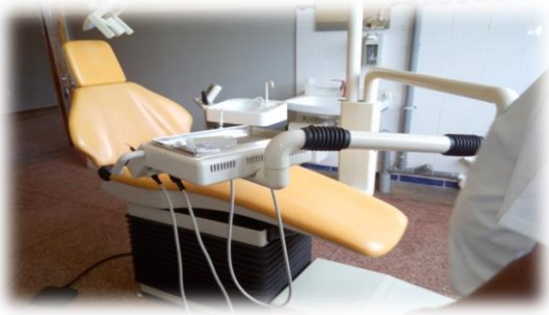
THE UNITED REPUBLIC OF TANZANIA

NATIONAL AUDIT OFFICE

PERFORMANCE AUDIT REPORT ON MANAGEMENT OF HOSPITAL AGREEMENTS BETWEEN THE GOVERNMENT AND PRIVATE HOSPITALS

Ministry of Health, Community Development, Gender, Elders and Children; and The President's Office – Regional Administration and Local Government



REPORT OF THE CONTROLLER AND AUDITOR GENERAL

MARCH 2017

THE UNITED REPUBLIC OF TANZANIA

NATIONAL AUDIT OFFICE

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PREFACE

Section 28 of the Public Audit Act No. 11 of 2008, authorizes the Controller and Auditor General to carry out Progress Audit (Value-for-Money Audit) for the purposes of establishing the economy, efficiency and effectiveness of any public expenditure or use of public resources in the MDAs, LGAs and Public Authorities and other Bodies which involves enquiring, examining, investigating and reporting, as deemed necessary under the circumstances.

I have the honour to submit to His Excellency, the President of the United Republic of Tanzania, Dr. John J.P. Magufuli and through him to the Parliament of Tanzania a progress Audit Report on the Management of Hospital Agreements between the Government and Private Hospitals in Tanzania.

The report contains conclusions and recommendations that directly concern the Ministry of Health, Community Development, Gender, Elders and Children as well as the President's Office – Regional Administration and Local Government.

The Ministry of Health, Community Development, Gender, Elders and Children as well as the President's Office – Regional Administration and Local Government were given the opportunity to scrutinize the factual contents and comments on the draft report. I wish to acknowledge that the discussions with the two audited entities have been very useful and constructive.

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

In completion of the assignment, the office subjected the report to the critical reviews of the following experts namely Prof. Bakari Lembariti and Dr. Faustine Njau who came up with useful inputs in improving this report.

This report has been prepared by Ms. Rebecca S. Mahenge (Team Leader), Mr. Deusdedit Sise Muhono and Ms. Sheila Mbwambo under the supervision and guidance of Mr. James Pilly – Assistant Auditor General and Ms. Wendy Massoy – Deputy Auditor General. I would like to thank my staff for their inputs in the preparation of this report. My thanks should also be extended to the audited entities for their fruitful interactions with my office.

Prof. Mussa Juma Assad,
Controller and Auditor General,
Dar es Salaam.
March 2017

LIST OF ABBREVIATIONS

BMC	Bugando Medical Centre
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CCHP(s)	Comprehensive Council Health Plan(s)
CDH(s)	Council Designated Hospital(s)
CHMTs	Council Health Management Teams
HSSP	Health Sector Strategic Plan
KCMC	Kilimanjaro Christian Medical Centre
LGAs	Local Government Authorities
MoH	Ministry of Health, Social Welfare, Gender, Elders and Children
MSD	Medical Store Department
PORALG	President's Office Regional Administration and Local Government
PPP	Public Private Partnership
RHMTs	Regional Health Management Teams
RS	Regional Secretariat
TZS	Tanzania Shillings

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EXECUTIVE SUMMARY

There was a growing demand for health care services, both in terms of physical and human resources in public sector. This led to contractual arrangements between the government and Faith Based Organisations in terms of subsidies. The Government provided subsidies according to the formula bed and staff grants to FBO owned hospitals in order for them to provide affordable health services to their surrounding community. In districts without Government hospital, FBO hospitals were designated to serve as council designated hospital and the Government supported operational costs in private hospitals.

The main objective of the audit was to assess Management of Hospital Agreements entered between the Government and Private hospitals. The main auditees were Ministry of Health, Community Development, Gender, Elders and Children and President's Office – Regional Administration and Local Government. The audit focused on assessing the manner in which the Government planed, implemented, monitored and evaluated hospital agreements in partnership with private health organizations. Four financial years i.e. 2012/2013 to 2015/2016 were covered. Data for the audit were collected from four regions namely: Shinyanga, Mwanza, Kilimanjaro and Lindi. Three methods for data collections were used namely, interviews, document reviews and observation.

Findings revealed that, the Government had no appropriate plans for entering into agreement with private health facilities. No need assessments were conducted prior signing the agreement, also MoH did not develop the guidelines for preparations process of signed agreement. In addition to that government did not conduct assessment to determine the capacity of the facility prior to its designations.

Similarly, the parties did not discharge their obligations in accordance with terms and conditions of the agreements. There were no transparency between the government and private partner during preparation of annual action plans and budgets as each party planned and budgeted separately.

The Government disbursed less funds to LGAs and health facilities to finance health activities. The funds were also not timely disbursed.

There were un-harmonized recruitment and Personal emoluments payment of staff. Health facilities were not adequately providing services they were supposed to in accordance to their level of operations, as some of hospitals were lacking skilled staff for specific and specialized services, whereas others had no equipment for providing some services.

Moreover, findings revealed that, monitoring was not adequately done by the government. Likewise, there was no evaluation conducted by the MoH, PORALG through LGAs on the progress of service agreements, despite the

existence of agreements implemented for an average of 13 years. There were no evaluation reports in place during the audit.

Based on the audit findings, it was concluded that hospital agreements between the government and private health facilities are inadequately managed and guided. There is no harmonized structure or system of recruitment and payment of staff working in the facilities with agreements.

Health facilities did not provide expected health services as per their accredited or designated levels and government health provision standards. Some services expected to be provided as per the facility level are not provided. This is because of the existing monitoring mechanisms or tools were not effectively implemented. But also, absence of coordination in the implementation and monitoring of agreement in ensuring that, health services are provided as required. Engagements of Key stakeholders in health service provision are not adequately coordinated by the Ministry of Health.

In view of the above findings, the audit recommends to the Ministry of Health, Community Development, Gender, Elders and Children as well as President's Office – Regional Administration and Local Government Authorities as follows:

Recommendations to the Ministry of Health, Community Development, Gender, Elders and Children:

The Ministry should effectively plan before it decides to enter into hospital agreements with private hospitals. In doing so, it should prepare, disseminate, review and update guidelines for hospital agreements by including indicative health services prices. Also, the Ministry should conduct assessments of private Hospitals' capacity before entering into agreements and accredit them to Zonal Referral Hospital.

Also, in collaboration with Ministry of Finance and Planning the Ministry should timely disburse funds to such hospitals and at the amounts agreed in the agreements. It should develop a mechanism of regularly reviewing the implemented Zonal Referral Hospital agreements and enhance transparency during the implementation of the agreements.

Further, the Ministry should monitor the implementation of Zonal Referral Hospitals Agreements by conducting supportive supervisions and inspections and report on their performance and strengthen hospital agreements performance reporting systems.

On the other hand, the Ministry should evaluate the currently implemented Zonal Referral Hospital Agreements so as to assess the extent of their implementation and their impacts to health service delivery in the country and regularly assess capacity to Zonal Referrals Hospitals to check if the facilities are providing services as per their level

of accreditation.

President's Office – Regional Administration and Local Government (PORALG):

PORALG should carry out needs assessments prior entering into agreements with private hospitals and conduct inspections to private hospitals in order to assess the capacity before accrediting them to Council Designated Hospitals and signing the Hospital Agreements.

Also, develop a mechanism of regularly reviewing the implemented Council Designated Hospital agreements. In collaboration with President's Office Public Service Management PORALG consider harmonizing employment and payment of staff working with Council Designated Hospitals. It should further, enhance transparency during preparations of annual action plans and budgets by involving Council Designated Hospitals throughout the process.

In addition, PORALG should monitor the implementation of Council Designated Hospitals Agreements by conducting regular supportive supervisions and inspections and report on their performance. It should further coordinate all matters related to Council Designated Hospitals Agreements and strengthen their Council Designated Hospitals performance reporting systems.

Furthermore, PORALG should periodically evaluate the currently implemented Council Designated Hospital agreements so as to assess the extent of their implementation and their impacts to health service delivery in the country. It should as well assess the capacity of the Council Designated Hospitals regularly to check if the facilities are providing services as per their level of accreditation.

CHAPTER ONE

INTRODUCTION

1.1 Background

Continuous demand for improved services led to Health Sector Reforms as initiatives in which partnerships with private sector was outlined as one of the strategies to reform and modernize the health sector by improving access, quality and efficiency in health service delivery[1]. Public Private Partnerships (PPPs) were in existence in Tanzania since independence. About 40% of the health facilities were owned by private sector, which included Faith Based Organisations (FBO), Civil Society Organisations and Private-for-Profit providers[2].

The Government also intended to compensate the shortage of public health facilities and avoid duplication in places where the Faith Based Organizations (FBOs) had hospitals and provided health services to people to the same extent as public health facilities. Due to inadequate resources in the public sector such as skilled staff, funds, medicines and supplies, medical equipment, the Government formally negotiated the Hospital Agreements in 1992 with Faith Based Organisations (FBOs)[3].

The decentralization policy led to 2005 revision of the 1992 MoUs so that the contracts may be signed at the district level. Subsequently, at the end of 2007, MOH, PMORALG, BAKWATA, Christian Social Services Commission and APHFTA finalised the national template for the Service Agreement between the Government and service providers in the country and introduction in the districts has started[4].

1.2 Motive for the audit

The government signed 42 Hospital agreements between 1985 and 2016 as shown in **Table 1.1**.

[1]The Public-Private Interface in Public Services Reforms: Analysis and Illustrative Evidence from the Health Sector, REPOA, 17th Annual Research Workshop, March, 2012

[2] Health Sector Strategic Plan, 2009-2015 pg. 33

[3] For the first time the government negotiated a MoU with Churches. The document officially recognized the role played by FBOs of which the government declared to offer its support. Case of Nyakahanga Hospital owned by Karagwe Catholic Diocese under TEC. (Source: Studies in Health Services Organisation & Policy, 29, 2012. Pg. 85)

[4] Health Sector Strategic Plan, 2009-2015 pg. 33

Table 1.1 Signed Health Hospital Agreements from 1985 to 2016

Years	Number Hospitals with signed agreement
Before 1992	1
1992 – 1996	4
1997 – 2001	0
2002 – 2006	3
2007 – 2011	9
20012 – 2016	25
Total	**42**

Source: MoH, Health Agreements and Registration Records

Due to the increase in number of privately owned health facilities which entered into agreement with the Government, the Government has been spending quite a significant amount of resources to fund services provided by respective facilities on behalf of the government. These services were provided in local, regional and zonal levels.

Table 1.2 indicates amount of medicine, other charges and salaries that were channelled by MoH to privately owned health facilities with agreements for the past three financial years.

Table 1.2 The government's Resources (Medicine, Other Charges and Salaries) released for health facilities for years 2013/2014 to 2015/2016

Year	Description			
	Resources	Total amount released to all health facilities (TZS in Millions)	Amount released for health facilities with agreements (TZS in Millions)	% released to health facilities with agreement
2013/2014	Salaries	133.2	48.7	36.6
	Medicines	59.1	5.8	10
	OCs	29.0	3.8	13
2014/2015	Salaries	145.9	83.9	58
	Medicines	37.2	4.1	11
	OCs	29.2	3.8	13
2015/2016	Salaries	189.4	93.6	49
	Medicines	37.2	30.6	82
	OCs	25.5	1.9	7
Total		**685.7**	**276.2**	**40.3**

Source: MoH Medium Term Expenditure 2013/2014 to 2015/2016

Table 1.2 above indicates that for a period of three years, MoH released a total of TZS 685.7 billion to carter for Medicines, Salaries and other Charges. Out of this, TZS 276.2 billion were for private health facilities with hospital agreements representing 40.3 percent of the total amount.

