering households and community in health care decisions, promoting cost sharing with strong local participation and providing a stimulus to local health care providers.

According to interview with incharges of HCs visited, the persistence shortage of drugs in their health facilities contributed in the decrease of CHF members. This was due to the fact that members did not benefit from their contribution made.

3.3.2 Less effective Health Facility governing committee

Each HC has governing committee which is required to sit at least four times in a year. The committee composed with members from the community and the incharge of the HC as a secretary. The purpose is to safeguard the resource and smooth operation of health facility.

According to the interview, these committees were found to be less effective in carrying out their task. Few meetings were conducted per year. Matters discussed in some of the conducted meeting did not reflect the performance issues such as discussing HC's HMIS monthly statistics and quarterly reports. Most of the committee members in the visited HCs had less capacity of discharging their responsibilities.

Chapter Four

Management of the Health centers

This Chapter deals with the management of the HCs' performance by the Councils at Municipal/district level and by the authorities at regional level. It aims at looking on the kind of activities available for the Councils and for the regional authorities and also on the actions that have been taken in order to safeguard an effective distribution and an efficient utilization of resources at the HCs. Findings under this chapter are structured as follows:

- The first section deals with management by the Councils in order to improve the performance of the HCs.
- The second section deals with monitoring activities by the Regional Authorities in order to support the HCs' performance and to provide the national level with appropriate information and feed back.
- The third section deals with linkage between the management authorities at district and regional levels and the HCs' performance.

4.1 Performance management among the Councils

The analysis of the HCs' performance in Chapter 3 above indicates several problems of efficiency and effectiveness. These shortcomings concern both the way the resources are allocated by the Councils at district level and the way the resources are utilized by the HCs. Both human resources and financial resources vary without considering certain variations of demand and performance.

The Councils' management of the HCs' performance is vital to safeguard efficiency and effectiveness. According to the interview and review of documents, the audit team has found that Councils have mainly three management tools for safeguarding of the HCs' efficiency and effectiveness. One tool is the budget system. Another tool is the Health Management Information System (HMIS)[31] and a third tool is supportive supervision. Based on reports from this information system as well as on supportive supervision, the HCs' performance is intended to be measured, evaluated and documented by the Councils.

4.1.1 A financial management system for HCs

Each HC is required to collect information and to notify its priority needs to the Council for the following financial year. At the Councils, this information is accommodated by an operating management team[32] in a yearly plan[33]. The budget for each HC is

[31] HMIS refers to the system used to collect health information in health facilities that can be used for decision making at different levels
[32] Council Health Management Team (CHMT)
[33] the Comprehensive Council Health Plan (CCHP)

supposed to be set in accordance with a national design, the National Essential Health Package (NEHP). All planned activities at the HCs are required to be in line with the design of this package. The Councils are also responsible for approving the above plan when all HCs' budgets are integrated.

The audit team has found several problems regarding how the budget is communicated and followed up between the Councils and the HCs. Firstly, most of the staff at the visited HCs were not aware of the package, "NEHP" as a guide for their priorities during the development of their yearly proposal of a budget to the Councils. Secondly, the HCs lack feed back from the Councils regarding their later on approved budget. Thus the management of the HCs have no proper information on how much was spent and for what and how much of the resources remain for the activities at the HC based on their approved budget. Thirdly, there is no system in place for monitoring the HCs' own spending. In addition, most of the HCs are hardly involved in the preparation of the Councils' planning.34 HCs' own source funds collected from cost sharing such as CHF, NHIF, user fees are combined in Account No.6 at the DMO's office. Put together, these problems are significantly hampering the ability of the HCs to promote transparency, accountability and good performance.

4.1.2 Information system – not updated and used for improvement

The aims of the above mentioned information system is to promote good performance of health service delivery. The information system is intended to provide current, accurate and reliable data on a timely manner. These data are intended to be collected, analyzed and used in order to support local health management and service delivery. Data analysis is assumed to assist identifying potential problems as well as improving performance.

The audit team's review of documents showed many shortcomings with the way this Information system is in use as explained below:

- The system is not updated[35]. Some health workers are not trained on how to fill in and use data in the system. Most of the essential parts of the so called HMIS register books concerning performance are left blank.
- Performance indicators are not used. Numbers of visitors at the HCs are rarely compared with resources available like health staff and WPT.
- Reports that the Councils receive from the HCs are rarely analyzed, compared and evaluated by the Councils' operating management team.
- Due to non- action on the reports by the council's management, the HCs lack feedback on their performance.

[34] For further information see appendix 7.

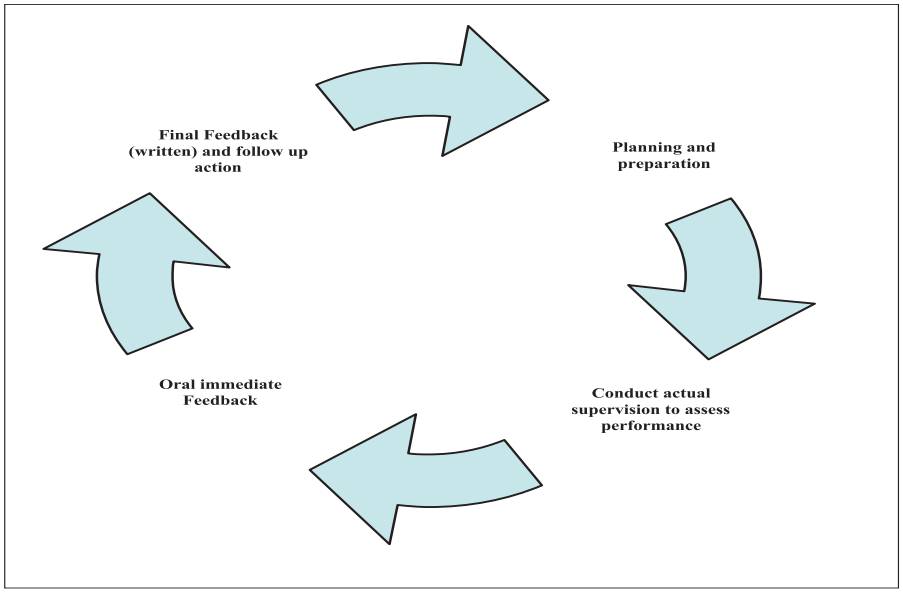
[35]The information system, HMIS, does not cover some important data like Expanded Program of Immunisation (EPI), Family Planning (FP) and HIV.

4.1.3 Many shortcomings with supportive supervision

Supportive supervision is another tool for the Councils to assess performance of the HCs. The purpose is to guide, support and assists the health providers to carry out their task. The aim is to focus on quality and standards and also to identify and address gaps in performance.

The Supervision Guidelines state that each HC should be visited at least four times a year. In order to be effective, the supervision also has to pass through four stages, illustrated in figure 5 below.

Figure 5: The supervision stages



Source: National Supervision Guideline -1999

In relation with the purpose and aim of the supportive supervision, the audit team has found many shortcomings when it comes to the Councils' performance as explained below:

4.1.4 Supportive supervision not in accordance with requirement

The supervision visits are neither prioritized nor planned in a proper way and nor in accordance with stated guidelines.

No one of the 20 visited Councils had a specific plan for the supervision visits with clearly stated objectives and priorities. A so called supervision route roster do exist showing the supervision team, the facility to be supervised and when. There is also no plan addressing how the supervision visits will be carried out. These shortcomings result in difficulties to determine which visits are for supportive supervision and which visits are for other purposes, like drugs distribution.

In addition, supervision visits are not conducted according to the guidelines when it comes to the content. Out of 20 visited Councils, the audit team managed to get documents from only 17 Councils on conducted supervision visits[36]. In less than one third of these Councils, the supervision visits were conducted according to the requirement while a great majority of the Councils (80 %) did not carry out their visits as they were expected to do. On the other hand, as shown in the Table 7, some Council conducted more supervision visits than what was required.[37]

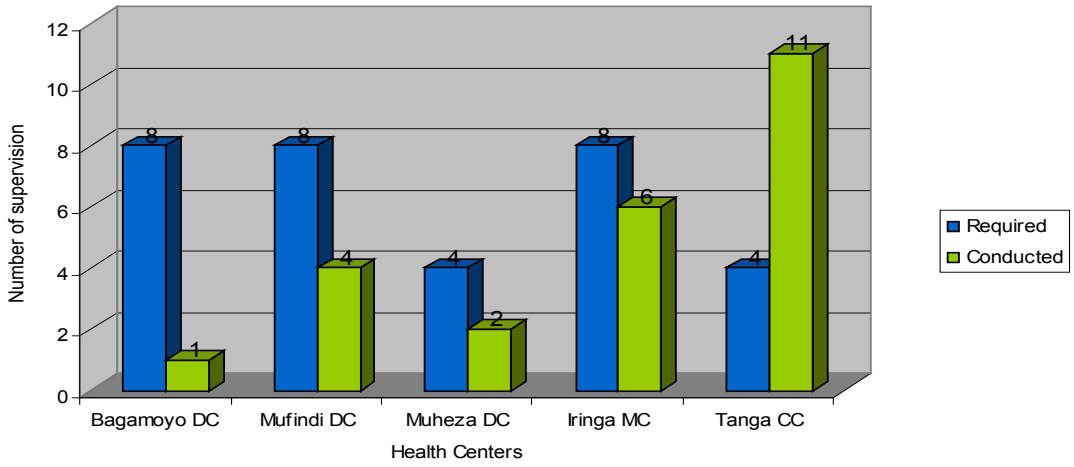
Table 7: Supervision visits to HCs carried out by CHMT during 2006 and 2007

SN	COUNCIL	NUMBER OF SUPERVISION		GOAL FULFILLMENT
		REQUIRED	CONDUCTED	
1	Bagamoyo DC	8	1	13%
2	Mufindi DC	8	4	50%
3	Muheza DC	4	2	50%
4	Iringa MC	8	6	75%
5	Tanga CC	4	11	275%

Source: MTUHA Book No.2 and Interview

The same can be visualised in the following chart:

4.1.5 No documentation from supportive supervision visits



There is also a lack of documentation and feedback to the HCs from conducted supervision visits. This hampers a proper use of the experiences from the supervision visits in order to improve the HCs' performance.

[36]Refer appendix 6

[37]National Supportive Supervision Guideline of 1999 requirement

According to interviews conducted by the audit team, most of supervision teams state that they discuss their findings with HCs staff orally, but without the required documentation.[38] Supervision reports are neither distributed to the supervised HCs for taking action nor for their reference. This hampers an overview and a follow up of important matters. Furthermore, the CHMTs do not compile any comprehensive Council supervision report[39]. As a matter of fact, the audit team has not been able to find any report that deals with analysis or advice of significant importance on how to improve the efficiency.

