NGO Comments for the 2004 Joint Health Sector Review and Poverty Reduction Strategy Review

This statement contains key issues of concern to NGOs engaged in health policy[i] and provides input to the 2004 Health Sector Review (HSR) and the review of the Poverty Reduction Strategy (PRS). NGOs commend the Government for notable achievements in health service delivery since the inception of the PRS and in the last year. At the same time, NGOs note that a large majority of people in Tanzania, and especially the poor, continue to live in critically ill health.

These inputs follow the format set forth by the Vice President's Office for the PRS review. The statement lists 1) main improvements in the health sector; 2) key problems/challenges; and 3) issues requiring action. NGOs reaffirm their commitment to work with Government and other actors to strengthen health services, with a particular focus on bringing meaningful change to people living in poverty.

Improvements

The availability of drugs, supplies and equipment at health facilities has increased, as has the level of funding allocated for preventive services. These have led to improvements in service delivery, a consistent area of concern among the poor. Greater, and deeper, improvements in these and other aspects of the sector are still required to create significant change.

Collaboration between public and private sector (not-for-profit as well as for-profit) has improved. District authorities are better able to oversee health care delivery as a result of decentralization. Infrastructure improvements in health, education and roads are likely to contribute to improving overall health and well-being.

Program-specific achievements include greater information on HIV/AIDS and the availability of voluntary counseling/testing, and prevention of maternal to child transmission efforts (although largely limited to urban areas). Acceptability of family planning is increasing, as is awareness among some adults of adolescents' health needs. IMCI is being extended.

Challenges

Serious limitations in human resources, financing, quality of care, and accountability mechanisms continue to constrain the health sector. The sector is under-funded. Government allocations are low and decreasing. While many providers are dedicated and hard working, many others are affected by low morale, corruption, poor working conditions and weak accountability. More, and better qualified, health workers and strengthened accountability are needed to provide the foundation for a health system able to deliver basic quality care.

Services are often inaccessible and unavailable, particularly in rural areas. Health education and services for vulnerable populations are lacking, especially for persons with HIV/AIDS, people with disabilities and the very poor. The weak state of roads and the enormous distances that people in rural areas must travel to health facilities further compromise the capacity of people to reach care. Official and unofficial charges exclude many from health care, often with tragic results. The exemption and waiver systems do not

work in practice, often privileging the well to do and excluding the poor they are meant to serve.

Information on health sector allocations to districts is disseminated through newspapers on a quarterly basis, but allocations below the district level or information on the use of money at any level is rarely available to the public. Health consumers are sometimes involved in village level planning but there is no systematized mechanism to bring these views to the ward or district level for inclusion in the comprehensive council health plans. Weak and unaccountable leadership at all levels compounds this problem. Health Facility Committees and Health Service Boards may improve this situation, but this will require that the committees/boards are truly representative of their constituencies and accountable to them.

Key issues for future action

Equity and financing

The new resource allocation formula is a positive development in the sector for which the Ministries of Finance and Health should be commended. However NGOs note with serious concern that the share of the Government budget to health is decreasing even though health is a priority sector in the PRS; reliance on donor funds is increasing. Government's share of funding of HIV/AIDS must increase to address the devastation caused by AIDS.

Cost sharing mechanisms need to ensure that the poor are not excluded from services. Safety nets must be effectively implemented and monitored if they are to safeguard vulnerable people, and a clear grievance procedure is required to enable abuses to be addressed.

Allocation of sector funds should continue to emphasize prevention and service delivery at the local level where the poorest typically access care. In addition, services that target the needs of under-served and neglected populations – including orphans, adolescents, the elderly, persons with disabilities and those with mental health conditions – need increased human, financial and technical resources. Mechanisms are needed to curb leakage in the purchase and distribution of drugs, as is stronger auditing of the drug supply chain.

Human resources

Deficiencies in qualified and equitably distributed health workers continue to be one of the greatest problems the sector faces. Urgent action is required to overcome the problems of hiring and deploying qualified providers. Monetary and non-monetary incentives should be implemented to motivate health workers to live in 'hardship' posts.

At the same time, newly hired personnel must be fully qualified and meet the needs of varying locations and facilities. Measures are also needed to ensure that providers who mistreat or abuse their patients are held accountable. Greater attention needs to be given to practical ways in which the poor can ensure their health rights are respected and enforced by providers and officials.