This justifies a significant amount of resources that the government incur in order to subsidize the said health facilities. Other financial resources which are channelled to finance these facilities include maintenance costs and basket funds.

Despite the efforts to involve private providers in health service provision through subsidies and grants, the partnerships in health care service provision still faced challenges which led to inadequate quality, affordability and accessibility of the health service to the citizens[5]. For instance:

- According to Research for Poverty Alleviation (REPOA) 2012, there were no documented monitoring mechanisms of larger amount of resources which were allocated by the Government to the faith based health facilities. The report added that, there were inadequate funds for operational activities and delay in release of funds for responding to emergencies in faith based health facilities[6].

- Inadequate administration of tax exemption of medical and medical consumables led to increase in cost of health services to people. The private for profit health facilities were being taxed for hospital equipment that were exempted for faith based hospitals. This contributed to increase in costs and hence limit availability, accessibility and affordability of health care service to the people[7].

Due to the above issues facing Public and Private Partnership in health sector NAOT decided to conduct a performance audit on Management of Hospital Agreements between the government and Private Hospitals.

1.3 Design of the Audit

1.3.1 Audit Objective

The main objective of the audit was to assess whether hospital agreements entered between the Government and private hospitals were adequately managed.

Specifically, the audit aimed at examining the adequacy in planning for hospital agreements including all preparatory activities before entering

[5]Delphine Boulenger and Bart Criel., 2012. The difficult relationship between faith-based health care organizations and the public sector in sub-Saharan Africa: *The case of contracting experiences in Cameroon, Tanzania, Chad and Uganda*. Studies in Health Services Organization & Policy, 29, 2012.pg 75

[6]REPOA: The Public Private Interface in Public Service Reform: Analysis and Illustrative from Health Sector, 17th Annual Research Workshop, March 2012.

[7]Tanzania Private Health Sector Assessment: February 2013 (SHOPS Project. 2013. Tanzania Private Health Sector Assessment. Brief. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates. Pg. 38

into agreement; the extent of the implementation of the agreements; and monitoring and evaluation of those hospital agreements.

1.3.2 Assessment Criteria

In order to assess the progress of MoH, PORLAG and respective RSs and LGAs, in managing hospital agreements, assessment criteria were drawn from various sources. These were extracted from legislations, regulations, policies, guidelines, manuals, plans and best practices for planning, implementation, monitoring and evaluation of hospital agreementsin provision of health services.

The criteria were categorized in three areas reflecting the audit questions namely; planning and preparatory activities before entering into agreement; implementation of the agreement; and monitoring and evaluation of the agreements as shown in **Table 1.3.**

Table 1.3: Assessment criteria

Topic	Requirements
Planning and developing of hospital agreements	The MoH, , PORALG and LGAs are expected to be pro-active in planning for Hospital Agreements by: • Conducting community needs assessments prior to entering into hospital agreement with private health facilities • Reviewing and updating hospital agreements • Develop guidelines for preparation of Hospital agreements in order to safeguard public interest while entering into agreement. • Developed and signed agreement safeguard the public interest
Implementation of Hospital agreements	The MoH, PORALG, MoFP and LGAs are expected to ensure: • Private health facilities operate in accordance with the signed Hospital agreements and that parties to the agreement do not deviate from hospital agreement's terms and conditions. • Availability of competencies and assessment teams in PORALG, MoH and MoF
Monitoring and evaluation of Hospital agreements	The MoH, PORALG and LGAs are expected to ensure: • That monitoring plans reflects issues of Hospital agreements • Supportive supervisions are regularly carried out to private hath facilities with Hospital agreements • Relevant authorities and health facilities have clear and working reporting systems. • Hospital agreements monitoring results are timely communicated and reports submitted the reports to relevant sector ministry. • Evaluation of Hospital agreements is carried out to assess their level of implementation.

Topic	Requirements
	• Multi-sectoral engagement in monitoring and evaluation of Hospital agreements.

Source: Analysis of Criteria from different sources as explained in Appendix 2.

1.3.3 Audit Scope

The audit was conducted across two ministries namely Ministry of Health, Community Development, Elders, Gender and Children (MoH) and President's Office – Regional Administration and Local Government (PORALG). MoH was covered as it was the parent ministry and so the custodian of all activities related to provision of health services. PO-RALG was covered because it was responsible for overseeing the process and progress of health activities at the LGA level.

Apart from MoH and PO-RALG, information was also collected from four Regional Secretariats (RSs), five Local Government Authorities (LGAs), three Zonal referral hospitals and five council Designated Hospitals (**Appendix 3**). The selection of hospitals was based on geographical representation and ownership of the hospitals by different religious denomination within geographical locations as shown in **Table 1.4.**

Table 1.4: Sampled hospitals, with Agreements and their respective levels

Facility Ownership	Level of facility					
	National	Specialized	Zonal	Regional	Council	Total
Public	1	3	2	23	78	107
Private	0	0	3	10	42	55
Sample for audit purpose	0	0	3	0	5	8

Source: MoH, Hospital Registry and Health Sector Public Private Partnership and Policy Guideline, June 2013

As shown in above table, three hospitals at the level of Zonal Referral Hospitals, and five at the level of the District were selected. The list of health facilities visited is provided in **Appendix 3.** National Hospitals were not covered as there was no any hospital which had an agreement with the government. Referral Hospitals at Regional Level were not covered because they had not signed agreements with the government despite being gazetted in the government gazette as regional referral hospitals.

The public health facilities were not part of the audit because they did not operate using the same arrangement.

The audit focused on the provision of health services by health facilities where the Government works with private organizations through service agreements. The audit covered basic aspects of planning, implementation,

monitoring and evaluation of Hospital agreements. The audit covered a period of four financial years from 2012/2013 to 2015/16.

1.3.4 Methods to collect information

The audit employed two main methods for data collection, namely document review and interviews as described below:

Document review

The audit team reviewed documents relating to planning, implementation monitoring and evaluation of hospital agreements. Documents reviewed are shown in **Appendix 4**.

Interviews

Interviews were used for the purposes of obtaining more information and get clarifications on the information obtained through reviewed documents. The audit team interviewed officials from MoH, PORALG and LGAs responsible for planning of Hospital agreements, officials charged with overseeing the implementation of Health Agreements at different level of Hospital agreements. The audit also interviewed officials who directly dealt with monitoring and valuation of provision of health services and in particular monitoring of Hospital agreements

Furthermore, management officials of selected private Hospitals with Hospital agreements were interviewed in order to assess their perspective in relation to planning, implementation and monitoring of Hospital agreements. Details of respective officials interviewed and specific information obtained from each interviewed officer are shown in **Appendix5.**

Data collected from different sources was analyzed using content analysis and descriptive statistical methods such as summary statistics, tables and graphs for both qualitative and quantitative data. Information from different types of data sources[8] were combined to gain information and knowledge about the actual conditions on the ground and compare with criteria.

1.3.5 Data validation process

The MoH and PO-RALG as main auditees were given an opportunity to go through the draft report in order to examine its contents from a factual point of view and correctness of the same. They confirmed that,

[8]Interviews and document reviews

information given in the findings was correct and provided their response to the audit recommendations as shown in **Appendix 7** and **8.**

1.3.6 Standards Used for the Audit

The audit was done in accordance with International Standards for Supreme Audit Institutions (ISSAIs) issued by the International Organization of Supreme Audit Institutions (INTOSAI).These standards require that the audit is planned and performed in order to obtain sufficient and appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives.

1. 4 Structure of the Report

The remaining part of this report is structured as follows;

Chapter Two provides for a detailed account of the system and processes for the management of hospital agreements, whereby the responsibilities of different key players are described;

Chapter Three provides for findings relating to planning of hospital agreements;

Chapter Four presents findings relating to the implementation of hospital agreements;

Chapter Five discusses findings in respect of monitoring and evaluation of hospital agreements;

Chapter Six provides for the conclusion resulting from observed findings; and

Chapter Seven provides for audit recommendations which are based from the observed findings and conclusion.

CHAPTER TWO

PLANNING, IMPLEMENTATION, MONITORING AND EVALUATION OF HOSPITAL AGREEMENTS

2.1 Introduction

This chapter describes the role of Government entities as well as other stakeholders in management of hospital agreements. Details on the system and activities regarding to hospital agreements is also described. Furthermore the criteria used to develop the audit findings are presented in the chapter.

2.2 Legal framework

Collaboration between the Government and private health providers in the country is legally governed by policies, Acts and guidelines. Furthermore, the service agreements entered by the parties remain to be the basic instruments that govern these partnerships. Key documents that govern these partnerships are explained below.

2.2.1 The National Health Policy of 2007

The vision of the National Health Policy (NHP) in Tanzania is to improve the health and wellbeing of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. Objective 2.4.8 of the policy recognizes the involvement of the private sector in health services delivery through promotion and sustainability of public-private partnership in the delivery of health services.

2.2.2 The Medical (Grants-in Aid to Voluntary Agencies) Regulations of 2006

The Government disburses funds to private health facilities in order to facilitate provision of health care services. The regulations stipulate that the funds should be used for payments of staff, maintenance of buildings or bed grants and how to account for fund disbursed. According to regulation 6, the purpose of the grant is to assist the Government in making health services available and attaining equity of access to health services and to minimize the burden of paying fees for clients who utilize private and voluntary agency health facilities.

Furthermore, the Medical (Grants-in Aid to Voluntary Agencies) Regulations of 2006 provides for conditions for private health facilities to receive grants from the Government. Such conditions are provision of health care services to all denominations and beliefs without

discrimination, establishment and maintenance of medical buildings, medical equipment and stocking of drugs to a standard accepted by the Director of Hospitals and the employment and maintenance of sufficient number of qualified staff. In addition, the regulations require the voluntary agencies (approved for receiving grants) to keep in a satisfactory manner and submitting records of accounts and returns as required. It should also permit representative of the MoH to visit the grant earning institution and inspect it from time to time.

2.2.3 The Hospital Agreement templates

The Hospital Agreement template is a legally binding agreement stating the responsibilities of the parties to the contract i.e. the Government and the private owned hospitals. It includes the range of services to be provided, the time span, the progress standards to be adhered to, the procedures for progress monitoring, terms of payment and costs, quality, arbitration and exemptions. The Zonal Hospital template was revised in 2004 while the template for CDHs was revised in 2008.

2.2.4 The Health Sector Public Private Partnerships Policy Guidelines of 2013

The Public Private Partnership (PPP) guidelines are the result of the PPP Act of 2010.It lays down the monitoring and coordination mechanisms of PPPs in the health sector. According to Paragraph 6.1.7 of the Guidelines, all PPPs related to health care service delivery are to be coordinated and monitored by MoH and LGA's. The ministry will monitor the progress of the 'PPP' projects through quarterly progress implementation and financial reports. The ministry will establish a mechanism of monitoring and evaluation of PPP activities.

The PPP office at MoH will monitor and evaluate all PPPs activities related to health and social welfare in public and private sectors at national, regional and district levels. The National PPP Coordinating Committee and PPP-Thematic Working Group will also track the operationalization and implementation of PPPs activities in the health sector at national, regional and district levels. Furthermore, the established for at regional, council and community levels will monitor and evaluate PPP activities at their respective area and submit quarterly progress report.