4.1.6 Few actions are taken on supervision visits conducted

Photo 3 below shows a picture of one of the HC's medical supplies store with louvers. These openings may result into drugs being damaged hence patients may be given expired drugs unknowingly. Also **Photo 4** shows a picture of another store used to store drugs with leaking ceiling, damaged door and window.

Photo 3: A store used to keep medical supplies with open space. Open space may result into damaging of drugs.

[38] HMIS book number 2

[39] A report which includes all supportive supervision conducted for each health facilities within the council in a given period of time.

Photo 4: A store used to keep medical supplies with ceiling leaking

4.1.7 The health centers' performance not correlated to supervision

Analysis of linkages between conducted supervision and HCs' performance does not confirm any correlation. This has been examined by using the ratio for performance where WPT is divided with workload. A lower ratio reflects a better performance while a higher ratio reflects a less good performance. This ratio of performance has been compared with higher and lower goal fulfilment for eight HCs. This is shown in Table 8 below.

Table 8: Analysis of supervision against HCs' performance

SN	Councils	HC	Supervision goal fulfilment	Performance Ration
1	Bagamoyo DC	Chalinze HC	13%	3.65
2	Bagamoyo DC	Lugoba HC	13%	9.6
3	Muheza DC	Mkuzi HC	50%	4.5
4	Tanga CC	Makorora HC	275%	9.3
5	Mufindi MC	Kasanga HC	50%	10.5
6	Mufindi MC	Kasanga HC	50%	13.4
7	Iringa MC	Ipogoro HC	75%	14.7
8	Iringa MC	Ngome HC	75%	15

Source: Data collected and analysed by audit team

The table shows that in spite of the lowest goal fulfilment for conducted supervisions, Chalinze HC has the lowest ratio[40], which reflects the best performance. Also, though Makorora HC registered the highest goal fulfilment for conducted supervisions, its performance ratio reflects a rather low performance. In addition, though Ipogoro and Ngome HCs had the second best goal fulfilment for conducted supervisions, they have a performance ratio that reflects the lowest performance. The picture is more or less the same when all HCs are analysed[41].

4.1.8 Performance issues hardly addressed at supervision visits

In order to check to what extent issues of performance are addressed in the supervision visits, a choice of 45 supervision reports were reviewed. Issues of performance showed to be rarely addressed compared to other issues like inadequate resources, poor condition of medical equipment and environmental cleanliness. Moreover, there are no major differences among Councils visited in terms of its contents. Also, quite general issues were addressed from each supervision visit and most of these issues were found to be not within the authority of HC management[42].

4.1.9 Supervision reports lack of consistency

Another weakness with the supervision reports is the low or non existing consistency of the reports. Few reports stated objective of the supervision visits though objectives stated differ with the findings and the findings differ with the recommendations. Also the team noted poor records keeping and documentation of these reports in the Councils as well as in the HCs.

4.1.10 Few actions taken to improve the use of resources

It was observed that various efforts were taken by the Councils to facilitate the HCs' provision of health services, including training of health staff, distribution of medical supplies, rehabilitation of premises, supportive supervision etc. But it was also observed that the Councils' operating team has hardly dealt with issues like reallocation of resources for health staff. Also other performance measures based on workload and WPT are to a small extent considered in improving the performance of the HCs.

The HCs assess themselves quarterly and annually based on criteria issued by the ministry[43]. But there is no documentation showing any more independent assessment conducted by the Councils' management.

4.2 Monitoring by the regional authorities

The Councils' management of the HCs' performance is a key to a successful implementation of the health policy at operating level. At the regional level the

[40] Performance ratio is a ratio of WPT to workload
[41] See Appendix 5
[42] For further information see Appendix 17 and 18
[43] The Ministry of Health and Social Welfare (MoHSW).

Regional Secretariats (RS) as an extended arm of the central government has an important role to play in order to monitor this issue of the HCs' performance. The Regional Medical Officer (RMO) is the one in charge of the health care activities while different actors are used as experts for the activities at the regional level. One important actor is the Regional Health Management Team (RHMT) where the RMO is head of this team.

This section deals with two main issues of the RMO's responsibility for policy interpretation and implementation at the HCs' performance:

- One issue concerns the monitoring of the Councils' management of the HCs.
- The other issue concerns information provided by the RMO to the Central government regarding the performance of PHC.

4.2.1 Monitoring of the Councils' management of the health centers

The RMO is in charge of monitoring and evaluation of the performance of the Councils. According to the planning guidance, the Councils' management of HCs' performance should be monitored quarterly by RHMT on behalf of RMO.[44] This should be done through supportive supervision and by assessment of the Councils' financial and technical reports[45].

a. The supervision frequency is far from the requirements

The RHMT, on behalf of RMO, does not fully conduct supportive supervision as required.[46] Out of the 20 Councils that were studied by the audit team, 17 Councils had information available about conducted supervision in year 2007. Only 4 of these 17 Councils were visited four times per year as required while 5 Councils were visited almost once per year. The remaining 8 Councils were not visited at all during 2007.[47] In short, only one fifth of the regions complied with the regulation in terms of number of supportive supervision.

It's obvious that supervision can not be a supportive tool if it is not conducted as required. As seen above, almost two thirds of the regions did not visit the Councils any time in year 2007 or visited them only once. It's likely that this may affect the efficiency of the management among Councils as well as the performance of HCs.

Frequency is one vital dimension, but even more important is the content and the effectiveness of the supervisions themselves – whether they promote better performance. The audit team assessed the relation between supervision

[44]Comprehensive Council Health Planning Guideline (CCHPG)
[45]Financial and Technical reports are reports prepared quarterly and annually which summaries major achievements, constraints, variances and the way forward in the implementation of Comprehensive Council Health Plan prepared quarterly and annually
[46]National Supportive Supervision Guideline requirement issued by the MoHSW.
[47]For further information see appendix 8.

frequency and performance of the council. This involved looking on the issues addressed during the supervision visits. The team did not find a link between council's performance and high or low frequency of supervision.

b. Insufficient supervision of Councils' activities by the regional level

There is no connection in activities (mainly supportive supervision) between Regional and Council level in managing HCs. The implementation officer in charge (RMO) through the operating team (RHMT) is responsible for providing advice to the Councils regarding management of health issues at Council level. However, regional supervision put less consideration on how Council manages HCs.

Regional health policies and guidelines are issued by the MoHSW and PMORALG. RMOs through RHMTs are required to interpret and ensure proper implementation of the policies in their respective regions. But regional policies do not vary between regions. All regions use the same policies and guidelines in the implementation of their roles in their respective region. This includes also the existing systems for follow up and analysis.

Staff's competence and experience varies between regions. Some regions have competent and experienced staff while others do not. Variance is caused by their qualifications and working experience. Managerial skills depend on the individual efforts. This results into management commitment varying between regions.

Differences in performance to a large extent depend on leadership at individual HCs rather than on systematic factors linked to responsible institutions. Experiences above illustrate that there are well and less well performing HCs. But the experiences also illustrate that the Councils mostly are rather passive. Consequently, it is not the Councils' behavior that "explains" the HCs' varying performance.

c. Reporting from the Councils is not sufficiently analyzed to detect HC performance.

As mentioned above (section 4.1) the HMIS reports from operating level lack data regarding e.g. supervision conducted, cost of resources received and spent, workload, records of action taken in improving performance and missing medical supplies. But this reporting is not analyzed by actors at the regional level, thus putting a limitation of detecting possible weaknesses.

When it comes to the financial and technical reports, these reports lack physical verification. During the document review, the audit team observed many examples where the reported activities were neither conducted nor provided with the assumed resources. But this incorrect information was neither analyzed nor detected at the regional level[48].

[48] For further information see Appendix 7

4.2.2 Not suitable information from regional to central level

The central government level needs adequate and suitable information as a base for their decisions on national health care services. According to the health planning guidelines, the RS/RHMT is required to assess technical and financial reports and provide recommendations to the national level.

The documents review and interviews conducted during the audit showed that the RS/RHMT only give priority to programmes initiated at the national level.[49] Information about activities and performance more in general at operating level is not reflected in the documents from the regional level.

As mentioned above, the audit team also found many examples of incomplete and not reliable data from the information system, HMIS, and from the financial and technical reports during the document review at the Councils. This information is however neither analyzed by the Councils nor by the regional authorities. This means that the reporting from the regional to the national level is not fully useful.

The RS/RHMT uses the reports and recommendations from the HMIS system to request further funding from the national level.[50] Also, assessment of financial and technical report gives less weight to performance issues. But also this assessment forms the basis for further funding.[51]

All put together these shortcomings of the information available hamper the RS/RHMT from providing the national level suitable information as a base for political decisions and funding system of PHC.

4.3 Linkage between management activities and the health centers' performance

The audit team has studied the linkage between the HCs' performance and the management by activities from the Councils and the regional authorities. The dominating impression is that there is very little – if any – linkage.

The health management team at district level shows a mainly passive behavior without response or resistance. The team accepts different performance from the HCs though it indicates a potential for improved efficiency and effectiveness.

Supportive supervision is one of the major activities by the Councils which also is consuming almost 20 % of the total health basket fund. These supervisions vary by frequency. They are however not efficiently conducted as they are not used to improve efficiency and effectiveness at the HCs. Neither do these supervisions

[49]Vertical programmes are those special projects or activities which are managed and controlled directly from the central level (MoHSW) and normally financed by external donors.

[50]For further information see appendix 7.

[51]For further information see appendix 12.

have any obvious influence on the HCs' performance. Also, resources to the HCs are not reallocated by the Councils although extended differences in workload and performance do exist.

Also, the supervision at the regional level varies by frequency. There is however hardly any indication of influence on the Councils performance. Neither is unreliable reporting from the Councils analyzed and detected by regional authorities before this information is forwarded to the national level.

These findings indicate that explanations to differences at the HCs' performance can not mainly be explained by management from the regional authorities or the Councils. The analysis indicates that the differences of the HCs' performance have to be explained mainly by individual factors within the HCs' own influence. The team has also noticed important differences between the studied HCs when it comes to – for instance – attitudes, motivation, the staff's presence etc. issues that are more or less linked to the local management. Good performance is rather a result of a good leadership at the HCs, than a result of management from the Councils at district level and from the authorities at regional level.