Governance and accountability

Guidelines and protocols for monitoring the delivery of quality services and the supply of drugs need to be implemented, including by District Councils and Council Health Management Teams. Existing guidelines should be harmonized to reduce confusion and unnecessary workload of providers. An open approach and partnership across public, private and not-for-profit actors needs to be strengthened and suspicion reduced. Service delivery agreements will assist in this regard, as would partnership agreements that clarify

the roles and responsibilities of all actors in developing and reporting on local health plans.

Simple and easily understood systems for public scrutiny of budgets, disbursements and uses of health funds need to be instituted in every village, ward and district. The implementation of effective and representative health committees and boards at all levels – as proposed in existing policies – are required. This should include effective mechanisms for providing feedback across all levels on issues of health worker performance, quality of care, flow of drugs, allocation and use of money, and other priorities as defined by health users and providers. Leaders should demonstrate that feedback is used and responded to, so that the public is assured that participation can lead to change.

[1] NGOs represented in this statement include: Bagamoyo Grassroots Educators, CARE, Chavita (Tanzania Association of the Deaf), Christian Social Service Commission, Evangelical Lutheran Church of Tanzania/Kagera Community Health Fund, Health Action Promotion Association/Singida, Iringa AIDS Network, Kimara Peer Educators, Marie Stopes, People's Health Movement/Bagamoyo, Save the Children, Shdepha +, Tanzania Public Health Association, UMATI, Women's Dignity Project

NGO Comments and Way Forward
for the Main Health Sector Review 2003

These inputs are provided by five NGOs involved in health policy: African Medical Research Foundation (AMREF), Tanzania Health Consumers Association (THCA), Tanzanian Network of Community Health Funds (TNCHF), Tanzania Public Health Association (TPHA), and the Women's Dignity Project (WDP).

We commend the Ministry of Health for the positive developments in the sector and reinforce our commitment to partnership. We are optimistic that MoH and NGOs will strengthen collaboration in future to meet the challenges set forth in the "Way Forward" sections noted below.

We point to four areas for particular attention in the 2003 – 2006 HSSP period. Where "Comments" address issues raised in the key documents (Public Expenditure Review, Health Sector Strategic Plan, Technical Review of Health Service Delivery, Medium Term Expenditure Framework) those documents are noted in brackets.

1. Equity with a focus on the poor and vulnerable

Comments

1. The share of GoT budget to health has increased less than 2% since FY00 (although as a percent of DRE health has gained more) and projections for the sector are lower than anticipated given PRS commitments. [PER]
2. Domestic funding to the health sector actually decreased in the first years of the PRS, and indications are that the basket fund is replacing GoT funds. [PER]
3. There is a positive trend in the proportion of resources allocated to basic and preventive services at the district level. However allocations to Central MoH are increasing slightly at the expense of funding to the LGA level. [PER]
4. Cost sharing has "contributed relatively little to the sector resource envelope" [PER]. At the same time, the HSSP proposes to extend user fees to the dispensary level. [HSSP]
5. Disparities across income groups and rural-urban areas suggest that resources (financial and human) need to be aligned to equity criteria. [HSSP]
6. The basket fund allocation is not clear to many Council Health Management Teams, and the Private Not for Profit/Voluntary Agency hospitals, health centers and dispensaries are not being funded fully as mandated by guidelines. Adequate resources could reduce reliance by these facilities on cost recovery, which disproportionately impacts the poor.

Way forward

1. Increase overall funding to the health sector, as well as the proportion to the LGA level. Ensure guidelines for allocation of basket funds to the LGA level are adhered to.
2. Continue increased funding for preventative services.
3. Document and monitor the impact of user fees on the poor; scrutinize whether exemptions are being properly applied; and make adjustments to these policies to reduce/eliminate barriers to care for the poor. Draw out lessons learned from evaluations of existing projects/funds.
4. Prioritize poverty and equity based criteria in resource allocation formulas and streamline resource allocation at council level into one formula for government and basket resources.

5. Disaggregate data on health status by income level, age, sex and rural/urban to accurately measure the impact of health policies, expenditures and services on the poor and vulnerable.