2.3 The health services Stakeholders and their respective roles

Different stakeholders play different roles in ensuring that these facilities meet their duties of providing health as per standards and levels. Details regarding the key stakeholders' responsibilities for planning, implementation, monitoring and evaluation of hospital agreement, are detailed in the table below;

Table 2.1: Stakeholders' Responsibilities in Hospital Agreement

Process	Responsible Entity	Activities
PLANNING	MoH	• Preparation of policy and legal documents. in collaboration with RSs and PORALG (for RRH and CDH)Assess the capability and capacity of facility for delivering service at a certain level; Advice the LGAs, RSs and PORALG on technical capacity and capability of the facility to work as a Referral Hospital at Regional level and Council Designated Hospital at Council Level)
	PORALG	• Assist MoH in preparation of policy and legal documents; Overseeing/technical support to LGAs in contract negotiation process. Implementation, monitoring and evaluation of CDH agreements.
	POPSM	• Co-ordinate, monitor and administer all matters related to the allocation of human resources in the Public Service
	LGAs	• Identification of community's health care needs; Consult the private health facility for possibility of entering into hospital agreement; Negotiation for hospital agreement with private health facility; Informing PORALG and MoH on their intention of using private facility as a CDH; Agreeing on the terms and conditions of the agreement; Signing of hospital agreement.
	Health Facilities	• Present the idea of entering into the agreement with the government; Negotiating with the LGA and sign the hospital agreement upon agreeing on terms.
IMPLEMENTATION	MoH	• Disbursement of funds to MSD for procurement of medical supplies and equipment; Disbursement of salary for staff to health facilities; Provides Technical Advices to LGAs through PORALG and RS; Fulfilment of general obligations as per service agreement.
	PORALG	• Disbursement of basket fund to LGAs for development projects; Allocates Staff, Appoints health leaders based on MoH advice (e.g. DMO, RMO etc.); Foreseeing LGAs to ensure that service agreement is implemented as

Process	Responsible Entity	Activities
		agreed.
	MoF	• Disbursement of funds to MoH for medicines, basket funds and personal emoluments.
	LGAs	• Disburse basket funds received from PORALG to respective health facilities; fulfil the obligations as per hospitalagreement.
	Health facilities	• Use the funds as per hospital agreement; Provide health services as per agreed terms and conditions of hospital agreement.
MONITORING AND EVALUATION	MoH	• Overall coordinator and overseer of health care provision in the country; provide supportive supervision to LGA and facilities in collaboration with PORALG and RS; Conduct situational inspection; Coordinate RMOs and DMOs annual meetings in collaboration with WHO; Provide technical advice to LGAs based on their progress reports; Sanctions to LGAs and health facilities in case of breach of agreement; follow-up and feedback to (reporting of health care provision); Evaluation of all health care activities and health service provision as per strategic plan.
	PORALG	• Overall coordination and technical support of health care activities and provision through LGAs; Follow-up and feedback (reporting of health care provision); Evaluate health care activities implemented by LGAs.
	LGAs	• Sanctions to health facilities which breach the agreements and health care standards; Report to PORALG on health care activities by health facilities within their area of jurisdiction as per CCHP (reporting of health care provision).
	Health facilities	• No roles on part of government responsibilities.

Source: Block Grant Guidelines, 2004, CDH Agreement template of 2008 and Zonal Referral Hospital agreement template of 2004; and Interviews with the MoH, PORALG and Hospitals

2.4 Process Description for Management of Hospital Agreements

There is a specific process for the Government and private organizations regarding agreements to provide health care services. The process can be seen as three stages: planning, implementation and, monitoring and valuation.

2.4.1 Planning for preparatory activities before entering into hospital agreement

The preparatory activities before entering the agreements are supposed to be similar for all hospital levels. The process starts with either the Governmnet or the board of trustee of the health facility putting forward the idea for the need of using the facility to be used as a public designated hospital. The two parties are then expectedto sit together and discuss the idea.

For CDHs: LGAs are expected to assess the capacity and capability of the facility to operate as a council designated hospital and produce an assessment report. If the LGA is satisfied, it writes to PORALG through RSsand copy the MoH asking for a permition to sign a contract. PORALG writes to MoH for technical advice regarding the intention of the specific LGA.

The MoH, PORALG and RHMT review the LGA's assessement report and the facility's registration records. MoH also conducts a physical and technical assessment of the facility to verify its capacilty to be granted a council hospital level status. If the Ministry is satisfied with technical capacity of the facility, it advices the LGA through RHMT and PORALG to continue with the agreemnt procedures. If not, the MoH advises on what to be done by the facility or LGA before signing the agreement.

The same process is followed by referral hospitals at Zonal levels. However with different government representatives, in this case it is MoH.

2.4.2 Implementation of hospital agreements

The implementation of the agreement starts after the parties have signed the agreement. Each part discharges the obligation as per the terms and conditions agreed in the respective agreement and as per the Government standards. Services offered are supposed to be those capable of being provided at particular designation level.

2.4.3 Monitoring and evaluation of hospital agreements

Monitoring is done through supportive supervisions, inspections and reporting:

- **Supportive supervision:** is required to be conducted once a year by MoH and PORALG. RHMTs conducts supportive supervision on quaterly basis to assess the progress of CHMTs, where as CHMTs should conduct monthly supervision of the facility management. A checklist is normally prepared based on the progress indicators identified in the medium strategic plan.

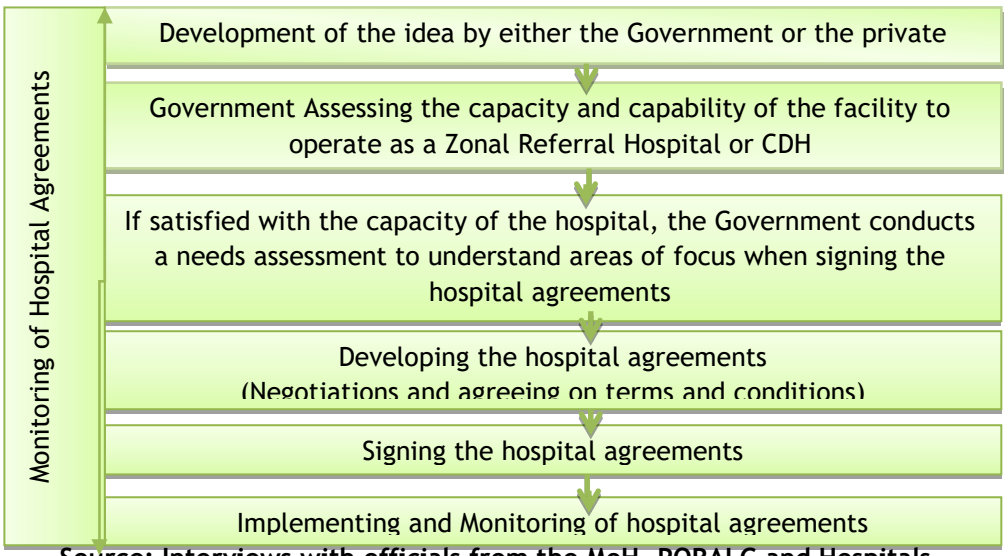
- **Inspections:** Inspections are carried out on ad hoc basis depending on complaints from the community or reports from the media. A checklist of what to be inspected is prepared based on issues raised.

- **Reporting:** are produced at each level for submision to the next level of authority. Each facility produces quarterly progress/technical and financial reports. The CDHs submit these reports to its corresponding LGAs. The referal hospitals at regional level submits to RSs and Zonal levels submit the reports straight to MoH. LGAs review and scrutinize the reports and submit them to RSs (RHMT), who again review and scrutinize before submiting to PORALG and copy to the minitsry of health for technical opinion.

- **Feedback and follow-up:** The recipient of any report should review the report and if there are technical issues to be addressed, the Ministry provides feedback to LGAs through PORALG. Areas that need technical improvement are identified.

The overall process of entring into hospital agreements between the Government and private health facilities is indicated in the diagram below.

Diagram 2.0. Process for Entering into Hospital Agreement with Private Hospitals



Source: Interviews with officials from the MoH, PORALG and Hospitals

2.5 Funding of joint health services

The health sector is financed primarily through two funding streams namely government block grants and basket funding. Other sources of non-directed funding include user fees, contributions to the Community Health Fund (CHF), and reimbursements from NHIF; these sources represent a much smaller portion of total funding. There are ongoing efforts by MoH with assistance from its partners, to develop a new financing strategy for the sector.[9]

[9] White, James, Barbara O'Hanlon, Grace Chee, Emmanuel Malangalila, Adeline Kimambo, Jorge Coarasa, Sean Callahan, Ilana Ron Levey, and Kim McKeon. (January 2013). Tanzania Private Sector Assessment. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc. Pg. 89

CHAPTER THREE

PLANNING FOR HOSPITALAGREEMENTS

3.1. Introduction

This chapter presents audit findings regarding the planning for hospital agreements.

In planning for hospital agreements, both HSSP III of 2009-2015 and MoH PPP Policy of 2013 require the Government to enter into hospital agreements when there is a need to do so. Accordingly, prior to entering into agreements the contracting authorities are expected to conduct needs assessments, inspections of facilities' capacity, involve stakeholders during negotiations. In addition, MoH in collaboration with PORALG is supposed to prepare guidelines for developing hospital agreements. The purpose of such activities is to identify areas of priority and needs in the service agreements, assurance of funds availability to pay for the hospital agreements, be sure of sufficient staff with correct skills mix and technology to deliver the quantity and quality of health service to the public.

The audit noted weaknesses in conducting such activities as explained below.

3.2. Lack of needs assessment prior to signing the agreement

The review of MoH, PORALG and RSs strategic and annual plans and LGAs' Council Comprehensive Health Plans (CCHPs) revealed that neither MoH, PORALG and LGAs included in their plans nor did they conduct needs assessment prior to entering into agreement.

Interviews with Officials from MoH, PORLAG, RSs and LGAs revealed that the Ministries and LGAs knew and acknowledged the importance of conducting needs assessment prior to entering an agreement. Yet agreements with private hospitals were signed without conducting needs assessment. According to interviews, causes for lack of needs assessment were direct instructions from MoH. MoH usually communicated to LGAs requiring them to sign the CDHs agreements. Similarly, it was noted that there were non-prioritization of needs assessment during planning for hospital agreements as this activity was not incorporated in MoH or LGAs' plans.

The audit found that, eight hospital agreements reviewed were signed between 1985 and 2016 without conducting needs assessments. As a

result, in some places the Government entered into agreements to private hospitals while there was an existing public hospital of the same level and capacity especially in Council Designated Hospitals (CDHs) levels. In particular, it was further noted that the Government entered into hospital agreement with two CDHs within the same LGA.

Further, it was revealed during interviews with RSs and LGAS, officials that even RSs and LGAs offices did not know which hospital among the two deserved to get basket funds support as a council hospital.

This was found in Kwimba, Hai and Moshi DC where each LGA had two Council Hospitals which provided health services of the similar level and received resources as if both were Council Hospitals. **Table 3.1** shows co-existence of similar level within the same LGA.

Table 3.1 Co-existence of hospitals within the same LGA

Name of LGA	Name of co-existing hospitals	
Kwimba DC	Ngudu Council Hospital	Sumve CDH
Hai DC	Hai Council Hospital	Machame CDH
Moshi DC	Kilema CDH	Kibosho CDH

Source: Review of LGA's CCHPs of 2012/13-2015/2016 and interviews with CHMTs

From **Table 3.1**, it can be noted that there were multiplicity of efforts to two hospitals of the same level within the same LGA. Consequently, this has led to multiplicity of resources in service delivery. **Table 3.2** shows the extent of resources which were distributed to two hospitals.

Table 3.2 Multiplicity of Resources to Hospitals of the Same Level from 2012/2013 to 2015/2016

Name of LGA	Facilities	Basket fund for additional Hospital within the same Council (TZS in Millions)	Basket fund for CDH (TZS in Millions)
Kwimba DC	SumveCDH	-	390.5
	Ngudu Council Hospital	815.9	-
Hai DC	MachameCDH	-	314.0
	Hai Council Hospital	202.1	-
Moshi DC	KiboshoCDH	-	502.4
	KilemaCDH[10]	-	502.4
Total fund paid to CDHs and additional Council's Hospitals		**1018.0**	**1709.3**

Source: Review of LGAs' CCHPs (2012/2013 to 2015/2016), interviews and observations

[10] Second CDH within Moshi DC

As shown in **Table 3.2** a total of TZS 1,709.4 Million and TZS 1,018 Million were disbursed to CDHs and to Councils' Hospitals respectively. These multiplicities of resources to the above hospitals meant that, with the existence of one council hospital the Government would save TZS 1,520.5 Million[11]. This amount would be used to capacitate CDHs to improve services in respective LGAs.

In addition, staff as another resource, were distributed to co-existing hospitals of the same level within the same LGA serving the same population. As a result, CDHs were understaffed compared to the minimum staffing level because other staffs were allocated to Councils' hospitals. This situation existed in Kwimba and Hai DCs. **Table 3.3** and **3.4** indicate staffing level of CDHs and Councils' Hospitals in LGAs with co-existing hospitals.
Number of Staff shown is for sampled cadres for three hospitals.