Chapter Five

Support from actors at national level

The main actors at national level are the Ministry of Health and Social Welfare (MoHSW) with the subordinated agency Medical Stores Department (MSD) and Prime Minister's Office Regional Administration and Local Government (PMO RALG). These actors have influence on the HCs' performance from two perspectives. On one hand there are actors in the system for PHC providing national support to actors at regional and council level. On the other hand there are supervisors of the way the system as a whole is set up and works.[52] The aim of this chapter is to examine the influence from actors at national level on improving the HCs' performance. The chapter thus covers two main issues:

- One issue concerns to what extent the actors at the national level support the actors at regional and council level in improving the HCs' performance.
- The other issue concerns follow up and support from actors at the national level in order to safeguard the way the PHC system is set up and works.

5.1 National support to regional and council level

5.1.1 Late approval and delivery of funds

Funds decided and allocated by the government to local authorities in PHC are delayed when it comes to both the Government's Block Grants and the donors' Health Basket Fund.[53] During the financial years 2005/06 to 2006/7 the delays of Basket Fund resources varied from 33-123 days. This hampers the quality and the quantity of the HCs' performance as these resources are disbursed to allow the achievement of the national minimum standards of service for PHC. The release these resources are also linked to pre-defined outputs/outcomes. (See Table 9 below.)

Table 9: Receipts of Basket Fund

Year	Period of activity	Date amount received	Delays (In days)	Impact
2005/06	Quarter 1	21/09/2005	81	Activities not done timely
	Quarter 2	21/09/2005	-	-
	Quarter 3	31/03/2006	89	Activities not done timely
	Quarter 4	31/03/2006	-	-
2006/07	Quarter 1	27/09/2006	87	Activities not done timely
	Quarter 2	27/09/2006	-	-
	Quarter 3	04/05/2007	123	Activities not done timely
	Quarter 4	04/05/2007	33	Activities not done timely

Source Documents reviews

[52]See section 2.2.1 for further information.
[53]Government and Basket Funds are released separately – on a quarterly basis, as far as the Basket Fund is concerned.

5.1.2 Inadequate and late allocation of drugs

Through the MSD the MoHSW is assumed to provide medical supplies, drugs, to the HCs as requested. The common situation is however that the drugs are not delivered timely and as requested by the HCs from the MSD although the HCs have the desired resources. [54].

Out of 20 orders picked for review from the visited HCs, only 3 orders were fully fulfilled during year 2007. For other orders some of the items were missed. Some of the visited HCs had been lacking for essential drugs for more than three months. The reason for this delay is not closely examined by the MoHSW. But according to interviews with the officials in the ministry, this can partly be explained by bad stock keeping at the MSD or by inefficiencies in the MSD activities.[55] This problem was also evident under the health sector evaluation conducted in the year 2007[56]. See Table 10.

Table 10: Deliveries of drugs and equipment by MSD to health facilities Year 2007

HC	Number of requested items	Number of delivered items	Number of missed items	Percentage of missed items
Mkoka	40	40	0	0
Ugogoni	49	49	0	0
Ugogoni	37	37	0	0
Ugogoni	45	39	6	13
Ugogoni	45	38	7	16
Mkoka	46	37	9	20
Ugogoni	60	48	12	20
Mkoka	58	44	14	24
Melela	60	44	16	27
Ugogoni	61	44	17	28
Melela	46	33	13	28
Ugogoni	46	33	13	28
Ngome	53	37	16	30
Melela	56	38	18	32
Ipogoro	66	44	22	33
Ipogoro	61	40	21	34
Mkoka	63	41	22	35
Ugogoni	53	33	20	38
Kasanga	67	40	27	40
Mkoka	50	26	24	48

Source: Reviewed documents from HCs

[54] See Appendix 10
[55] See Appendix 10.
[56] 'The supply of drugs, equipment and other medical supplies provided by the Medical Stores Department has improved over the evaluation period. But shortages and delays in delivery are still common'

The government has currently issued a list of drugs that can be procured outside the MSD. But most of these items were not highly demanded by the HC facilities.[57]

5.1.3 Insufficient attention to the supportive supervision

The MoHSW has formulated supportive supervision guidelines to ensure efficient provision of health services to citizens. These guidelines are however not followed effectively by the supervisor actors neither at regional nor at council level. Since 1999 the MoHSW has failed to enforce the effective use of these guidelines to bring the desired impacts on performance of PHC.

There is no adequate monitoring from the central level on improving supportive supervision to bring impact on performance. An Inspectorate unit in the MoHSW deals with supervision. But this Inspectorate has not received any supervision report from the regional and council levels. Thus the ministry has no effective system of reporting from the lower administrative levels to central level concerning experiences from provided supervisions.

Moreover, most of the recommendations provided by the supervisors are irrelevant regarding the issue of performance. Some recommendations are also beyond the HC management's authority of HCs, e.g. construction of staff quarters[58].

5.1.4 Ineffective assessment of progress reports

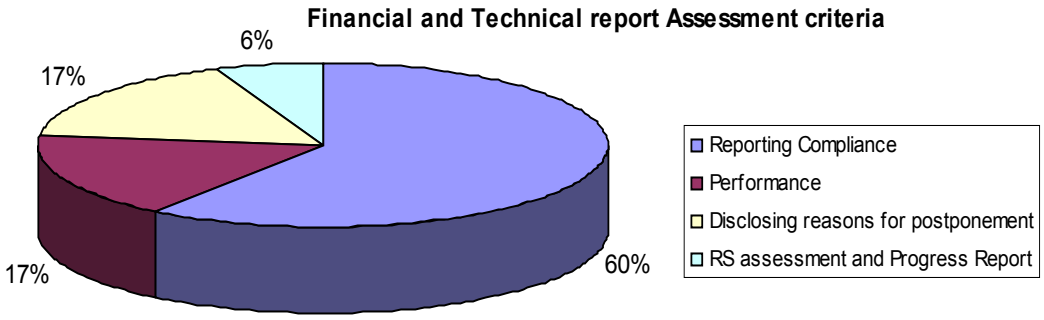
The MOHSW in collaboration with PMORALG have formulated guidelines on management of resources concerning health activities at the council level. The aim is to make effective use of these resources. One major issue is evaluation on the use of these resources. The result is reported in so called progress reports.

According to the guideline, the progress reports are assessed at the regional level and reassessed at the central level. The reason for this double checking is, according to the Health District Coordinator at the MoHSW, most of regional teams have no capacity to carry out such evaluation. However, the central team lacks experience and knowledge of the local environment where the activities were carried out.

Moreover the criteria – set by the MoHSW – for assessing the progress report for the purpose of further funding gave less weight to issues like performance and service delivery. The criteria were rather focusing on compliance on format of the report[59]. This is as shown under Chart 6.

[57]For further information see appendix 10
[58]Refer Appendix 17
[59]Refer Appendix 12

Chart 6:



Source: Data summarised by auditors from the CCHPG 2007

Also, the 20 Councils' health performance indicators[60] were not given adequate consideration in this evaluation. According to the interview with RHMT members, this was due the fact that these indicators are complicated and time consuming and thus not suitable for the short term evaluation. [61]

5.2 Actions to follow up the PHC system

The actors at the central level are responsible for the way the PHC system as a whole works. In order to fulfil this task it is important the ministerial level to be well informed with the actual, adequate and over viewing information about the performance and service delivery at operational level. As said above (section 5.1) this is neither provided in the progress reports nor in the conducted supportive supervision reports.

In order to improve the performance at the HCs through exchange of strong and suitable information, the MoHSW introduced a health information system in 1993, the HMIS. As stated above, the implementation of this system has shortcomings which hamper the possibilities of an adequate use of the system for a suitable communication between the national, regional and operating levels.[62] The system does not reflect the activities at the HCs in a relevant way; the system is neither up dated nor the data analyzed by the regional authorities.

All put together, the audit team has found many indications of problems with the management of PHC concerning the HCs' performance. The problems deal with resource allocations combined with inefficiency and ineffectiveness. These problems are however not detected by the supportive supervision or other kinds of reporting. Furthermore there is no clear channel with adequate, relevant and suitable information between the operating level, the management levels (council), regional levels and the national level. The MoHSW has neither asked for suitable and relevant information nor initiated any evaluation of the system (HMIS) for PHC.

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[60]These are performance indicators based on the council minimum health standards
[61]This according to the interview with the management of MoHSW
[62]See section 3.2 and 4.1.

Chapter Six

Conclusions

Audit findings in the preceding chapters make us to conclude the following:

General conclusion

The purpose of the audit is to examine whether HCs are managed efficiently and whether their performance is being measured and appropriately considered in allocating the available resources. The aim is to find room for improving the management and efficiency of the HCs' services to the citizens.

The PMORALG being the owner of the PHC centers and MoHSW as a technical ministry have not adequately and to a large extent fulfilled their responsibilities of distributing resources to the HC.

There are problems relating with the performance of the HCs. There was a lack of enough knowledge at national level on how well HCs perform. There were also reasons to believe that available resources were not always effectively distributed and efficiently utilized. In addition there were indications of shortcomings in management and monitoring at the varying administrative levels.

Specific conclusion

6.1 Correlation between resource allocation and performance

Insufficient Correlation between resource allocation and performance

Health Sector Reforms gave the Councils mandate to execute PHC services with the DMO and the operating health management team - CHMT- as main actors. The Councils thus have an important role to play regarding performance improvement. Our audit has revealed some shortcomings on this issue as explained below:

6.1.1 Resource allocation is not related to performance

Resources are vital inputs used by the health service providers to enable them to provide good services to the citizens. For adequate and fair resource allocation to the HCs the issues of performance and transparency are important to be considered.

However, the allocation of resources from the Councils to the specific HCs lacks transparency and there are no objective criteria for allocating these resources. Also, the actual allocation of resources from the Councils to HCs does not reflect the actual performance by terms of workload and WPT. The consequences are that HCs with high workload in many cases receive fewer resources as compared with HCs with low workload. In addition, there are no indications of advantages of bigger HCs, rather it seems to be the opposite situation.

In general, the examination of 30 HCs indicates on average a low level of performance activities in terms of workload and Waiting and Processing Time. This indicates that a general potential of improved efficiency might be considered at the HCs. A conclusion of this is that, it is possible to provide the citizens with more health care services within the same amount of resource allocation.

A more systematic combination of high/low workload and short/long WPT provides four categories of the HCs' efficiency in performance. This is illustrated by the four squares in figure 6 below. The model is a tool for comparing and analysing performance. As all models, it's a simplification, but in combination with other and more detailed analysis it may contribute to better learning and decision making on how to improve the HCs' performance – how to shorten WPT and increase service production.