2. Service Delivery

Comments

1. Increased focus on service delivery and quality of care at the district level is important (and can have positive pay-offs for the very poor and those in rural areas if implemented fully) [HSSP, Technical Review]
2. The Clients' Charter, and Facility and District Health Boards are positive steps to improving service delivery and increasing stakeholder participation in health planning, budgeting and monitoring. Efforts to fully establish these mechanisms should be pursued. [HSSP]
3. Human resource development is a key factor in raising the quality of care at all levels. Specific and realistic plans are urgently needed to increase the skills of health workers. (For example, Faith Based Organizations, which serve ~40% of the population but have only 21% of national health workers note they are losing high numbers of staff to higher paying jobs in government facilities. This leaves poor people in remote locations with fewer, and less trained health workers.) [HSSP]
4. Private Not for Profit/Voluntary Agencies are not fully involved in planning processes undertaken by the Council Health Management Teams, and there are strains in the relations between PNP/VA and CHMT's particularly over budgeting and resource allocations. [Technical Review]

Way forward

1. Emphasize training/human resource development as a priority in improving health services, and focus in particular on upgrading lower cadres of health workers in remote areas.
2. Consider introducing a health worker re-registration scheme based on obligatory participation in Continuing Medical Education programs that address quality improvement.
3. Proceed with establishing Facility Boards and District Health Boards with the involvement of clients/users in determining criteria for these boards and appropriate representatives.
4. Develop mechanisms to genuinely involve PNPs/VAs in Council planning processes. Continue the practice of rationalizing government and PNP/VA services to avoid duplication of service delivery sites (e.g., through sharing the use of facilities/establishing partnerships and supporting District or other Designated Hospitals).
5. Explore a range of "incentives" to bring more highly qualified health workers and supervisors to remote areas, including through training opportunities, housing, etc. in addition to pay schemes.
6. Increase harmonization of guidelines and policies, decrease duplication, and involve health workers in the development of these procedures to make them useful and relevant.
7. Involve clients/users in strengthening the Clients' Charter, developing a tool to measure quality of care based on the Charter, and popularizing the Charter.

3. Governance in health

Comments

1. GoT/MoF procedures for publishing budgets for priority PRS sectors are very positive and should be commended. More work is needed, however to publish information on actual expenditures and to disseminate this information widely.
2. The Auditor General's reports and the REPOA Pro-Poor Expenditure Tracking Study show that misappropriation of funds occur widely in the health sector. Little action seems to be taken to recover these funds, or hold people responsible for this. Similarly, the PER process has not addressed issues of corruption/mismanagement of funds in the sector. [PER Terms of Reference]

Way forward

1. Disseminate and post health budgets *and expenditures*, together with health performance data and mechanisms for complaint at the hospital level, district level and below. Guidelines should stipulate who is responsible for these tasks.
2. Analyze reports of the health sector (Pro-Poor Expenditure Tracking Study by REPOA; Service Delivery Survey; etc.) as well as Auditor General's Reports for information on health user's experiences of corruption and develop specific mechanisms of re-dress.
3. Implement mechanisms by which local health care providers, health facility users and community based organizations participate in developing Council Health Plans, monitor service delivery, and assist with health advocacy programs. Hold Councils accountable for stakeholder involvement.

4. HIV/AIDS

Comments

1. It appears from the MTEF that funding for HIV/AIDS activities in the health sector are drastically under-funded. This needs to be addressed immediately so the sector has adequate resources to implement the new HIV Strategy. [MTEF]
2. Initial efforts to promote workplace HIV/AIDS programs, community based responses, and public-private partnerships have begun. However these efforts are too small and too late given the enormity and impact of the epidemic. Most efforts are concentrated in urban areas, leaving people in rural areas with few services, care and other supports.
3. District plans are currently being developed to address HIV/AIDS, but there is not evidence that they have sufficiently involved people living with AIDS or affected by AIDS, or that the plans are adequately resourced. The extent to which funds channeled through DHMTs are actually available for services and care at the community level needs investigation.
4. Home based care and stigmatization/discrimination need special attention in the health sector (and other) planning processes.

Way forward

1. Rectify the current MTEF projections for HIV/AIDS activities in the health sector so they are fully funded.
2. Ensure adequate allocation of funds for HIV/AIDS at the local level according to needs and priorities determined by communities.
3. Actively involve persons living with AIDS and those affected by AIDS in development of local and national level HIV/AIDS plans, specific interventions, and monitoring.

4. Include all HIV/AIDS activities (facility and community level, PNP/VAs) in Council Development Plans. Include NGOs and CBOs that are active on HIV/AIDS in coordinating boards to avoid duplication of efforts.
5. Build capacities of community groups in home based care and related services and decentralize services to be closer to communities.

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