Table 3.3 Staffing levels for three CDHs in three LGAs with co-existing hospitals for 2015/2016.

S/N	Cadre	Required	Kwimba DC		Moshi DC		Hai DC	
			Sumve CDH (Available)	Deficit	Kibosho CDH (Available)	Deficit	Machame CDH (Available)	Deficit
1	Medical doctors	8	4	4	3	5	5	3
2	Assist. Medical Officers	16	2	14	3	13	5	11
3	Dental Officer	1	1	0	1	0	0	1
4	Nursing Officers	12	4	8	3	9	2	10
5	Laboratory Technologist	3	2	1	2	1	2	1
6	Physiotherapists	1	0	1	1	0	1	0
7	Radiologists	1	0	1	0	1	0	1
8	Radiographer	2	1	1	1	1	1	1
9	Pharmacist	1	1	0	0	1	0	1
10	Mortuary services	2	1	1	1	1	2	0

Source: Hospitals' Staff payroll and staff establishments, 2015/2016

Table 3.4 Staff available in three council hospitals and one CDH three LGAs with co-existing hospitals for 2015/2016.

[11] Amount includes Ngudu, Hai council Hospitals and KilemaCDH

S/N	Cadre	Required	Kwimba DC		Moshi DC		Hai DC	
			Ngudu Council Hospital (Available)	Deficit	Kilema CDH (Available)	Deficit	Hai Council Hospital (Available)	Deficit
1	Medical doctors	8	4	4	3	5	5	3
2	Assist. Medical Officers	16	2	14	3	13	5	11
3	Dental Officer	1	0	1	1	0	0	1
4	Nursing Officers	12	3	9	3	9	2	10
5	Laboratory Technologist	3	1	2	2	1	2	1
6	Physiotherapists	1	0	1	1	0	1	0
7	Radiologists	1	0	1	0	1	0	1
8	Radiographer	2	1	1	1	1	1	1
9	Pharmacist	1	1	0	0	1	0	1
10	Mortuary services	2	1	1	1	1	2	0

Source: Hospitals' Staff payroll and staff establishments, 2015/2016

Based on **Tables 3.3** CDHs were generally understaffed in all ten sampled cadres. Among the sampled cadres, Radiology was the most affected services as all CDHs lacked Radiologists. This was caused by the existence of other hospitals of the same level serving the same population which led to distribution of staff.

Accordingly, **Table 3.4** shows staff available at respective council hospitals and one additional CDH. These hospitals were also generally understaffed. However, the audit noted that, council owned hospitals were not accredited to operate as council hospitals as per referral system and staff establishment.

This implies that the Government allocated resources to council hospitals to the same extent as if such hospitals were CDHs. If the Government had chosen to improve services at the CDHs the facilities would be fairly staffed and thus services would be improved. **Table 3.5** shows deficits for each LGA in respect of staffing requirements.

Table 3.5 Staffing level in three LGAs with co-existing district hospitals as at 2015/2016

S/N	Cadre	Required	Available staff per LGA		
			Kwimba DC	Moshi DC	Hai DC
1	Medical doctors	8	8	9	16
2	Assist. Medical Officers	16	4	8	15
3	Dental Officer	1	1	1	0
4	Nursing Officers	12	7	3	7
5	Laboratory	3	3	6	6

S/N	Cadre	Required	Available staff per LGA		
	Technologist				
6	Physiotherapists	1	0	2	1
7	Radiologists	1	0	2	0
8	Radiographer	2	2	1	1
9	Pharmacist	1	2	0	0
10	Mortuary services	2	2	2	2

Source: Hospitals payroll and staff establishments, 2015/2016

Key: = Staff cadre with no deficit in respective LGAs
= Staff cadre with deficit in respective LGAs

Table 3.5 indicates that there were slight deficits and excesses in staffs in three LGAs. For instance in ten sampled staff cadres, Kwimba DC had required number of staff in six cadres, whereas Moshi DC and Hai DC had required staff in six and four cadres respectively. However, allocation of staff to co-existing hospitals created deficits in CDHs. This deficit could be reduced if the focus of allocation of staff was to recognize designated council hospitals.

The audit noted that, the reason for these redistributions of resources was the need for councils to have their own hospitals. Thus the reallocated amounts from CDHs (for the case of basket funds) to Council's hospitals were to improve the services to the level that they would be promoted and accredited council level status by MoH. As a result the recognized CDHs received less financial and human resources than they deserved. For instance, Sumve CDH received 12.26 percent of the basket fund instead of 25-30 percent it deserved as a CDH.

This has caused tensions in service delivery especially to CDHs as some of them declined from giving free services to special groups as well as not accepting Community Health Fund (CHF) policy. It was further revealed that Sumve CDH declined from signing a new agreement with Kwimba DC as a Voluntary Agency Hospitals (VAH) as suggested by Kwimba DC though the MoH provided the template to LGAs for the new CDH agreement to be signed. At the same time in Moshi DC, the co-existence of CDHs has caused a redistribution of resources on equal basis between the two (Kibosho and Kilema) i.e. 15 percent of basket fund each. This is a rate that a Voluntary Agency Hospital (VAH) is expected to get as per CCHP Guideline. The same applies to staffing as explained above.

Consequently, CDHs were not providing services at their capacities as Hospitals at a Council/District level as some services were not provided due to inadequate resources such as skilled staff as explained in **Section 4.6** of the following chapter.

3.3. Inadequate Assessment of Private hospitals' capacity

The MoH and LGAs for zonal referral hospitals and CDHs respectively were required to conduct comprehensive assessment to hospitals to determine their capacity in terms of (1) infrastructure (2) human resources (3) equipment and (4) health services delivered before accrediting them as zonal or council Designated Hospitals.

In eight hospitals visited, only one assessment was conducted before hospital's accreditation as a CDH. The assessment was conducted to Kolandoto Hospital in 2012. However, the report[12] indicated that there were weaknesses in the services that were to be corrected before signing the agreement as a CDH.

The report showed that Kolandoto CDH was understaffed in medical Doctor and nursing staff by 62 and 78 percent respectively. Other weaknesses included non-existence of physiotherapy and casualty services, inadequate laboratory and dental services as well as existence of a dilapidated incinerator.

According to the Basic Standards for Health and Social Welfare facilities of 2015 Volume I-V, among other requirements, these services were essential prior to granting accreditation to any health facility as a Zonal Referral Hospital or CDH. Despite these shortcomings the inspection report recommended Kolandoto Hospital to be granted or used as a CDH. **Table 3.6** indicates list of accredited hospitals and whether or not inspections were conducted

Table 3.6 Inspections Conducted To Hospitals Prior to Entering into Agreements

S/N	Health facilities	Level	Inspection conducted	Report in place
1	Bugando Medical Hospital	Zonal	No	No
2	KCMC	Zonal	No	No
3	CCBRT	Zonal	No	No
4	Kolandoto	CDH	Yes	Yes
5	Sumve	CDH	No	No
6	Kibosho	CDH	No	No
7	Machame	CDH	No	No
8	Nyangao	CDH	No	No

Source: Inspections Reports and Hospital Documentations (2012/2013 – 2015/2016)

[12] Taarifa ya Ukaguzi wa Hospitali ya "African Inland Church of Tanzania KolandotokatikaHalmashauriyaManispaayaShinyangakuainishakamainafaakutumiwakamaHospitaliteuleil iyofanyikatarehe 12 July 2012.(Inspection Report of the African Inland Church of Tanzania Kolandoto in Shinyanga Municipal Council to Assess whether it can be used as a Council Designated Hospital which was done on 12th of July, 2012)

From **Table 3.6** it can be noted that, in all hospital levels both MoH and LGAs did not conduct inspections prior to signing the hospital agreements. As a result, hospitals were accredited to operate as Zonal Referral Hospitals and CDHs regardless of their respective capacities. This indicates poor planning and prioritization of important activities and commitment to hospital agreements.

3.4. Lack of Negotiations Prior to Signing the Hospital Agreements

In all visited entities[13]the audit found that, there were no records which indicated the existence of negotiations. Likewise, interviews with MoH, PORALG, LGAs and hospitals' officials revealed that no negotiations were carried out before signing the agreements, despite the fact that officials acknowledged that there was a room for negotiating terms and conditions of the agreement.

Interviews with MoH and LGAs officials indicated that parties did not consider negotiations as a crucial part of hospital agreements' preparations. Interviews with officials from MoH, PORALG and LGAs indicated that with absence of negotiations parties to the agreement failed to appreciate the contents of the agreements. Consequently, the implementation of the signed agreements was surrounded by many challenges as explained in chapter four of this report.

3.5. Inadequate Guidelines for Development of Hospital Agreements

MoH in collaboration with PORALG were required to develop a guideline for developing hospital agreements as well as agreement's progress guideline[14]. The guidelines were supposed to indicate the areas to be considered when the LGAs, RSs and the Ministry develop the respective agreements. Such guidelines should be attached to the signed agreement.

The audit found that neither MoH nor PORALG prepared guidelines for development and progress of hospital agreements. Instead, only the zonal and CDH agreement templates were developed in 2004 and 2008 respectively to be used as a format when LGAs and MoH entered into agreements. In this regard, hospital agreements at Zonal and Council levels were prepared without specific guideline.

The audit noted further that, three zonal hospital agreements were not aligned to the Zonal Hospitals template of 2004. This is because two Zonal hospital agreements for Bugando Medical Center (BMC) and Kilimanjaro Christian Medical Center (KCMC) were signed as far back as 1985 and 1992 respectively. The Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) signed the hospital agreement with MoH in 2013 however the agreement was not aligned to the template. Likewise, all five

[13]MoH, PORLAG, RSs (RHMTs), LGAs (CHMTs) and Health Facilities.
[14]According to HSSP III of 2009-2015 and MoH-PPP Guideline Manual of 2011.

CDH agreements reviewed at LGA's level aligned to the agreement template as they were signed without any alterations or adjustments to suit their environment. This was attributed by lack of guidelines for developing and performance of hospital agreements.

It was revealed during interviews with MoH, LGA and CDHs officials that templates were not present at the respective offices. In all three zonal referral hospitals and five LGAs visited, it was only Moshi DC and Kwimba DC which had hospital agreements template in place. This was because MoH in collaboration with PORALG did not adequately disseminate the agreement templates to RSs and LGAs. The same was the case with zonal referral hospitals and CDHs.

Due to absence of the guidelines for developing and progress of hospital agreements the hospital operated using the signed agreements which were found to be incomprehensive as they did not include annexure which were part of the hospital agreement template. The annexure provided for requirements such as services to be provided, service outputs and costs, sanctions, service quality standards, financing, exemption process and reimbursement mechanisms as well as management outputs.

3.6. Hospital Agreements did not Safeguard Public Interests

The audit found that, the signed hospital agreement could not adequately safeguard public interests. This is because the agreements did not meet the criteria for standard agreements as per the MoH's PPP Policy Guideline of 2013, which include the life span of the agreements, scope of services to be provided, reviews, termination or sanctions for breach of agreements.

Lack of such components weakened the hospital agreements. For instance; eight reviewed hospital agreements did not indicate the life-span of their existence or implementation. Due to this, both parties[15] to the agreement were forced to implement the agreements which were signed between 1985 and 2016 without reviews or renewal. Some agreements have been implemented for over 20 years since when they were signed as shown in **Table 3.7.**

Table 3.7 Agreements life-span

S/N	Name of health facility	Government entity	Date of signed agreement	Number of years
1	Bugando MC	MoH	28th Aug. 1985	31
2	KCMC	MoH	28th Aug. 1992	25
3	CCBRT	MoH	17th Apr. 2013	3
4	KolandotoCDH	Shinyanga MC	14th Mar. 2013	3
5	SumveCDH	Kwimba DC	3rd Jun. 1991	25
6	KiboshoCDH	Moshi DC	1st Jul. 2014	2

[15]The government and Private Health Facilities

S/N	Name of health facility	Government entity	Date of signed agreement	Number of years
7	MachameCDH	Hai DC	3rd Oct. 2011	5
8	NyangaoCDH	Lindi DC	23rd May 2013	3

Source: Hospital agreements

As indicated in the **Table 3.6** agreements between government and hospitals were operational for an average of 13 years without reviews, regardless the presence of significant health sector policy reforms such as free health service to special groups and waivers[16] and Community Health Fund (CHF). As a result, special groups and waivers missed free services they deserved. Likewise, CHF services were not reflected in the hospital agreements because all hospital agreements were not reviewed by the MoH or RSs and LGAs to accommodate such reforms.