Figure 6: Model for analysis of efficiency of the HCs' performance

		Workload	
		Low	**High**
Waiting and processing time	**Long**	1 (3 HCs)	2 (5 HCs)
	Short	3 (9 HCs)	4 (1 HCs)

Square 1: A low workload combined with a long WPT indicates inefficiency which means that corrective measures are needed.

Square 2: A high workload combined with a long WPT indicates that more resources are needed.

Square 3: A low workload combined with a short WPT indicates that resources available can be reallocated to the HCs belonging to square 2.

Square 4: A high workload combined with a short WPT indicates that HCs in this category work efficiently and deserve rewarding.

With certain criteria set for high/low workload and for short/long WPT for the examined 30 HCs, this model could be used as a tool to illustrate how they can be divided into the above four categories of efficiency. A workload considered as high for HC with 9 visitors or more per staff per day and low for 5 visitors or less. Also a WPT considered as short for say 45 minutes or less per visit and long for 80 minutes or more giving the following four categories:[63]

[63] See appendix 2. Ten HCs with waiting and processing time between 46 to 79 minutes and work load between 6-8 visitors per day and medical staff are not represented in this example (they are viewed as average performance) in this example.

- Square 1 include 3 HCs
- Square 2 include 5 HCs
- Square 3 include 9 HCs
- Square 4 include 1 HC

This allocation of HCs results in the following conclusions:

- Resources from the depicted HCs in square 3 can be reallocated to the depicted HCs in square 2.
- Corrective measures for a more efficient performance are needed for the depicted HCs in square 1.
- The depicted HCs in square 4 should be provided with rewarding activities for an efficient performance.

The result of these or similar examinations may serve as inputs for more detailed analysis or create a basis for actions to reallocate resources and for improving performance. The above analysis of performance at the visited HCs shows however that this has not been the common case.

6.1.2 Variation in efficiency are explained by internal factors

The above miscorrelation between resources and performance at the HCs can not be explained by varying environmental factors, like rural or urban areas or varying patterns of population and illnesses. Furthermore, the miscorrelation doesn't seem to reflect the different numbers of medical staff available at the HCs. Neither are there indications of advantages in terms of efficient utilization of resources for bigger HCs.

The conclusion is that the differences of the HCs' performance mainly have to be explained by individual issues within the HCs' own influence, more or less linked to the local management.

6.1.3 Poor communication between the Councils and the HCs

The Councils do not adequately manage the HCs' performance. This is because of a poor communication between in charge of HCs and the DMO which has influence on the conditions and the priorities for the HCs' activities. One of the factors that cause councils to inadequately manage the HCs performance is poor communication for disseminating important information such as Guidelines to HCs as a result staff at the HCs are un aware of the Guidelines for setting their priorities during the planning session. For example the MoHSW has set up a package with priorities for the burden of diseases in Tanzania[64], but the staff at the HCs were not aware of this guide for setting their priorities.

[64] CCHPG

Most of the HCs also lack a system of budgetary control. The HCs provide the Councils with their approved budget. But the Councils don't give any feed back to the HCs about the amount of budget for their activities although this kind of documentation does exist at the Councils. This means that the HCs are not aware of the approved amount from different sources that is available.

6.1.4 Few actions to improve performance

The Councils do have possibilities for correcting of miscorrelating resource allocation and for corrections of the HC's performance. But few actions are taken by the Councils to use these possibilities.

There is a national standard for the number of medical staff at each HC without considering the varying needs and the performance of activities. Based on this national standard for allocation of staff, the DMO has a mandate to reallocate staffs between the different HCs in the council's area in charge. This kind of reallocation of staffs' resources might be based on performance factors like workload and WPT. But very few Councils use their mandate by reallocating of the staff between HCs.

Supportive Supervision is a tool for assessing the performance of HCs, but the supervision visits are not effective. The Councils' operating team, CHMT, does not plan their supportive supervision which results in a lack of priorities. The supervision visits are limited in terms of frequency and they are neither properly planned nor communicated to the HCs.

The conducted supervision at regional level is linked with similar shortcomings of a low frequency and inefficient conducted supervision visits. This results in an unreliable reporting from the regional to the national level in the PHC system.

In general there is very limited documentation from conducted supervisions. This results in a lack of information when it comes to both experiences from single supervisions and from the supervisions as a whole.

There is also lack of systematic ways of measuring and evaluating the HCs' performance.

6.2 Health management information system

Insufficient problem oriented information about performance that is vital for improvement of services

For any information to be useful for decision making it is important to provide accurate information that is timely delivered and adopted to the decisions at different levels. In order to contribute to an improved performance, it is also important to have data related to problems linked with performance.

This is not the case with the existing management information system of PHC. On the other hand the availability of HC information is more of a mechanical kind, by not being updated, analyzed and problem oriented.

There is no systematic way of measuring the performance of the HCs. A tool used by the Councils to measure and evaluate HCs' performance – Health Management Information System – is not updated. The system does not consistently provide current, accurate and reliable data for management purposes.

The system for collecting data at the HCs is not being updated. In addition, the system consists of unreliable information and has thus been underutilised for a long time. Furthermore too few refresher courses on HMIS result in health staff – especially new ones – to be less competent on how to fill and to use the information generated from the system for decision-making.

6.3 Linkage between performance and policy making

The RS does not provide the important linkage between performance and policy making

The RS is an extended arm of the Government, through the RMO and the operating team, RHMT. These regional actors are however "weak" and unable to fully perform their mandate to support Councils to improve their services. The team does not fulfil its supervisory role in accordance with requirements. The team's assessment made on council's performance is also done more or less mechanically. The team does not analyze and detect that the reports from the Councils are provided without physical verification and are not reliable.

The quality problems with the information about the HCs at the regional level also resulted into inadequate and unreliable information from the RS to the MoHSW and PMO-RALG at national level. This means that these actors at the national level are not provided with suitable data for their policy decisions and allocation of resources.

6.4 Information to the national level

The national level does not get the overview of how the system works

The findings in the audit suggest that support provided to enhance PHC services is not adequate by many means. Varying causes and explanations appear for this situation.

The communication between the actors at national, regional and operating levels is not adequate for many reasons. The information system, HMIS, is not proper because it is not updated. The supportive supervision at the council and the regional levels is not conducted as intended and does not provide the assumed information

about the HCs' performance. The communication, concerning e.g. budget issues, is improper between the operational, regional and national level.

All together this brings about an inadequate situation for the actors at the national level. They don't get proper feed back from the regional and operating level. Neither have the actors at the national level asked for more proper and accurate information about performance in the PHC system suitable for decision making at national level. This hampers their role as supervisors of the way the PHC system is set up and works. This in turn, may explain why few corrective actions have been taken by the MoHSW and PMO-RALG at the national level.

Chapter Seven

Recommendations

The audit findings and conclusion point out many problems with resource allocation and communication that hampers the possibilities for a more efficient Primary Health Care. Changed actions at both the operative and the administrative levels in the area are important in order to improve the services provided at the HCs. Our recommendations are addressed as follows:

- To Municipal/District Councils
- To Regional Administrative Secretariat
- To the Prime Minister's Office Regional Administration and Local Government
- To the Ministry of Health and Social Welfare

7.1 To Municipal/District Council

For an improved efficiency in Primary Health Care, the Council Director (CD) has an important role to play[65]. The CD should ensure that resources allocation to the HCs is related with performance. To provide this the Councils through the health management team, need to establish performance based criteria related with the performance at the specific HCs. This will promote fair distribution of available resources to citizens.

The HC's budget control system also needs to be strengthened. In order to achieve this, it is important that the Councils provide the HCs with:

- National priorities on essential health package to guide them during preparation of their yearly proposal of a budget.
- estimated ceilings of the annual budgets
- Information on the approved annual budgets.

Strengthening budgeting system will create awareness to HCs' staff and other stakeholders on the resources available. This will assist the ability of HCs to promote transparency, accountability and good performance.

The District Medical Officer (DMO) with his team, CHMT, needs to contribute to improved activities at the HCs. In order to achieve this, the team needs to safeguard and ensure the following:

- proper delivery of the essential medical drugs and supplies to the HCs

[65]Council Director refers to Executive Director in City, Municipals, Districts and Town Councils

- proper collection, analysis of the HC data and reporting system according to the Health Management Information System
- reallocation of staff, drugs, funds and other resources between different HCs according to performance indicators like work load and WPT.
- Decentralisation of HCs' funds by ensuring that each facility has its own account and petty cash with a certain ceiling.
- building capacities to the Incharges of HCs regarding keeping proper records and control of funds and other resources at their health facilities.
- effective health governing committees is in place for each HC together with building the capacity of its members.

This will improve performance and ensures that suitable information are reported timely. Furthermore for the DMO to detect and correct shortcomings at the HCs, he/she needs to properly plan, conduct and follow up supportive supervision visits regularly which will result into improvement of quality and standards and also being able to identify and address gaps in performance.

7.2 To the Regional Secretariat

At the regional level, the Regional Medical Officer with his team, RHMT has an important role to play between the operating and the policy making levels by ensuring that:

- CHMT supervision visits at the HCs are properly planned, conducted and followed up
- the RS/RHMT should provide the MoHSW and PMORALG with reliable, problem oriented and analyzed information regarding health issues for their decision making.

Effective supervision will promote better performance. Provision of suitable information to the PMORALG and MoHSW timely will assist in ensuring that political decisions and funding system of PHC base on these information. This will result into fair distribution of resources.

7.3 To the PMORALG

The Prime Minister's Office Regional Administration and Local Government is responsible for the overall coordination and implementation of the health sector in the Regions and Local Government Authorities and ensuring that health basket funds is disbursed to them on time. For effective discharging of her roles PMORALG should:

- Ensure that assessment of financial and technical reports give more weight to performance issues so as to help facilitate positive changes by enabling HCs to take full advantage of both technical and financial assistance.

- Contribute to a more decentralized decision making of basket funds in accordance with the requirement at the Ministry of Health of Social Welfare CCHPG.

- Ensure that a more efficient procedure for the disbursements of fund is followed including a benchmark for time. The ministry needs to develop more direct and transparent links between the funds allocated to HCs and expected activities, service levels and targets. This will promote timely implementation of activities at regional, council and HC level.

7.4 To the MoHSW

The Ministry of Health and Social Welfare should:

- allocate essential medical drugs, equipment, supplies and funds by taking into consideration performance indicators like HCs' workload and visitors' waiting and processing time.

- ensure that HCs are provided with adequate drugs and medical supplies by the Medical Stores Department according to their requests.

- ensure that the Health Management Information System is updated to address critical gaps in terms of performance.

- strengthen the Regional Health Management Team to fully perform their mandate of supporting CHMT and evaluating CCHPs and progress report before forwarding them to PMORALG/MoHSW.