Other components for standard hospital agreements which were not included in the signed agreements are scope of services, cost of services sanctions and termination clauses.

This indicates knowledge gap, and lack of commitment and accountability. As a result, agreements were signed and hence they were mismanaged for all the years, as parties to the agreements did not know the scope of services and cost of services charged by hospitals. Moreover, due to lack of sanctions and termination clauses in the signed agreements, parties neither knew the measures to take in case one party breached the agreement nor the basis for termination of the existing signed hospital agreements.

[16]Reproductive Health Services, Children under five, Elders, e.t.c.

CHAPTER FOUR

IMPLEMENTATION OF HOSPITAL AGREEMENTS

4.1 Introduction

This chapter presents audit findings on the implementation of hospital agreements. According to fourth Comprehensive Council Health Plans Guidelines (CCHP) of 2011 issued by MoH, during preparation of CCHP, available resources have to be jointly and rationally allocated in the proportion of services delivered by public and private partners.

The guideline also requires that, resources allocated to each private provider for delivery of health services have to sign a hospital agreement to be implemented jointly by the Government and respective health facility. The guideline further requires each party to the agreement to fulfill the obligations as stipulated in the hospital agreements.

The audit found that parties to the agreement did not adequately discharge their contractual obligations as explained in the sections hereunder:

4.2. Inadequate Transparency during Planning and Budgeting

Health Sector PPP Policy Guideline of 2013 and CCHP Guideline of 2011 required parties to the agreements be involved during planning and budgeting on the implementation of the hospital agreements.

The audit found that, parties to the hospital agreements were inadequately involved during planning and budgeting. Zonal referral hospitals prepared their own plans and budgets and submitted them to MoH according to budget ceiling given by MoH. During planning Zonal Hospitals were only involved in discussing health services activities falling under such government ceiling. Activities falling out of the ceiling such as own sources or hospital's collections were not discussed.

For CDHs, hospitals were involved during preparation of CCHPs but only on basket fund component. This is because CDHs received only basket fund from the LGAs. Other CDHs' activities implemented using sources other than basket fund were not jointly discussed. Similarly, MoH and LGAs did not involve hospitals in the preparation of other components of their plans.

The review of both MoH's Medium Term Expenditure Framework (MTEF) of 2014/2015 to 2018/2019 and CCHPs for financial years 2012/2013 to

2015/2016 revealed that parties to the agreements planned separately for issues other than hospital development (for zonal referral hospitals) and basket fund (for CDHs).

Hospitals did not show other sources of income they generated such as user fees, cost sharing, insurances, Community health funds, receipts in kind in their respective action plans and CCHPs. It was revealed during interviews with officials from the hospitals that the Government did not disclose in their plans the amount to be remitted to hospitals such as funds for medicines and medical consumables, on-call allowances, other charges and reimbursement for free services to vulnerable groups.

CCHP guideline requires the LGAs which received funds to publish on the Council and Hospitals' Notice Boards according to cost centers for transparency and accountability. However, details of the funds received by LGAs and disbursed to CDHs were not published on the notice boards in all hospitals and LGAs' office as required by the guideline.

The reason for non-disclosure to the hospital was because MoH and LGAs did not equally involve the hospitals in planning. Similarly, MoH and LGAs did not provide feedback on the approved budget to the hospitals.

Subsequently, the Government introduced some activities such as provision of free service to vulnerable groups and use of CHF and directed the hospitals to implement them. However, the said activities were not initially incorporated in the plans (MoH action plans and CCHPs). In that basis, the hospitals did not deliver free service to vulnerable group and CHF system for LGAs where it operated was not accepted by the CDHs. Consequently, the community did not enjoy the CHF and free services for vulnerable groups wherever they sought it from the hospitals.

4.3 Fluctuation of Funds Disbursement to Hospitals

According to the hospital agreements and CCHP guideline, Hospitals were expected to receive funds from the government for staff salaries, medicines/medical consumables through MSD and other charges

Review and analysis of hospitals' Medical Store Department (MSD) accounts and the MoH's approved budgets for medicines and medical consumables for the years 2012/2013-2015/2016 showed that there was fluctuation of funds disbursed to hospitals through MSD. **Table 4.1** indicates the approved and disbursed amount to hospitals for medicines and medical consumables via their respective accounts maintained at MSD.

Table 4.1 Amounts Approved and Disbursed for Medicines and Medical Consumables to Zonal Referral Hospitals (2012/2013 to 2015/2016)

Financial Years	Amount approved (TZS Billions)	Amount disbursed (TZS Billions)	% of under/over payments
2012/2013	-	4.24	-
2013/2014	1.98	2.60	34
2014/2015	1.94	1.11	-43
2015/2016	0.80	1.23	80
Total	**4.72**	**9.18**	**71**

Source: MoH and MSD funds disbursement records for 2012/2013 to 2015/2016

Table 4.2 Amount Approved, Disbursed to CDHs (2012/2013 to 2015/2016)

Financial year	Amount approved (TZS Millions)	Amount disbursed (TZS Millions)	% of overpayments
2012/2013		176.4	-
2013/2014	167.5	348.4	108
2014/2015	224.6	248.2	10
2016/2016	91.7	206.7	125
Total	**483.8**	**979.7**	**103**

Source: MoH and MSD funds disbursement records for 2012/2013 to 2015/2016

Tables 4.1 and **4.2** show that generally, MoH disbursed more funds to both zonal referral hospitals and CDHs by 71 and 103 percent respectively than what was approved with the exception of the year 2014/15 where there was an under payment of 43 percent for zonal referral hospitals. MoH did not avail to the auditors details of the approved amounts for medicines and medical consumables for Zonal and CDHs for the years 2012/2013. Approved amounts for years 2012/2013 were not availed to auditors.

Interviews with officials from MoH, PORALG, LGAs and visited Hospitals' officials indicated that the cause for fluctuation in disbursement of funds to zonal hospitals and overpayment to CDH was insufficient joint planning and budgeting as MoH and LGAs did not request for inputs from hospitals during preparation of budgets as explained in **Section 4.2** of this report. Also lack of communication of the approved budget to hospitals attributed to the situation as the approved budget did not reflect the actual needs of the respective hospitals. Consequently; hospitals claimed that, in most cases some medicines and medical consumables needed were out of stock at MSD even though there was enough funds in their accounts.

4.4 Delayed Disbursement of Funds to Hospitals

According to the eight hospital agreements reviewed, the Government was to disburse funds to hospitals on monthly basis for zonal referral hospitals and on quarterly basis for the case of CDHs. However, it was noted that there were significant delays in disbursement of funds to hospitals.

Interviews with LGAs officials showed that the reason for the delays in disbursing funds to CDHs was attributed by delays in receipt of funds from the central government (MoH through PORALG).Moreover, interviews with MoH and PORALG officials revealed that delays in disbursing basket funds to LGAs was caused by delays in funds receipts from Ministry of Finance and Planning (MoFP). In response of this, MoFP interviewed officials showed that; Funds are disbursed to MoH in accordance to receipt from donors.

The interviews further indicated that, where the donors delay in depositing fund in government basket will eventually lead to MoFP to delay to disburse to MoH. This implies that, funds were disbursed upon its availability (Cash budget).In addition; reallocation of funds intended for basket fund to fund other activities such as staff emoluments. **Table 4.3** shows the extent of delays for basket funds disbursed to CDHs.

Table 4.3 Delays in Disbursing Basket Funds to CDHs from 2012/2013 to 2015/2016

Year	Quarter	Kolandoto	Sumve	Kibosho	Machame	Nyangao
2012/2013	Q1	×	×	×	×	×
	Q2	×	×	×	×	✓
	Q3	✓	✓	✓	✓	✓
	Q4	✓	✓	✓	✓	✓
2013/2014	Q1	×	×	×	✓	×
	Q2	×	X	×	×	×
	Q3	×	✓	✓	×	✓
	Q4	×	✓	✓	✓	✓
2014/2015	Q1	×	×	×	✓	×
	Q2	×	✓	✓	✓	✓
	Q3	×	×	✓	×	✓
	Q4	×	✓	✓	✓	✓
2015/2016	Q1	×	×	×	×	×
	Q2	×	×	×	×	×
	Q3	×	✓	✓	✓	✓
	Q4	×	✓	✓	✓	✓

Source: Hospitals' basket fund disbursement records from 2012/2013 to 2015/2016

Key: ✓ -Funds received
× - No fund received

Table 4.3 indicates that the Government did not timely disburse funds to CDHs. In all four years under audit, none of the CDHs timely received

funds in all consecutive quarters of the year. The trend showed that for the first two quarters, equivalent to a period of 6 months, the government did not disburse funds while some CDHs received fund in the third quarter.

The review and analysis of basket fund disbursement records indicated that the Government disbursed funds for three quarters in the last quarter of the year and sometimes on the last day June, of the financial year. Some funds were not actually disbursed throughout the year to some of the facilities. It can further be noted that, up to the end of financial year, facilities received only amount equivalent to two quarters instead of four. The analysis indicated that in a total of TZS 1.6 billion disbursed to all five CDHs for a period of four years collectively, TZS 1.0 billion which is equivalent to 63 percent of the total amount was disbursed in the third and fourth quarter.

On top of that, in four financial years under audit, MoH made a total of 28 disbursements to CDHs. Out of this, 10 disbursements of TZS 0.5 billion (31 percent) of total disbursements were made in the last month of the last quarter of the financial year.

This situation impacted services which were supposed to be funded from the basket fund because activities of the 3rd and 4th quarters could not be implemented as facilities had to firstly implement activities of the 1stand 2nd quarters which were initially not funded due to delays in disbursement of funds. For detailed analysis on delays in disbursement of basket funds to CDHs see **Appendix 6.**

4.5 Disparities in Mode of Recruitment of Staff and Payments of Salaries to Hospitals Staff

The audit noted that the Council Designated Hospital agreement template of 2008 and signed agreements were silent on the mode of payments of salaries to staff. According to interviews with MoH, LGAs and Hospitals officials, this led to differences in payments of staff salaries. Some hospitals were paid in form of block grants to hospitals whilst others were paid directly to individual staff's bank accounts.

The audit noted that the Government paid staff salaries directly to staff bank accounts only to Bugando Medical Centre (BMC) since the signing of the agreement. Other hospitals continued to receive staff salaries as block grant since they signed the agreements until the mode of payment changed as shown in the **Table 4.4.**

Table 4.4 Change in Staff Salaries Mode of Payment

S/N	Facility	Year of change of salary payments from block grant to direct staff accounts
1	KCMC	2010
3	Kolandoto	2008
4	Kibosho	2014
5	Machame	2016
6	Sumve	2016
7	Nyangao	2016

Source: Interviews and payroll records (2012/2013-2015/2016)

Changing from block grant to direct into staff bank account model was not discussed by the parties. The Government directed the hospitals to disclose the staff personal bank accounts. In this regard, CCBRT did not obey to the directive of disclosing staff personal bank accounts to the Government. As a result the Government stopped to disburse staff salaries to the hospital since March, 2015. The remaining hospitals obeyed to government's directives and changes were made to mode of payment in different periods as indicated in **Table 4.4.**

Due to stopping of salary payment to CCBRT as block grant, a dispute arose between the MoH and CCBRT. In this regard, the hospital was forced to pay the staff salaries from its own sources. Consequently, it closed down some of health services such as clubfoot clinics in Dar es Salaam that were provided for free[17].

The clubfoot clinics served an average of 21 patients per month. The clinics aimed at bringing services close to the community so as to enable compliance to medical treatments. Patients who benefited from free clubfoot Services which were provided before closure were as indicated in the **Table 4.5.**

Table 4.5 Number of Clubfoot Patients Treated at Municipal Hospital Clinics in Dar es Salaam, April-Sept 2015

Month	Amana	Temeke	Mwananyamala	Total
April	6	7	9	22
May	3	7	4	14
June	10	11	6	27
July	4	14	4	22
August	6	5	5	16
September	9	7	7	23
Total	**38**	**51**	**35**	**124**

Source: Interviews and CCBRT paper presented to CHMTs and RHMTs

[17]Amana, Temeke and Mwananyamala Hospitals

Table 4.5 indicates that for a period of six months the facility managed to provide services to 124 clubfoot patients. The trend shows that with time many patients could have benefited from these clinics as this special treatment is not found elsewhere in Tanzania other than CCBRT.

According to CCBRT management, if the facility continues to miss contributions from the Government, treatment services for Fistula, children under five, elders, eye clinics and rehabilitation centers might no longer be free as it was before. The treatment services will be charged in order to make the facility sustainable by paying the staff salary using funds from other donors.

4.6 Inadequate Provision of Health Services

Basic standards for Health Social Welfare Facilities of 2015 provided for type of services which must be provided by respective hospitals according to the level they operate. However, the audit noted inadequacies in services which were supposed to be provided by some of the health facilities.

Zonal referral hospitals had weaknesses in some super specialist services which were supposed to be provided as shown in Table **4.6**:

Table 4.6 Services which were not adequately provided by zonal referral hospitals

SN	Health facility	Services	Observed weaknesses
1	Bugando Medical Centre	Laboratory	Uric acid test not done, Virology test not in place, Immuno-histochemistry, Reagents for laboratory tests not regularly available. Fridge for storage of blood did not have temperature control equipment.
2	KCMC	Radiology	Lack of consumables such as films, processing chemical for radiographic films, contrast media, film envelops, themo printing papers frequent breakdown of aging equipment
		Main Operating Theatre	Operating tables, Operating lamp, Electrical manual, Amputation saw – electrical and manual, Hand brace, Skin grafting handle and brakes, Mash machine, sanction curative machine, hank drill, power drill, proctoscopy set, deosophagoscopes, autoclave machine heavy and light duty, orthopedic table, gynecology general surgery

SN	Health facility	Services	Observed weaknesses
		Laboratory	Lack of Clinical laboratory materials for microbiological routine procedures.
		Pharmaceutical	About 72 items of medicines had stock instability at MSD thus not supplied.

Source: Interviews and physical observation

Similarly, the audit noted that CDHs did not adequately provide a number of services which were supposed to be provided as per MoH standards services guideline. Examples of health services which were not provided by respective CDHs are as shown in **Table 4.7.**

Table 4.7 Sampled services not provided or partially provided by CDHs

SN	Name of CDH	Services not provided	Services partially provided
1	Kolandoto	Casualty, physiotherapy and dental services, ambulance	Incinerator
2	Sumve	Casualty, physiotherapy, ambulance,	Incinerator, Mortuary
3	Kibosho	Physiotherapy and casualty	Incinerator, ambulance
4	Machame	Casualty and physiotherapy	-

Source: Interviews and physical observations

From **Table 4.7** it can be seen that in all CDHs, an average of two to three health services were not provided. Further details of standards and type of services which were supposed to be provided by the hospital according to their level of operation are provided in the MoH's Basic Standards for Health and Social Welfare Facilities of 2015 Volume 1-5**.**

Tables 4.6 and **4.7** indicate that most of the services were either partially or not provided at all because of inadequate supportive supervisions conducted by the MoH and LGAs for zonal referral hospitals and CDHs respectively. Review of hospital staff payroll as well as staff establishment of 2015 revealed that, all five CDHs had a shortage of staff and skilled personnel. Therefore, patients were denied of their right for treatment thus they were forced to seek for such services from other hospitals.

4.7 Outdated Health Service Indicative Prices

According to MoH's Cost Sharing Guideline of 1997, Hospitals were supposed to follow the Government[18] price list schedule indicated in the Cost Sharing Guideline when charging for health services. However, the

[18]Cost sharing Guideline of 1997 provided for fees that will be charged to patients while receiving health servic6es from public health facilities, and the health service agreement template of 2008.

review of the Cost Sharing Guideline, hospitals's price lists as well as interviews with officials from MoH, PORALG, LGAs and hospitals revealed that both CDHs and Zonal Referral Hospitals did not adhere to health service prices indicated in the guideline.

Hospitals were setting their own prices which were higher than the prices indicated in the Cost Sharing Guideline. **Table 4.8** and **4.9** show a sample of services with different prices from government health services indicative prices.

Table 4.8 Outdated Service Charges vs Current Prices used by Zonal Referral Hospitals

S/N	Description of Service	Indicative Price as per cost sharing Guideline of 1997 (TZS)	Average Prices for Zonal Hospital in 2016 (TZS)	Increase in Price (Number of Folds)
1	Ultra sound	100	72,000	720
2	X-Ray	750	21,000	28
3	Urine analysis	100	3,833	38
4	Registration fee	100	14,333	143
5	Admission	100	14,000	140
6	Blood grouping and X matching	200	6,000	30
7	Hemoglobin - HB	100	3,167	32
8	Blood Slide for Malaria Parasite	100	3,500	35
9	Permanent tooth extraction	100	11,667	117
10	Stool analysis	100	3,167	32
11	Major operations	3,000	133,333	44
12	Minor operations	1,000	33,333	33
13	Lid repair/rotation	3,000	93,333	31
	Average difference in folds for cost of service as compared to indicative price			**109.4**[19]

Source: Ministry of Health's Cost Sharing Guideline of1997 and Zonal Referral Hospitals' price lists 2015/2016

[19] This is an average increase in folds between the fees charged by Zonal Hospitals as compared to indicative prices.

Table 4.9 Sampled services prices increase charged by CDHs

S/N	Description of services	Indicative Price as per cost sharing Guideline of 1997 (TZS)	Average prices for 5 CDHs	Increase in Price (Number of Folds)
1	Ultra sound	500	18,750	38
2	X-Ray	400	17,500	44
3	Urine analysis	100	2,750	28
5	Registration fee	300	4,500	15
6	Admission	500	2,500	5
7	Blood grouping and X matching	200	4,250	21
9	Hemoglobin - HB	100	3,000	30
10	Blood Slide for Malaria Parasite	100	2,000	20
11	Permanent tooth extraction	500	13,750	28
12	Stool analysis	100	2,750	28
	Average difference in folds for cost of service as compared to indicative price			**25.7**[20]

Source: Ministry of Health's Cost Sharing Guideline, 1997, CDH's Price Lists.

From **Table 4.9**, it can be noted that, average service prices charged by the zonal referral hospitals were above the indicative prices by between 26 and 109 times as much whilst for CDHs health services prices charged by the hospitals were above the indicative prices by between 5 and 44 times as much.

Further review of price lists noted that, council owned hospitals were also not following the indicative prices scheduled in the Cost Sharing Guideline. **Table 4.10** shows the prices charged by council owned hospitals and those indicated in the cost sharing guideline.

Table 4.10 prices increase charged by Council's owned hospitals

S/N	Description of services	Indicative Price as per cost sharing Guideline of 1997 (TZS)	Average prices charged by the council's owned hospitals	Increase in Price (Number of Folds)
1	Ultra sound	500	7,000	14
2	X-Ray	400	8,667	22
3	Urine analysis	100	2,833	28
5	Registration fee	300	3,000	10
6	Admission	500	1,667	3
7	Blood grouping and X matching	100	4,333	43

[20] This is an average increase in folds between the fees charged by CDHs as compared to indicative prices.

S/N	Description of services	Indicative Price as per cost sharing Guideline of 1997 (TZS)	Average prices charged by the council's owned hospitals	Increase in Price (Number of Folds)
9	Hemoglobin - HB	100	4,333	43
10	Blood Slide for Malaria Parasite	100	1,833	18
11	Permanent tooth extraction	500	6,000	12
12	Stool analysis	100	7,000	70
	Average difference in folds for cost of service as compared to indicative price			**26**

Source: Ministry of health cost sharing guideline of 1997 and Council Owned Hospitals price lists of 2015/2016

Table 4.10 shows that, the prices charged by council owned hospitals about 26 times higher than the indicative prices shown in the cost sharing guideline of 1997.

The reason for this difference in service charges in both the CDHs and Council owned hospital was lack of review of the indicative prices. The indicative prices were outdated by 20 years, obsolete and unrealistic. Interviews with officials from MoH, PORALG, RS, and LGA's revealed that, this was attributed by lack of Hospital agreement regulatory function of hospital agreements that would closely manage their implementation.

As a result, lack of review of prices, hospitals were setting their own prices for services offered and both MoH and LGAs did not make effort to know the actual market price.

However, interviews with MoH officials revealed that, at the time of this audit, the MoH was in a process of reviewing the cost sharing guide of 1997. This implies that, the findings and recommendations of the ongoing cost sharing study will inform the new cost sharing guide that the ministry intends to come up with and hence will reflect the current economic change, service technological change, and change in world prices of health sector inputs.

4.8 Non-disclosure and Display of Health Services Provided and their Prices

According to cost sharing guideline of 1997, CDH hospital agreement template of 2008 required that all services offered by hospitals and their respective prices were required to be displayed on the hospitals' notice boards. This was important as it enabled the public to know actual prices for services. By knowing the actual prices of services in advance, they

would be able to communicate to the hospitals' management or Government authorities in case they were overcharged.

However, the audit noted that in eight hospitals visited three (Kolandoto, Kibosho and Sumve) disclosed some of the services they provided and their respective prices. Nevertheless, not all health services prices were disclosed as indicated in **Picture 4.1.**

Picture 4.1 List of Some Services and their Respective Prices for Kolandoto CDH and Sumve CDH

Source: Kolandoto CDH Billboard (left) and Kibosho CDH Notice Board (Right) displaying list of services and their respective prices. (Picture taken by Auditors at Kolandoto CDH on 30th November 2016 and Kibosho CDH on 12th December 2016)

Based on **Picture 4.1**, it is evident that the list on the two boards for both Kolandoto and Kibosho CDHs did not mention all the services provided as well as prices charged. Inadequate supportive supervisions and inspection by MoH and CHMTs led to non-identification of disclosure of services and prices as an area of priority. As a result, patients have been charged higher than they were expected thus increasing costs to the patients and community.

CHAPTER FIVE

MONITORING AND EVALUATION OF HOSPITALAGREEMENTS

5.1 Introduction

This chapter presents finding on monitoring and evaluation of hospital agreements as conducted by MoH and PORALG.

According to National Supportive Supervision for Quality Control Guideline of 2015, MoH and PORALG are supposed to monitor and conduct supportive supervisions at least once per year, Regional Health Management Teams (RHMTs) were supposed to conduct supportive supervisions to Council Health Management Teams (CHMTs) in each quarter whereas LGAs through CHMTs were to conduct supportive supervision to hospitals monthly.

The audit found weaknesses in all areas of supportive supervisions, inspections, reporting, coordination and evaluation of health service provision for facilities with hospital agreements. These shortfalls are as explained in the sections below.

5.2. Inadequate Supportive Supervisions

The audit found that supportive supervisions were inadequately conducted in all levels of hospitals. It was noted that MoH conducted two supportive supervisions for the whole period under audit (four years). Review of supervision reports revealed that it specifically aimed at assessing the quality of service in Infection Prevention and Control (IPC) at BMC and KCMC[21]. The consultative meetings were also regarded as supportive supervisions. It was noted that, one consultative meeting with BMC was held in March 2014[22] but it focused on assessing the implementation of the 5s[23] knowledge and activities. In supervisions conducted issues regarding hospital agreements were neither addressed nor discussed.

Similarly, the audit noted that PORALG conducted one supportive supervision onto LGAs during the whole period under the audit. This was done in financial year 2015/2016. Only three CDHs were visited for supervision. A review of supportive supervision reports showed that issues regarding to hospital agreement were not covered.

[21] Supportive Supervision of Quality of Service in Infection, Prevention and Control
[22] Report on 5s-Kaizen Consultation Visit at Bugando Medical Centre From 12th To 14th March, 2014
[23] 5s is an abbreviation for 'Sort, Set, Shine, Standardize, and Sustain'

Same weaknesses were noted in RHMTs with regard to supervisions to CHMTs in quarterly basis[24]covering aspects of health care service provision including issues from the signed agreements between LGAs and private hospitals. However the audit discovered that RHMTs did not do as expected as shown in **Table 5.1**.