- Ensure that the Medical Stores Department prepare and issue accountability statement quarterly in regard to each LGA. The same report has to be incorporated in council's implementation report prepared quarterly.

This will result into fair distribution of resources and hence promote better performance at different levels as per existing health system. Measuring waiting time enables benchmarking and also identifying local resource allocation, service model and service planning issues together with the good practice strategies for managing high demand. Also, it can support evidence that supports funding application.

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APPENDICES

Appendix 1

Average number of visitors per day compared with drugs allocation per quarter in Tanzania shillings

SN	Name of the HC	Average number of visitors per day	Amount allocated (Tshs)
1	Kilimarondo HC	18	2,000,000
2	Mndemu HC	30	2,000,000
3	Malangali HC	32	2,000,000
4	Mgeta HC	33	1,755,000
5	Ngome HC	40	2,000,000
6	Nkowe HC	40	2,000,000
7	Mkuzi HC	42	1,755,000
8	Kisiju HC	43	2,000,000
9	Kasanga HC	48	2,000,000
10	Mkamba HC	49	2,000,000
11	Kitangari HC	51	2,000,000
12	Chiwale HC	53	2,000,000
13	Mwera HC	55	1,755,000
14	Mkoka HC	55	2,000,000
15	Njinjo HC	62	2,000,000
16	Chihangu HC	67	2,000,000
17	Chamwino HC	70	2,000,000
18	Nagaga HC	70	2,000,000
19	Namikupa HC	70	2,000,000
20	Masoko HC	75	2,000,000
21	Ipogoro HC	95	2,000,000
22	Lugoba HC	97	2,000,000
23	Mandawa HC	100	2,000,000
24	Sabasaba HC	115	1,755,000
25	Mahuta HC	125	2,000,000
26	Mlandizi HC	135	2,000,000
27	Kimamba HC	165	2,000,000
28	Mafiga HC	225	1,755,000
29	Chalinze HC	231	2,000,000
30	Makorora HC	380	1,755,000
31	Melela	50	740,000

Source: Raw data collected by auditors

Appendix 2

List of HCs with their respective workload and WPT

Sn	Name of HC	Average number of visitors per day	Number of full time health staff	Average workload	Average WPT
1	Kilimarondo	18	6	3	31
2	Mndemu	30	8	4	16
3	Malangali	32	9	4	42
4	Mgeta	33	11	3	30
5	Nkowe	40	9	4	120
6	Ngome	40	27	1	15
7	Mkuzi	42	12	4	18
8	Kisiju	43	11	4	101
9	Kasanga	48	10	5	67
10	Mkamba	49	8	6	29
11	Kitangari	51	11	5	81
12	Chiwale	53	5	11	79
13	Mwera	55	17	3	31
14	Njinjo	62	7	9	17
15	Chihangu	67	8	8	88
16	Namikupa	70	6	12	180
17	Chamwino	70	7	10	60
18	Nagaga	70	8	9	128
19	Masoko	75	16	5	65
20	Ipogoro	95	30	3	44
21	Lugoba	97	18	5	48
22	Mandawa	100	7	14	150
23	Sabasaba	115	39	3	35
24	Mahuta	125	12	10	210
25	Mlandizi	135	43	3	49
26	Kimamba	165	20	8	45
27	Mafiga	225	32	7	75
28	Chalinze	231	10	23	84
29	Makorora	380	48	8	75
30	Melela	50	16	3	75

Source: Raw data collected, interviews and documents review by auditors

Appendix 3

List of HCs with their respective classes of performance scores

Sn	Name of the HC	WPT	Average number of visitors per day	Number of staff available	Amount allocated (Tshs)
1	Ngome HC	15	40	27	2,000,000
2	Mndemu HC	16	30	8	2,000,000
3	Njinjo HC	17	62	7	2,000,000
4	Mkuzi HC	18	42	12	1,755,000
5	Mkamba HC	29	49	8	2,000,000
6	Mgeta HC	30	33	11	1,755,000
7	Kilimarondo HC	31	18	6	2,000,000
8	Mwera HC	31	55	17	1,755,000
9	Sabasaba HC	35	115	39	1,755,000
10	Malangali HC	42	32	9	2,000,000
11	Ipogoro HC	44	95	30	2,000,000
12	Kimamba HC	45	165	20	2,000,000
13	Lugoba HC	48	97	18	2,000,000
14	Mlandizi HC	49	135	43	2,000,000
15	Chamwino HC	60	70	7	2,000,000
16	Masoko HC	65	75	16	2,000,000
17	Kasanga HC	67	48	10	2,000,000
18	Mafiga HC	75	225	32	1,755,000
19	Makorora HC	75	380	48	1,755,000
20	Chiwale HC	79	53	5	2,000,000
21	Kitangari HC	81	51	11	2,000,000
22	Chalinze HC	84	231	10	2,000,000
23	Chihangu HC	88	67	8	2,000,000
24	Kisiju HC	101	43	11	2,000,000
25	Nkowe HC	120	40	9	2,000,000
26	Nagaga HC	128	70	8	2,000,000
27	Mandawa HC	150	100	7	2,000,000
28	Namikupa HC	180	70	6	2,000,000
29	Mahuta HC	210	125	12	2,000,000
30	Melela HC	75	50	16	740,000

Source: Raw data collected by auditors

Appendix 4

A comparison of performance (WPT & average number of visitors per day) with resource allocation

Sn	Name of the HC	WPT	Average number of visitors per day	Number of staff available	Amount allocated (Tshs)
1	Ngome HC	15	40	27	2,000,000
2	Mndemu HC	16	30	8	2,000,000
3	Njinjo HC	17	62	7	2,000,000
4	Mkuzi HC	18	42	12	1,755,000
5	Mkamba HC	29	49	8	2,000,000
6	Mgeta HC	30	33	11	1,755,000
7	Kilimarondo HC	31	18	6	2,000,000
8	Mwera HC	31	55	17	1,755,000
9	Sabasaba HC	35	115	39	1,755,000
10	Malangali HC	42	32	9	2,000,000
11	Ipogoro HC	44	95	30	2,000,000
12	Kimamba HC	45	165	20	2,000,000
13	Lugoba HC	48	97	18	2,000,000
14	Mlandizi HC	49	135	43	2,000,000
15	Chamwino HC	60	70	7	2,000,000
16	Masoko HC	65	75	16	2,000,000
17	Kasanga HC	67	48	10	2,000,000
18	Mafiga HC	75	225	32	1,755,000
19	Makorora HC	75	380	48	1,755,000
20	Chiwale HC	79	53	5	2,000,000
21	Kitangari HC	81	51	11	2,000,000
22	Chalinze HC	84	231	10	2,000,000
23	Chihangu HC	88	67	8	2,000,000
24	Kisiju HC	101	43	11	2,000,000
25	Nkowe HC	120	40	9	2,000,000
26	Nagaga HC	128	70	8	2,000,000
27	Mandawa HC	150	100	7	2,000,000
28	Namikupa HC	180	70	6	2,000,000
29	Mahuta HC	210	125	12	2,000,000
30	Melela HC	75	50	16	740,000

Source: Raw data collected by auditors

Appendix 5

Health center average number of visitors per day compared with the staff available

Sn	Name of the HC	Average number of visitors per day	Number of staff available as per schedule
1	Kilimarondo HC	18	6
2	Mndemu HC	30	8
3	Malangali HC	32	9
4	Mgeta HC	33	11
5	Nkowe HC	40	9
6	Ngome HC	40	27
7	Mkuzi HC	42	12
8	Kisiju HC	43	11
9	Kasanga HC	48	10
10	Mkamba HC	49	8
11	Kitangari HC	51	11
12	Chiwale HC	53	5
13	Mwera HC	55	17
14	Njinjo HC	62	7
15	Chihangu HC	67	8
16	Namikupa HC	70	6
17	Chamwino HC	70	7
18	Nagaga HC	70	8
19	Masoko HC	75	16
20	Ipogoro HC	95	30
21	Lugoba HC	97	18
22	Mandawa HC	100	7
23	Sabasaba HC	115	39
24	Mahuta HC	125	12
25	Mlandizi HC	135	43
26	Kimamba HC	165	20
27	Mafiga HC	225	32
28	Chalinze HC	231	10
29	Makorora HC	380	48
30	Melela HC	50	16

Source: Raw data collected by auditors

Appendix 6

Supervision carried by CHMT to their respective health centers for year 2006 and 2007

Sn	Council	Goal fulfilment (Supervision)	Number of Supervision	
			Required	Conducted
1	Bagamoyo DC	13%	8	1
2	Morogoro MC	25%	8	2
3	Kilwa Masoko DC	25%	8	2
4	Ruangwa DC	25%	8	2
5	Mufindi DC	50%	8	4
6	Muheza DC	50%	4	2
7	Kibaha DC	50%	4	2
8	Mkuranga DC	50%	8	4
9	Iringa MC	75%	8	6
10	Chamwino DC	75%	4	3
11	Newala DC	75%	8	6
12	Bahi DC	100%	4	4
13	Mvomero DC	100%	8	8
14	Pangani DC	125%	4	5
15	Masasi DC	163%	8	13
16	Kilosa DC	225%	4	9
17	Tanga MC	275%	4	11

Note: The column above named number of supervision required; 8 means two years i.e 2006 and 2007 while 4 is for only one year.