Table 5.1 Supportive supervisions conducted by RHMTs, to CHMTs 2012/2013 to 2015/2016

Financial year	Expected Number of Supportive Supervisions per year CHMT	Number of Supportive Supervision Done to CHMTs	Average supportive supervision conducted per year
2012/2013	12	2	5
2013/2014	12	7	
2014/2015	12	2	
2015/2016	12	4	
Total	**48**	**15**	

Source: RHMTs' Supportive Supervision and reports 2012/2013-2015/2016

Likewise, CHMTs were not conducting monthly supportive supervision to hospital as required. For four years under audit, there should be 240 supportive supervision reports for all five facilities. However, 14 reports were available as shown in **Table 5.2** below.

Table 5.2 Supportive supervisions conducted by CHMTs to CDHs

Financial year	Expected Number of Supportive Supervisions per year for five facilities	Number of Supportive Supervisions to CDHs	Average supportive supervision conducted per year
2012/2013	60	3	4
2013/2014	60	4	
2014/2015	60	3	
2015/2016	60	4	
Total	**240**	**14**	

Source: CHMTs Supportive Supervision reports 2012/2013-2015/2016

As indicated in **Table 5.1** and **5.2**, RHMTs and CHMTs conducted an average of five and four supportive supervisions per year to selected CHMTs and CDHs respectively for a period of four years under audit.

Furthermore, supportive supervision reports found at all levels, did not address matters regarding to hospital agreements. This was because the

[24]Functions of Regional Health Management System (second Edition) Guideline of 2014

checklist used during supportive supervision did not include matters pertaining to signed hospital agreements that were being implemented. This led to facilities to operate without regard to the agreements as a result each health facility was setting its own service prices as well as provision of services below government requirements.

5.3 Inspections of Health Facilities with Agreements were not Adequately Done

Interviewed officials at MoH, PORALG and CHMT's acknowledged that inspections to hospitals were one of the monitoring mechanisms used by the Government in assessing the progress of health facilities. This was done based on occurrences of some health incidents in repeated supportive supervisions, quarterly progress reports, complaints from the community and reports from the Media. Inspections did not have plans rather a checklist which was developed depending on that particular occurrence or complaint. The interviews indicated that MoH conducted inspections to hospitals with service agreements for the period under audit however inspection reports were not in place.

In addition, interviews with PORALG officials showed that the Ministry conducted seven inspections during the period under audit. Six inspections focused on cleanliness of the facilities and one on staffing level of the facilities. However, in all seven facilities visited, facilities with service agreements and hospital agreement issues were not covered.

5.4 Weak Reporting Systems on Agreement Implementation

The CDH Agreement Template of 2008, National Supportive Supervision Guideline of 2015 and CCHP Guideline of 2014, require the hospitals to prepare and submit quarterly progress reports to MoH for the zonal Referral Hospitals and to LGAs for CDHs. The receiver of the reports is required to scrutinize the reports and provide feedback and recommendations back to the submitting authority.

The audit found weaknesses in reporting on progress of hospital agreements on part of MoH, PORALG and hospitals. For the case of zonal referral hospitals, it was found that there were trends of the facilities not adequately preparing and submitting reports to MoH as shown in **Table 5.3.**

Table 5.3 Trend in Preparing and Submitting of Quarterly Progress Report for Zonal Referral Hospitals (BMC, KCMC and CCBRT)

Year	Required Number of reports per year	Number of reports prepared	Total number of reports submitted	Missing reports
2012/2013	12	0	0	12
2013/2014	12	1[25]	1	11
2014/2015	12	1[26]	1	11
2015/2016	12	1[27]	1	11

Source: National Supportive supervision Guideline 2015, BMC, KCMC and CCBRT Progress reports.

As shown in **Table 5.3**, zonal referral hospitals had a tendency of not preparing and submitting the progress reports to MoH as required. For the whole period under the audit, zonal hospitals prepared and submitted only three progress reports to the MoH. However, all three reports were prepared by CCBRT. Other zonal hospitals did not have any reports in place. In addition CCBRT reports still did not report matters concerning the implementation of agreements. However, the interviews held with CCBRT officials revealed that, CCBRT was not satisfied with the way the Government discharged its duties as per the agreement.

Likewise, CDHs were supposed to prepare and submit quarterly progress reports to LGAs (CHMTs). Similarly, the audit found that there were discrepancies in preparation and submission of these reports. In some CDHs quarterly reports were being prepared but were not submitted to CHMTs for review and scrutiny. For instance in Sumve CDH it was noted that four cumulative annual reports were in place but copies were not submitted to Kwimba DC at the same time Kwimba did not request for them. The cumulative trend and tendency of CDHs in preparation of quarterly progress reports is as shown in the **Table 5.4.**

Table 5.4 Trend in Preparation and Submission of Quarterly Progress Report for CDHs (Kolandoto, Sumve, Kibosho, Machame and Nyangao)

Year	Required number of quarterly reports per year for all CDHs	Number of reports prepared	Total number of reports submitted to LGAs	Missing reports
2012/2013	20	4[28]	0	16
2013/2014	20	4[29]	0	16
2014/2015	20	4[30]	0	16

[25]CCBRT-annual report 2013/2014
[26]CCBRT-annual report 2014/2015
[27]CCBRT-annual report 2015/2016
[28]Sumve quarterly progress reports 2012/2013
[29]Sumve quarterly progress reports2013/2014
[30]Sumve quarterly progress reports 2014/2015

Year	Required number of quarterly reports per year for all CDHs	Number of reports prepared	Total number of reports submitted to LGAs	Missing reports
2015/2016	20	8[31]	0	12

Source: National Supportive Supervision Guideline of 2015, Progress Reports for Kolandoto, Sumve, Kibosho, Machame and Nyangao of 2012/13-2015/16.

From the **Table 5.4**, it can be seen that, with the exception of Sumve CDH which prepared quarterly progress report each year while Nyangao CDH prepared four quarterly reports for the year 2015/2016, other CDHs did not prepare quarterly reports as expected. Nonetheless, the respective quarterly reports did not address matters of service agreements implementation.

Interviews with officials from eight visited hospitals revealed that, the reason for non-preparation of the reports and inclusion of agreement issues was absence of follow-up on part of the MoH for zonal hospitals and LGAs for Disregarding the preparation and submission of the reports. This means that, MoH and LGAs did not make efforts of seeking or reminding the hospitals to submit the reports regarding implementation of agreement.

Consequently, some of crucial information that was part of the agreement from the hospitals was not communicated to the MoH or LGAs. For instance, the exemption policy[32] requires private health service providers to administer the exemptions and present their bills to MoH for them to be compensated provided that appropriate procedures have been observed. However, details on the number of exempted services and their respective costs were not reported. Likewise, matters discussed by hospitals' board of trustees who were the signatory to the agreements were not shared to the Government. **Table 5.5** shows amounts emanating from exempted services which were incurred by Zonal hospitals that were supposed to be reimbursed by the government. These amounts were not adequately disclosed to the Government.

[31]Sumve quarterly progress reports2015/2016 and Nyangao quarterly progress reports, 2015/2016
[32]Godfrey Martin Mubyazi; (Department of Health Systems and Policy Research, National Institute For Medical Research (NIMR)

Table 5.5 Patients Exemptions from Zonal Hospital for 2012/13-2015/16

Facility	Year	Number of patients exempted	Cost amount (TZS Millions)
KCMC	2012/2013	213	66.6
	2013/2014	268	63.3
	2014/2015	299	126.0
	2015/2016	251	151.0
	Total	**1,031**	**407.0**
BMC	2012/2013	36,856	863.5
	2013/2014	18,428	1,056.6
	2014/2015	21,542	1,395.2
	2015/2016	8,871	1,171.8
	Total	**85,697**	**4,487.0**
CCBRT	2012/2013	464	350.7
	2013/2014	8,380	341.9
	2014/2015	14,789	390.6
	2015/2016	22,696	509.6
	Total	**50,500**	**1,592.7**

Source: Hospitals' Board of Governors' Meetings Minutes/records, 2012/2013 - 2015/2016

As indicated in **Table 5.5,** there were costs which were incurred by hospitals but not communicated to MoH. Interviews with officials from eight visited hospitals showed that, the MoH and LGAs did not show interest for the exemption reports. As the hospitals did not submit the records, MoH did not have the records of total amounts exempted to and therefore did not set aside the budget to finance the services exempted to patients. Hospitals reported the exemption records to only board of governors and Hospital management. Therefore, hospitals recovered the costs incurred for exemptions by increasing cost of service as explained in **Section 4.7** in Chapter Four.

5.5 Inadequate Feedback

The National Quality Assurance Strategic Plan of 2013 – 2018 and National Supportive Supervision Guidelines of 2015 require that whoever receives the reports from other agreement stakeholder to give formal (written) feedback accordingly. MoH received three annual progress reports from CCBRT, however the ministry did not give the formal feedback rather, the MoH officials declared that, they made phone calls whenever there were issues in the reports that needed clarifications. Since the feedback was given through phone calls, the instructions or recommendations given to the hospitals by the MoH could not be sustainably recorded and properly addressed.

5.6 Weak Coordination of Hospital Agreements

The Ministry of Health as a parent ministry of health sector in collaboration with PORALG has a responsibility of coordinating all issues regarding health services in the country. MoH is required to know or share or disseminate to other stakeholders whatever is done by other government authorities or any private health stakeholder in relation to health issues as deemed necessary.

However, it was noted that, the MoH in collaboration with PORALG were not adequately coordinating operations activities carried out by the hospitals with hospital agreements as well as RSs and LGAs. For instance, interviews with MoFP revealed that, the exemption and waivers policy is not known by the MoF and thus the ministry has never disbursed funds or rather required to know the exemption budget from MoH.

Similarly, the audit team found that, in five CDHs visited, there were different staffs that worked at one CDH but employed and paid by three different employers i.e. MoH, RSs, and LGAs. Neither of these Government's Institutions had records of staffs recruited and paid by the other institution. Whenever CDHs requested for staff employment permits from MoH, they did so without notifying their respective LGAs who basically were their immediate overseers at the Local Government level. Likewise, when MoH issued employment permit to CDHs, LGAs were not notified.

Moreover, MoH did not adequately coordinate health activities discharged by PORALG through RS and LGAs as well as Hospitals in respect to management of hospital agreements. As a result, matters relating to hospital agreements were not reported from CDHs, LGAs, RSs, PORLAG and Zonal Hospital levels. Review of correspondence between MoH and five LGAs visited in respect of accrediting the private hospitals to Council Designated Hospitals revealed that PORALG and respective RSs were not adequately involved in the process. This was because all correspondence from MoH to LGAs did not go through the PORLAG or RSs which are custodians of the LGAs.

Further, MoH did not coordinate preparatory activities before entering into hospital agreements including the community and NGOs dealing with health issues within the respective LGAs. The reason for weak coordination was due to reactive approach that MoH applied before deciding to enter into partnership with private hospitals as these activities such as needs assessment, negotiations and inspections to hospitals were not done as discussed in **Chapter Three** of this audit report.

Consequently, MoH did not have information on real time and status regarding the implementation of agreements. As a result, there were duplication efforts or roles and responsibilities of stakeholders. For

instance, MoH, PORALG, RSs and LGAs were conducting same activities such as supportive supervisions using the same checklist and at the same time reporting to separate authorities.

5.7 Evaluation of Hospital Agreements not Done

MoH in collaboration with PORALG did not evaluate on performance of the implementation of hospital agreements since the beginning of partnerships with private health service providers. Likewise, both RSs and LGAs did not evaluate performance of such partnerships.

This was a result of not setting budget to specifically carter for evaluation of performance of the agreements. Similarly, this was caused by absence of the contractual clauses that require evaluation of the agreements after a specified period of implementation.

CHAPTER SIX

CONCLUSION

6.1 Introduction

This chapter presents overall and specific audit conclusions based on audit objectives and findings as explained in previous chapters.