A list of activities budgeted by Councils for rural health centers and reported as fully implemented while HC have not been benefited

Sn	DC	Number of HC visited	Percentage of HC covered in the DC	Activity reported as implemented	Remarks
1	Kibaha DC	1	100%	• 37 staff were paid extra duty allowances Tshs. 1,665,000/= (Activity No. RHC 1) • Collection of CHF contributions from 12 HFs amounting Tshs. 1,746,023.83 (Activity No. RHC 10) • Purchase of 2 (two) toner for computer printer Tshs. 114,042.83 (Activity No. RHC 1) • Laundry services conducted Tshs. 3,561,450/= (Activity No. RHC 19) • Leave travel ticket paid to staff. Tshs. 3,362,000/= (Activity No. RHC 18)	Health facilities were not provided with the said amount
2	Nachingwea DC	1	100%	• Procurement of equipments, medical supplies and laboratory reagents Tshs.1,600,000 (Activity No.101) • Provision of office/hospital supplies Tshs. 3,070,618/= (Activity No.102)	• Not delivered to Kilimarondo HC • Not delivered to Kilimarondo HC
3	Masasi DC	2	100%	• Procurement and distribution of 50 BP Machine and 1045 cord damps amounting Tshs. 21,468,150/= • 25 health workers trained on IMCI for 14 days amounting Tshs.14,771,000/=	• The Council has only 2 HC. Only one HC received one BP machine from Clinton Foundation. The other HC do not have BP machine even cord damps. • Only 3 staff attended IMCI training in October 2007 and it was for 5 days only
4	Newala DC	2	100%	• Purchase of stationeries Tshs. 5,507,023/= (Activity No. 128) • Training IMCI management Tshs.3,246,000/= (Activity No.114)	• The Council has only two HCs. These health facilities are not provided with stationeries. • Last training attended was on 2004 for Chihangu and 1998 for Kitangari.
5	Tandahimba DC	2	100%	• Clearance of quarterly utilities amounting Tshs. 7,262,243.23 (Activity No. 167)	• HCs do not have electricity. • Sterilisation is done locally using firewood • They are not provided with kerosene • They are not provided with diesel as they do not have motor vehicle

Appendix 8

Supervision visit at Councils conducted by the RHMTs

Sn.	Council	Region	Requirement	2006	2007
1	Morogoro MC	Morogoro	4	0	0
2	Kilosa DC	Morogoro	4	3	4
3	Mvomero DC	Morogoro	4	3	4
4	Iringa MC	Iringa	4	1	1
5	Mufindi DC	Iringa	4	1	1
6	Pangani DC	Tanga	4	0	2
7	Tanga CC	Tanga	4	1	0
8	Kilwa Masoko DC	Lindi	4	0	0
9	Nachingwea DC	Lindi	4	0	0
10	Ruangwa DC	Lindi	4	0	0
11	Masasi DC	Mtwara	4	0	0
12	Newala DC	Mtwara	4	0	0
13	Tandahimba DC	Mtwara	4	0	0
14	Kibaha DC	Coast	4	3	1
15	Kongwa DC	Dodoma	4		
16	Bagamoyo DC	Coast	4	2	1
17	Muheza DC	Tanga	4		
18	Mkuranga DC	Coast	4		
19	Bahi DC	Dodoma	4	4	4
20	Chamwino DC	Dodoma	4	4	4

Appendix 9

A comparison of performance (waiting time and workload) with outstanding balance in MSD for year ended 31st December 2007.

Sn	Name of the HC	WPT	Average visitors per day	Staff available as per schedule	Amount (Tshs)
1	Ngome HC	15	40	27	-3,189,102
2	Mndemu HC	16	30	8	-2,204,520
3	Njinjo HC	17	62	7	1,748,194
4	Mkuzi HC	18	42	12	1,573,294
5	Mkamba HC	29	49	8	2,590,094
6	Mgeta HC	30	33	11	5,956,918
7	Kilimarondo HC	31	18	6	2,009,494
8	Mwera HC	31	55	17	1,062,094
9	Sabasaba HC	35	115	39	-1,936,122
10	Malangali HC	42	32	9	-2,198,637
11	Ipogoro HC	44	95	30	
12	Kimamba HC	45	165	20	5,815
13	Lugoba HC	48	97	18	-18,045
14	Mlandizi HC	49	135	43	2,873,794
15	Chamwino HC	60	70	7	-2,763,346
16	Masoko HC	65	75	16	1,214,494
17	Kasanga HC	67	48	10	-1,241,755
18	Mafiga HC	75	225	32	-5,278,612
19	Makorora HC	75	380	48	1,211,394
20	Chiwale HC	79	53	5	9,254,018
21	Kitangari HC	81	51	11	8,307,133
22	Chalinze HC	84	231	10	2,458,148
23	Chihangu HC	88	67	8	
24	Kisiju HC	101	43	11	3,242,044
25	Nkowe HC	120	40	9	2,695,594
26	Nagaga HC	128	70	8	7,226,848
27	Mandawa HC	150	100	7	1,086,094
28	Namikupa HC	180	70	6	2,709,812
29	Mahuta HC	210	125	12	-3,570,097

Source: Raw data collected by auditors

Appendix 10

Numbers of days Essential drugs were missing in the health center against funds balance at the MSD for the year 2007

SN	Drugs / HC	Amoxycilline tabs	Benzylpenicilliine emulsion	Benzylpenicilliine injection	Co-trimoxazole susp.	Co-trimoxazole tab.	Doxycycline tabs	Ergometrine inj	Fe (2+) folic acid tabs	Lidocaine inj.	Mebendazole tabs	Metronidazole tabs	Oral Rehydration Salt sachet	Oxytetracycline eye ointment	Paracetamol tabs	Procaine Penicillin fortified inj.	Water for injection	Examination gloves latex	Povidone iodine solution	Silk suture	Surgical gloves disposable	Syringe reusable	Drugs balance at MSD 31/12/07
1	Mgeta HC**	NA	0	59	NA	0	0	0	0	80	0	90	0	31	0	0	0	31	0	NA	31	NA	5,956,918.00
2	Ngome HC**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-3,189,102.00
3	Mkuzi HC**	0	0	0	15	8	0	0	10	0	0	0	0	0	30	0	0	50	5	0	40	25	1,573,294.00
4	Kasanga HC**	0	0	0	181	0	0	0	20	181	0	181	0	0	0	0	0	10	107	14	0	0	
5	Mlandizi HC*	148	126	135	175	134	67	149	185	31	20	80	120	67	183	80	114	195	131	189	210	169	2,873,794.00
6	Chalinze HC	136	88	143	139	152	0	106	0	119	103	130	96	0	218	12	12	229	152	216	191	196	2,458,148.00
7	Lugoba HC**	46	81	108	91	44	104	32	86	55	91	56	0	0	87	151	180	88	81	92	104	38	-18,045.00
8	Mkamba HC*	24	19	20	26	25	0	27	20	0	4	27	0	20	27	29	29	30	30	0	30	32	2,590,094.00
9	Masoko HC*	0	3	50	38	18	2	28	20	28	2	6	300	0	27	50	63	17	1	0	20	0	1,214,494.00
10	Kitangari HC	276	0	0	365	304	184	0	0	0	0	0	0	0	242	0	0	0	0	0	0	0	8,307,133.00
11	Chihangu HC	114	0	0	90	90	204	0	0	0	0	0	0	0	41	0	0	0	0	0	0	0	
12	Nagaga HC	282	210	90	280	290	180	90	180	90	90	285	122	270	90	90	0	0	180	360	0	85	7,226,848.00
13	Mandawa HC*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,086,094.00

Note:

* - Only data for three quarters were available

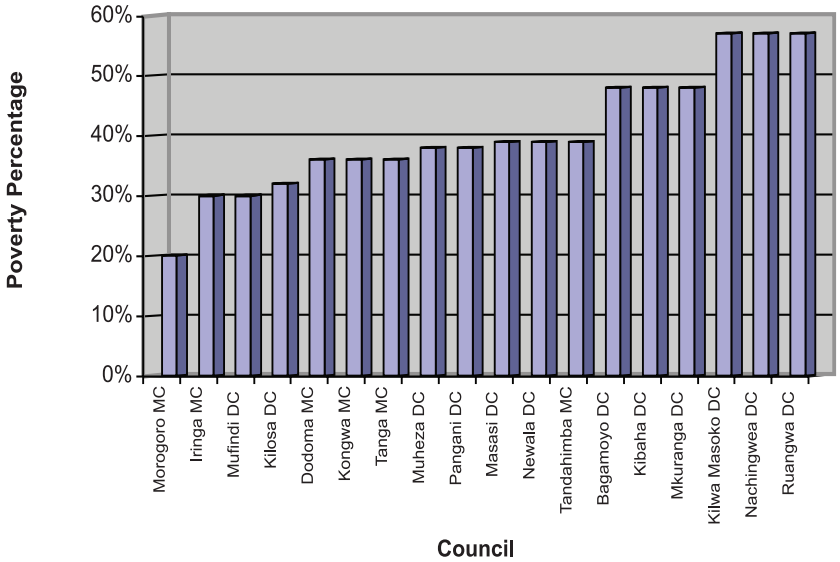
** - Only data for two quarters were available

Poverty (Percentage of People living below basic poverty line in the council)

SN	Council	Poverty
1	Morogoro MC	20%
2	Iringa MC	30%
3	Mufindi DC	30%
4	Kilosa DC	32%
5	Dodoma MC	36%
6	Kongwa MC	36%
7	Tanga MC	36%
8	Muheza DC	38%
9	Pangani DC	38%
10	Masasi DC	39%
11	Newala DC	39%
12	Tandahimba MC	39%
13	Bagamoyo DC	48%
14	Kibaha DC	48%
15	Mkuranga DC	48%
16	Kilwa Masoko DC	57%
17	Nachingwea DC	57%
18	Ruangwa DC	57%

Source:

Chart 7: Council's Poverty percentage



Appendix No .12

Criteria used to assess council progress Financial and technical reports

Sn.	Basis of criteria	Maximum assigned value	
		Points	Percentage
1	Compliance with reporting requirements	18	60
2	Implementation of activities - Performance	5	17
3	Provision of reasons for partial or postponement of activities implementation	5	17
4	RS assessment of CCHP and Progress Reports	2	6
	Total	30	100

Source: Data summarized by auditors from the CCHPG 2007

Appendix No. 13

List of Regions, Councils and Health Centers visited during the audit assignment.

SN	REGIONS	COUNCILS	HEALTH CENTERS
1	DODOMA	1. Chamwino DC 2. Bahi DC 3. Kongwa DC	1. Chamwino HC 2. Mndemu HC 3. Mkoka and Ugogoni HC
2.	IRINGA	1. Iringa MC 2. Mufindi DC	1. Ipogoro and Ngome HC 2. Malangali and Kasanga HC
3	MOROGORO	1. Mvomero DC 3. Morogoro MC 4. Kilosa DC	1. Melela and Mgeta HC 2. Sabasaba and Mafiga HC 3. Kimamba HC
4	TANGA	1. Tanga MC 2. Muheza DC 3. Pangani DC	1. Makorora HC 2. Mkuzi HC 3. Mwera HC
5	PWANI	1. Bagamoyo DC 2. Mkuranga DC 3. Kibaha DC	1. Lugoba and Chalinze HC 2. Mkamba and Kisiju HC 3. Mlandizi HC
6	LINDI	1. Kilwa Masoko DC 2. Nachingwea DC 3. Ruangwa DC	1. Masoko and Njinjo HC 2. Kilimarondo HC 3. Mandawa and Nkowe HC
7	MTWARA	1. Masasi DC 2. Newala DC 3. Tandahimba DC	1. Nagaga and Chiwale HC 2. Chihangu and Kitangari HC 3. Mahuta and Namikupa HC

Appendix 14

List of Councils with their respective number of HCs and Medical Staff

SN	Council	Number of HC	Number of staff
1	Bagamoyo DC	4	119
2	Iringa MC	2	37
3	Kibaha DC	1	43
4	Kilosa DC	5	81
5	Kilwa Masoko DC	5	62
6	Masasi DC	2	13
7	Mkuranga DC	2	40
8	Morogoro MC	3	96
9	Mvomero DC	3	94
10	Mufindi DC	4	36
11	Muheza DC	4	56
12	Nachingwea DC	1	9
13	Newala DC	2	19
14	Pangani DC	1	17
15	Ruangwa DC	2	16

Appendix 15

Methods used to collect data of waiting and processing time (WPT) and workload from HCs visited.

S/n	Data collection method	Name of Health Centers
1	Physical count and observation[1],	Ipogoro,Makorora, Mkuzi ,Malangali,Kasanga Lugoba , Chalinze Mkamba , Kisiju, Mlandizi,.Masoko, Njinjo,Kilimarondo, Chihangu ,Kitangari Nagaga and Chiwale HC
2	Interview and review of documents	Chamwino , Mndemu, Mkoka, Ugogoni Ngome ,Melela Mgeta ,Sabasaba, Mafiga ,Kimamba Mandawa , Nkowe Mahuta,Namikupa and Mwera HC

Appendix 16

Number of supervision visits conducted by RHMTs

SN	Region	Councils	Number of supervision visit required for 2006 and 2007	Number of actual supervision conducted
1	DODOMA	1 .Chamwino DC 2. Bahi DC 3 .Kongwa DC	24	
2.	IRINGA	1. Iringa MC 2. Mufindi DC	16	4
3	MOROGORO	1. Mvomero DC 2. Morogoro MC 3. Kilosa DC	24	14
4	TANGA	1. Tanga CC 2. Muheza DC 3. Pangani DC	24	3
5	COAST	1. Bagamoyo DC 2. Mkuranga DC 3. Kibaha DC	24	7
6	LINDI	1. Kilwa Masoko DC 2. Nachingwea DC 3. Ruangwa DC	24	0
7	MTWARA	1. Masasi DC 2. Newala DC 3. Tandahimba DC	24	0

Appendix 17

Analysis of findings of CHMTs' supervision reports reviewed

S/n	Categories	Total number of reports addressing the issues	Total number of reports not addressing the issues	Percentages of reports addressing the issue %
1	Findings address HMIS and training.	18	27	40
2	Findings address issues of inadequate resources, poor conditions of medical equipments, buildings e.g. staff quarters	29	16	64
3	Findings address administration issues like, staff meetings, uniforms, punctuality, and cooperation shown to supervisee.	15	30	33
4	Findings address issues of general cleanness and environment caring.	18	27	40
5	Findings regarding availability and good utilization of resources such as drugs, equipment, reagents	6	39	13
6	Findings regarding issues of workload, waiting- processing time, customer satisfaction, allocation and reallocation of resources.	0	0	0
7	Findings regarding financial management e.g. records receipts books, bin card	8	37	18

Appendix 18

Analysis of recommendations of CHMTs' supervision reports reviewed

S/n	Categories	Total number of reports addressing the issues	Total number of reports not addressing the issues	Percentages of reports addressing the issue %
1	Findings address Health Management information System and training.	14	31	31
2	Recommendation address issues of inadequate resources, poor conditions of medical equipments, buildings e.g. staff quarters	21	24	47
3	Recommendation addresses administration issues like, staff meetings, uniforms, punctuality, and cooperation shown to supervisee.	9	36	20
4	Recommendation address issues of general cleanness and environment caring.	13	32	29
5	Recommendation regarding availability and good utilization of resources such as drugs, equipment, reagents	5	40	11
6	Recommendation regarding issues of workload, waiting- processing time, customer satisfaction, allocation and reallocation of resources.	2	0	0.04
7	Recommendation regarding financial management e.g. records receipts books, bin card	5	40	11
8	Recommendation addressing issues of supervision and immunization coverage	5	40	11

Individuals/management interviewed

SN	Name	Details	Place
1	Top Management	PMO RALG	Dodoma
2	Top Management	MOHSW	Dar es Salaam
3	Mr. Muhume	Chief Pharmacist	
4	Dr. D.Lyimo	Municipal Medical Officer Ilala	ILala
5	Dr. linda	Staff	Mnazi Mmoja HC
6	Mr. Maswi E.C.J	Assistant Commissioner of Budget (MoFEA)	Dar es Salaam
7	M.W.F Maganga	Coordinator-HBF(D) PMO-RALG	Dodoma
8	Ms. Anna Nswilla	Coordinator DHS-MoHSW	Dar es salaam
9	Dr. J.M.N Maro	Retired Doctor DMO	Kibaha
10	Dr.Emmanuel J. Mwanemile	DMO-Chamwino DC	Chamwino DC Dododoma.
11	Mr. Henry S.Mlelwa	Clinical Officer In charge Malangali HC	Malangali -Mufindi DC, Iringa
12	Dr. G.J.B Mtey	MMO-Morogoro	Morogoro MC
13	Dr. Ezekiel Mpuya	RMO-IRINGA	RAS-Iringa
14	Dr. Felista Kwai	In charge-Mnazi Mmoja HC	Ilala M Council
15	Mr. Pascal W. Kanyinyi	Acting RMO-Tanga	RAS-Tanga
16	Mr. Saile	Coordinator Joint Rehabilitation Fund PMO RALG	Dar es Salaam
17	RHMT	Team Members	Morogoro
18	RHMT	Team Members	Mtwara
19	RHMT	Team Members	Lindi
20	RHMT	Team Members	Pwani
21	RHMT	Team Members	Tanga
22	CHMT	Team Members-Bagamoyo DC	Bagamoyo
23	CHMT	Team Members- Kongwa DC	Kongwa
24	CHMT	Team Members- Iringa MC	Iringa
25	CHMT	Team Members- Kibaha DC	Kibaha
26	CHMT	Team Members- Kilosa DC	Kilosa
27	CHMT	Team Members- Kilwa Masoko DC	Kilwa Masoko
28	CHMT	Team Members- Masasi DC	Masasi

SN	Name	Details	Place
29	CHMT	Team Members Mkuranga DC	Mkuranga
30	CHMT	Team Members Morogoro DC	Morogoro
31	CHMT	Team Members Mvomero DC	Mvomero
32	CHMT	Team Members Mufindi DC	Mufindi
33	CHMT	Team Members Muheza DC	Muheza
34	CHMT	Nichangwea Dc Team Members	Nichangwea
35	CHMT	Team Members Newala DC	Newala
36	CHMT	Team Members Pangani Dc	Pangani
37	CHMT	Team Members Ruangwa Dc	Ruangwa
38	CHMT	Team Members Ruangwa Dc	Ruangwa
39	CHMT	Team Members Tanga Dc	Tanga
40	CHMT	Team Members Chamwino	Chamwino
41	CHMT	Team Members Bahi Dc	Bahi
Health Centers			
42	Kilimarondo	In charges and staff of HC	Nachingwea – Lindi
43	Mndemu	In charges and staff of HC	Bahi – Dodoma
44	Malangali	In charges and staff of HC	Mufindi – Iringa
45	Mgeta	In charges and staff of HC	Mvomero – Morogoro
46	Nkowe	In charges and staff of HC	Ruangwa – Lindi
47	Ngome	In charges and staff of HC	Iringa Municipal – Iringa
48	Mkuzi	In charges and staff of HC	Mheza – Tanga
49	Kisiju	In charges and staff of HC	Mkuranga – Pwani
50	Kasanga	In charges and staff of HC	Mufindi – Iringa
51	Mkamba	In charges and staff of HC	Mkuranga – Pwani
52	Kitangari	In charges and staff of HC	Newala – Mtwara
53	Chiwale	In charges and staff of HC	Masasi – Mtwara
54	Mwera	In charges and staff of HC	Pangani – Tanga
55	Mkoka	In charges and staff of HC	Kongwa - Dodoma
56	Njinjo	In charges and staff of HC	Kilwa Masoko – Lindi
57	Chihangu	In charges and staff of HC	Newala – Mtwara

SN	Name	Details	Place
58	Namikupa	In charges and staff of HC	Tandahimba – Mtwara
59	Chamwino	In charges and staff of HC	Chamwino – Dodoma
60	Nagaga	In charges and staff of HC	Masasi – Mtwara
61	Masoko	In charges and staff of HC	Kilwa Masoko – Lindi
62	Ipogoro	In charges and staff of HC	Iringa Munispal – Iringa
63	Lugoba	In charges and staff of HC	Bagamoyo – Pwani
64	Mandawa	In charges and staff of HC	Ruangwa – Lindi
65	Sabasaba	In charges and staff of HC	Morogoro Munispal
66	Mahuta	In charges and staff of HC	Ruangwa – Lindi
67	Mlandizi	In charges and staff of HC	Kibaha DC – Pwani
68	Kimamba	In charges and staff of HC	Kilosa – Morogoro
69	Mafiga	In charges and staff of HC	Morogoro DC – Morogoro
70	Chalinze	In charges and staff of HC	Bagamoyo – Pwani
71	Makorora	In charges and staff of HC	Tanga Municipal – Tanga
72	Melela	In charges and staff of HC	Mvomero – Morongo
73	Ugogoni	In charges and staff of HC	Kongwa – Dodoma

Appendix 20

Workload and waiting and processing time Concept
For the purpose of this study, the combination of workload (WL) and waiting-processing time (WPT) concept used as the criteria for assessing performance of HC and application on allocation of available resources to HC within Councils.

Seven regions were chosen, out of which 20 Councils were chosen. Sample selected is almost equal to 10% (32 HCs) of the total HCs (331). Due to availability of data, only 30 HCs were analysed in terms of workload and WPT.

Workload per day per medical staff
Workload refers to average number of visitors at HC per day per fulltime working medical staff.

This is computed as follows:

$$\text{Average number of visitors per day} = \frac{\text{Total number of visitors in day one} + \text{Total number of visitors in day two}}{2}$$

Fulltime working medical staff measured in the audit refers to total number of all medical staff available working in the HC visited. This excludes medical staffs that were on leave. Medical staff includes Assistant Medical Officer (AMO), Clinical Officer (CO), Nurse, Medical Attendant (MA) and Technician.

Table 20.1: Computation of Average workload per day per staff

SN	Name of HC	Average number of visitors per day	Number of full time health staff	Average workload per day per staff
1	Kilimarondo	18	6	3
2	Mndemu	30	8	4
3	Malangali	32	9	4
4	Mgeta	33	11	3
5	Nkowe	40	9	4
6	Ngome	40	27	1
7	Mkuzi	42	12	4
8	Kisiju	43	11	4
9	Kasanga	48	10	5
10	Mkamba	49	8	6
11	Kitangari	51	11	5
12	Chiwale	53	5	11
13	Mwera	55	17	3
14	Mkoka	55	8	7
15	Njinjo	62	7	9
16	Chihangu	67	8	8
17	Namikupa	70	6	12
18	Chamwino	70	7	10
19	Nagaga	70	8	9
20	Masoko	75	16	5
21	Ipogoro	95	30	3
22	Lugoba	97	18	5
23	Mandawa	100	7	14
24	Sabasaba	115	39	3
25	Mahuta	125	12	10
26	Mlandizi	135	43	3
27	Kimamba	165	20	8
28	Mafiga	225	32	7
29	Chalinze	231	10	23
30	Makorora	380	48	8
31	Melela	50	16	3
32	Ugogoni	65	10	7

Waiting and processing time (WPT)
WPT refers to the total time in minutes spent by a visitor at the HC from time of entry to the HC to time of exit from the HC, including time for treatment (processing time). This was computed by observing the time that the visitor arrived to the time he/she left the HC.

This is computed as follows:
Visitors WPT (in minutes) are classified into five classes. These are 1-30, 31-60, 61-120, 121-240 and 240+. Average WPT for each class is computed by taking visitors' frequency in day one in each class plus visitors' frequency in day two then divided by 2. This is shown in Table. No 20.2

Table 20.2: Computation of Average visitor's frequency based on each class

SN	Name of HC		1 - 30	31 - 60	61 - 120	121 - 240	240<	Total
1	Makorora	Day 1	64	95	129	45	3	336
		Day 2	77	98	147	48	9	379
		Total	141	193	276	93	12	715
		Mean	**71**	**97**	**138**	**47**	**6**	**358**
2	Njinjo	Day 1	62	5	0	0		67
		Day 2	53	3	0	0		56
		Total	115	8	0	0		123
		Mean	**58**	**4**	**0**	**0**		**62**
3	Chihangu	Day 1	10	16	44	29		99
		Day 2	6	6	16	7		35
		Total	16	22	60	36		134
		Mean	**8**	**11**	**30**	**18**		**67**
4	Kisiju	Day 1	3	2	15	15	0	35
		Day 2	8	9	18	15	0	50
		Total	11	11	33	30	0	85
		Mean	**6**	**6**	**17**	**15**	**0**	**43**
5	Mkamba	Day 1	37	10	1	0	0	48
		Day 2	27	20	3	0	0	50
		Total	64	30	4	0	0	98
		Mean	**32**	**15**	**2**	**0**	**0**	**49**
6	Kitangari	Day 1	27	12	5	18		44
		Day 2	10	9	9	12		40
		Total	37	21	14	30		84
		Mean	**19**	**11**	**7**	**15**		**42**
7	Masoko	Day 1	30	19	28	12		89
		Day 2	16	13	23	8		60
		Total	46	32	51	20		149
		Mean	**23**	**16**	**26**	**10**		**75**

SN	Name of HC		1 - 30	31 - 60	61 - 120	121 - 240	240<	Total
8	Mlandizi	Day 1	50	18	51	7		126
		Day 2	80	32	24	7		143
		Total	130	50	75	14		269
		Mean	**65**	**25**	**38**	**7**		**135**
9	Mkuzi	Day 1	38	9	2	0	0	49
		Day 2	13	6	16	0	0	35
		Total	51	15	18	0	0	84
		Mean	**26**	**8**	**9**	**0**	**0**	**42**
10	Kilimarondo	Day 1	11	2	0	0		13
		Day 2	12	5	4	1		22
		Total	23	7	4	1		35
		Mean	**12**	**4**	**2**	**1**		**18**
11	Ipogoro	Day 1	79	10	8	3	0	100
		Day 2	36	11	30	12	0	89
		Total	115	21	38	15	0	189
		Mean	**58**	**11**	**19**	**8**	**0**	**95**
12	Malangali	Day 1	7	10	10	1	0	28
		Day 2	26	7	2	1	0	36
		Total	33	17	12	2	0	64
		Mean	**17**	**9**	**6**	**1**	**0**	**32**
13	Kasanga	Day 1	13	16	12	2	0	43
		Day 2	21	9	22	0	0	52
		Total	34	25	34	2	0	95
		Mean	**17**	**13**	**17**	**1**	**0**	**48**
14	Lugoba	Day 1	31	21	37	0	0	89
15	Nagaga	Day 1	3	8	18	38	3	70
16	Chiwale	Day 1	17	12	23	0	0	52
17	Chalinze	Day 1	36	61	81	49	4	231

Average WPT for each HC is then computed by calculating mean time. Mean time (in minutes) is calculated by taking summation of visitors' frequency in each class multiplied by class mean then divided by summation of frequency for all classes per HC (∑(fx)) as shown in Table 20.3.

Table 20.3: Computation of HC average visitors per day (∑(fx))

	1 – 30 (A)	31 – 60 (B)	61 – 120 (C)	121 – 240 (D)	240< (E)	Total (F)	∑(fx) x mean) (G)	Average WPT G/ F
Class mean	15.5	45.5	90.5	180.5	300		1073.25	17
HC						∑(fx)	1359.5	28
Njinjo	57.5	4	0	0	0	61.5	608.75	35
Mkamba	32	15	2	0	0	49	1551	37
Kilimarondo	11.5	3.5	2	0.5	0	17.5	1366	43
Mkuzi	25.5	7.5	9	0	0	42	4442.25	47
Malangali	16.5	8.5	6	1	0	32	6802.25	51
Ipogoro	57.5	10.5	19	7.5	0	94.5	2551.25	54
Mlandizi	65	25	37.5	7	0	134.5	4784.5	54
Kasanga	17	12.5	17	1	0	47.5	2891	56
Lugoba	31	21	37	0	0	89	5197.25	70
Chiwale	17	12	23	0	0	52	28165.75	79
Masoko	23	16	25.5	10	0	74.5	20708.5	90
Makorora	70.5	96.5	138	46.5	6	357.5	4105.5	98
Chalinze	36	61	81	49	4	231	6588.5	98
Kitangari	18.5	10.5	7	15	0	42	4536.25	107
Chihangu	8	11	30	18	0	67	9798.5	140
Kisiju	5.5	5.5	16.5	15	0	42.5	457	16
Nagaga	3	8	18	38	3	70	512	16
Mndemu	30					30	1820	46
Mgeta	33					33	2503	46
Ngome		40				40	3792	68
Mwera		55				55	5430	91
Nkowe	28	38	18			56	3185	46
Namikupa			60			60	6335	91
Chamwino		70				70	9050	91
Mandawa			70			70	5233	46
Mahuta			100			100	7508	46
Sabasaba		115				115	20363	91
Kimamba		165				165		
Mafiga			225			225		

The HC with high workload and short WPT is said to perform better than the HC with less workload and long WPT.

Methods used in data collection include physical observation, Interview and document review. The data for workload and WPT which were collected physically were from 17 HCs while data from 13 HCs were obtained through interview and review of documents. This method of data collection depends on the accessibility of HCs i.e logistic consideration and any events which seem to interfere with the collection exercise. For example phase one of data collection was interfered with the campaign of Voluntary HIV test to the regions visited where most of the health staff were not available at their stations.

Data were collected from HCs for two consecutive working days starting from 07:30 am to 3.30 pm. The total number of visitors for two days was divided by two to get the average number of visitors per day which was divided by the number of staff available at the HC and the number of workload was obtained.

Data for WPT were collected through issuing the paper to each visitor which the time of arrival and exit at HC is noted. The time spent by the visitor is the difference between arrival and exit time. The average WPT was obtained by dividing WPT by two.

The selection is not based on random, since the purpose is not to present a scientifically valid general picture but to answer the three audit questions with a reasonable degree of assurance. Experts in the field have provided valuable information on how to select samples that are small but still allow for conclusions.

Appendix No. 21.

A comparison of external factors between health centers

Average Out-Patient Department (OPD) Visitors per month

HC	OPD Above 5	OPD Under 5
Masoko	257	194
Lugoba	336	308
Mkamba	370	165
Kisiju	729	237
Ngome	900	627
Chalinze	950	454

Source: HMIS Report 2007

Average visitors per quarter Pregnant Clinic

HC	Visitors
Kisiju	71
Masoko	130
Mkamba	142
Lugoba	180
Chalinze	398
Ngome	505

Source: HMIS Report 2007

Top Diseases

Average Malaria cases per month

HC	**Above 5**	**Under 5**
Mkamba	90	103
Kisiju	147	158
Lugoba	185	190
Ipogoro	411	247
Chalinze	754	377

Source: HMIS Report 2007

Average Pneumonia cases per month

HC	**Above 5**	**Under 5**
Lugoba	16	41
Mkamba	25	12
Kisiju	34	57
Ipogoro	40	63
Chalinze	66	76

Source: HMIS Report 2007

Average Diarrhoea cases per month

HC	**Above 5**	**Under 5**
Chalinze	0	14
Kisiju	7	28
Mkamba	19	22
Lugoba	33	42
Ipogoro	42	38

Source: HMIS Report 2007

Appendix 22

Workshop participants

Name of staff	Position	Organization	Contact	Region
Mr. Maswi E.C.J	Assistant Commissioner of Budget	Ministry of Finance	+255 715 555 555	Dar es Salaam
M.W.F Maganga	Coordinator - HBF(D)	PMO-RALG	+255 754 313 469	Dodoma
Ms. Anna Nswilla	Coordinator DHS-MoHSW	MoHSW	+255 754 293 617	Dar es Salaam
Dr. J.M.N Maro (Retired Doctor)	Regional Health Officer	Retired Doctor	+255 786 938 737	Pwani
Dr.Emmanuel J. Mwanemile	DMO-Chamwino DC	Chamwino DC	+255 754 561 895	Dodoma
Mr. Henry S.Mlelwa	Clinical Officer In charge	Malangali HC - Mufindi DC	c/o DMO-Mufindi DC (+255 784 501 020)	Iringa
Dr. G.J.B Mtey	MMO-Morogoro	Morogoro MC	+255 754 623 428	Morogoro
Dr. Ezekiel Mpuya	RMO-IRINGA	RAS-Iringa	+255 26 270 226 4 Mob. +255 754 312 959	Iringa
Dr. Felista Kwai	In charge-Mnazi Mmoja HC	Ilala Municipal Council	+255 784 898 945	Dar es Salaam
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