6.2 General Conclusion

The general conclusion of this audit is that, MoH and PORALG do not adequately manage hospital agreements. Consequently, planning, implementation and monitoring of hospital agreements are not efficiently and effectively done. The Government does not apply active and proactive approach when entering into agreement with private health facilities.

6.3 Specific Conclusions

Planning

There are weak planning and preparations for hospital agreements characterized by absence of needs assessments, lack of guidelines for developing the agreements, lack of crucial clause in the agreement and not involvement of key stakeholders. There are weaknesses in preparation and entering into agreements because community health care service's needs assessments are not conducted prior to entering into contract, contract negotiation meetings are not conducted, key stakeholders to the agreement implementation such as community, RHMT, CHMTs or Civil Societies are not involved. MoH in collaboration with PORALG has not developed a guideline for developing and performing of hospital agreements.

Implementation

Both the government and health facilities with hospital agreements do not discharge their contractual obligations as activities relating to agreements are not incorporated into government and health facilities' annual plans and budget. The Government and health facilities do not plan and budget together as required by CCHP guideline. In addition, both were not disclosing to each other some of the information such as, hospitals' income generated from other sources. Equally, MoH and PORALG do not disclose health facilities approved budgets.

Health facilities do not provide expected health services that met approved Government health standards. Some services expected to be

provided as per the hospitals' levels were not provided. In addition, health facilities are not following the indicative health service prices due to outdated health service cost indicated in the cost sharing guideline. Furthermore, facilities do not disclose the list of services they provide and their respective prices to the public, and also facilities do not communicate the exemption status to the government.

The Government does not disburse fund to the hospitals as budgeted and approved. There are significant Government delays in disbursing Funds to health facilities. In addition, the Government does not set aside the budget to finance the exemption policy of the vulnerable groups.

Monitoring and evaluation

Furthermore, there has been inadequate monitoring and evaluation of the implementation of hospital agreement. Consequently, agreements have been made redundant and the hospitals are operating without proper guidance and follow-up. MoH and PORALG have monitoring and evaluation systems in place such as supportive supervisions, inspections and reporting in place, but they are tailored to accommodate hospital agreements to ensure that they are properly implemented, monitored and evaluated.

Moreover, MoH does not adequately coordinate health services activities implemented by health facilities with agreements. Information generated from the level of hospitals and government are not shared and disseminated among other public and private health sector stakeholders.

The Government and health facilities have not evaluated the implementation of the health agreements since when they were signed as they do not give priority to evaluation activities as there are no budgets set aside in their action plans to carter for the said activity.

CHAPTER SEVEN

RECOMMENDATIONS

7.1 Introduction

This chapter provides for the recommendations based on audit findings. The aim is to address the identified gaps and weaknesses and that are directed to the MoH and PORALG, the ministries responsible for overseeing the implementation of health care service Agreements between the government and the private health facilities in the country.

7.2 Planning for Hospital Agreements

The Ministry of Health, Community Development Gender, Elders and Children should:

7.2.1 Prepare and disseminate guidelines for developing and implementation of hospital agreements;

7.2.2 Review and update the existing agreement templates to include indicative prices of health services:

7.2.3 Conduct assessments of private Hospitals' capacity before entering into agreements with private hospitals and accredit them to Zonal Referral Hospital.

The President's Office -Regional Administration and Local Government through Regional Secretariats and Local Government Authorities should:

7.2.4 Carry out needs assessments prior to entering into agreements with private hospitals;

7.2.5 Conduct inspections to private hospitals in order to assess the capacity before accrediting them to Council Designated Hospitals and signing the Hospital Agreements;

7.3 Implementation of the Hospital Agreements

The Ministry of Health, Community Development Gender, Elders and Children should:

7.3.1 In collaboration with Ministry of Finance and Planning, timely disburse funds to facilities and at the amounts agreed in the agreements;

7.3.2 Develop a mechanism of regularly reviewing the implemented Zonal Referral Hospital agreements;

7.3.3 Enhance transparency during preparations of annual action plans and budgets by involving Zonal Referral Hospitals throughout the process.

The President's Office-Regional Administration and Local Government through Regional Secretariats and Local Government Authorities should:

7.3.4 Develop a mechanism of regularly reviewing the implemented Council Designated Hospital agreements;

7.3.5 In collaboration with President's Office Public Service Management consider harmonizing employment and payment of staff working with Council Designated Hospitals.

7.3.6 Enhance transparency during preparations of annual action plans and budgets by involving Council Designated Hospitals throughout the process.

7.4 Monitoring and evaluation of the Hospital Agreements

The Ministry of Health, Community Development Gender, Elders and Children should:

7.4.1 Monitor the implementation of Zonal Referral Hospitals Agreements by conducting supportive supervisions and inspections and report on their performance;

7.4.2 Coordinate all matters related to planning and implementation of Zonal Referral Hospitals Agreements and strengthen its reporting system on their performance.

7.4.3 Evaluate the currently implemented Zonal Referral Hospital Agreements so as to assess the extent of their implementation and their impacts to health service delivery in the country;

7.4.4 Assess capacity to Zonal Referral Hospitals regularly to check if the facilities are providing services as per their level of accreditation;

7.4.5 Involve all agreements' stakeholders in development and implementation process of the zonal hospital agreements.

The President's Office - Regional Administration and Local Government through Regional Secretariats and Local Government Authorities should:

7.4.6 Monitor implementation of Council Designated Hospitals Agreements by conducting supportive supervisions and inspections as well as report on its performance;

7.4.7 Coordinate all matters related to planning and implementation of Council Designated Hospitals Agreements and strengthen their reporting system on their performance;

7.4.8 Evaluate the currently implemented Council Designated Hospital agreements so as to assess the extent of their implementation and their impacts to health service delivery in the country;

7.4.9 Assess capacity to Council Designated Hospitals regularly to check if the facilities are providing services as per their level of accreditation;

7.4.10 Involve all agreements' stakeholders in development and implementation process of the zonal hospital agreements.

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APPENDICES

Appendix 1: Audit Questions and Sub-Questions

1.	**Does MoH and PO-RALG adequately pre-plan and develop hospital agreement?**
1.1	Do the plans for hospital agreements identify community's health services needs and capacity of the hospital to be designated for the required level?
1.2	Do the MoH and PORALG set out specific guidelines in respect of development and performance of hospital Agreements?
1.3	Do the developed and signed agreements safeguard governments' interest regarding provision of health services?
2	**Do the MoH and PORALG adequately implement the agreements?**
2.1	Do parties discharge their obligations as per the service agreement?
3.	**Do the MoH and PORALG adequately monitor, coordinate, and evaluate the implementation of hospital agreement?**
3.1	To what extent do the MoHin collaboration with PORALG monitor the implementation hospital agreement?
3.2	To what extent do MoH and PORALG conduct inspections to hospitals with agreement?
3.3	Do MoH and PORAG ensure reporting system on agreement implementation adequately followed?
3.4	To what extent do MoH coordinate activities related to implementation of hospital agreement?
3.5	To what extent do the MoH evaluate the implementation of hospital agreement?

Appendix 2: Audit assessment criteria

AUDIT CRITERIA

The main sources of the audit criteria are the Acts, Regulations and guidelines, strategic and action plans of MoHCDGEC and PO-RALG and service agreements between the Government and private health service providers. The following are the criteria to be used for the audit:

Planning of health care services agreements;

i. The Contracting Authority is required to collaborate with the private party during planning and preparation of monitoring and evaluation framework. Such framework shall be comprised of:
   - Project management plan;
   - Progress criteria;
   - External audit and reporting requirements;
   - Submission of progress reports;
   - Verification of project assets and value; and
   - Stakeholder's communication.

   (Source: MoHCDGEC PPP Guidelines of 2013 paragraph 6.1.7)

ii. The organizations i.e. the contracting party (the government) and the health facilities management, are expected to have guidelines for progress of the agreement. **(Source: Health Sector Strategic Plan III. Planning)**

iii. MoHCDGEC PPP Guidelines requires the ministry to lay down the guidelines for development of service agreement**. (Source: MoHCDGEC PPP Guidelines of 2013)**

iv. All LGAs are required to set their own progress objectives within the context of local health plans which takes into account national priorities, local conditions and local priorities. **(Source: Health Basket and Health Block Grant Guidelines of 2004)**

Implementation of health care services agreements

i. The government is required to provide funds required for running the hospitals and operating other services including funds for minor maintenance and repairs of equipment and buildings.**(Source: Service agreement template of 2004 Clause 19)**

ii. The government shall be required to disburse the funds quarterly to the hospital. **(Source: Service agreement template of 2004)**

iii. The Disbursement of first quarter's funds to the councils will be dependent upon submission of first 6 months financial accounts report, first 6 months technical report of previous year and approved Comprehensive Council Health Plan for current year;

iv. The Disbursement of 1st and 3rd quarter's funds will be dependent upon submission of previous years' annual accounts and annual technical report that also reports on progress made to attain expected outputs

v. The disbursement of 2nd and 4th quarter funds will be automatic unless there are serious financial flaws detected in any of the council's first quarter financial reports; and financial irregularities are detected in any preceding financial quarterly or technical report;
(Source: The Basket and Block Grant Guideline of 2004)

vi. The service agreement should provide for responsibilities of the parties to the contract, the range of services to be provided, time span, the progress standards to be achieved, and procedures for progress monitoring, terms of payment and costs, quality, arbitration and exemptions.**(Source: The MoHCDGEC-PPP Policy Guidelines of 2013)**

Monitoring and evaluation Coordination, of implementation of Hospital agreements

i. MoHCDGEC and PO-RALGare required to establish a mechanism of monitoring and evaluation of PPP activities.**(Source: The MoHCDGEC - PPP Policy Guidelines of 2013: (Paragraph 6.1.7)**

ii. The Council Comprehensive Health Plan should among others be the chapter which shows/indicates monitoring progress indicators and targets.**(Source: Health Basket And Health Block Grants Guidelines of 2004 paragraph 4.4)**

iii. PO-RALG is required to monitor and evaluate health development projects implemented by the LGAs annually.**(Source: MoHCDGEC and PO-RALG's (2011/2012 to 2015/2016) Strategic and Annual action plans.)**

iv. The ministry will monitor the progress of the PPP projects through quarterly progress implementation and financial reports.(**Source: The MoHCDGEC PPP guidelines of 2013 paragraph 6.1.7)**

v. The hospital shall be required to prepare and submit quarterly financial and technical reports. **(Source: Memorandum of understanding template of 2008 clause 20)**

Appendix 3: Details of Selected entities and Health which were visited during data collection.

S/N	Health Facility	Category	Region	LGA
1.	Kilimanjaro Christian Medical Centre	Zonal Referral Hospitals	Kilimanjaro	Moshi Municipal Council
2.	Bugando Medical Centre	Zonal Referral Hospital	Mwanza	Nyamagana Municipal Council
3.	Comprehensive Community Based Rehabilitation in Tanzania (CCBRT)	Zonal Referral Hospital	Dar es Salaam	KinondoniMunicipal Council
4.	Kibosho Hospital	Council Designated Hospital	Kilimanjaro	Moshi Rural District Council
5.	Machame Hospital	Council Designated Hospital	Kilimanjaro	Hai District Council
6.	Sumve Hospital	Council Designated Hospital	Mwanza	Kwimba District Council
7.	Kolandoto Hospital	Council Designated Hospital	Shinyanga	Shinyanga Municipal Council
8.	Nyangao Hospital	Council Designated Hospital	Lindi	Lindi Municipal Council

Appendix 4; Documents which were reviewed during the audit

Description of government entities/Stakeholders	Type of document to be reviewed	Reasons for review
Ministry of Health, Community Development, Gender, Elders and Children and President's Office - Regional and Local Government	1. The Health Policy, 2003 2. Ministries Strategic Plans 3. Health Sector Strategic Plan III, 2009-2015. 4. Annual Work Plans 5. Health Basket and Health, Block Grants Guidelines for the Disbursement of Funds, Preparation of comprehensive Council Health Plans, Financial and Technical Reports and Rehabilitation of PHC Facilities by Councils of 12th March 2015. 6. Hospital agreements (for every sampled health facility)	1. To understand the policy content regarding to management of health project /programmes where the government works with the government. 2. To generally understand strategic planning and implementation of set objectives especially to those health facilities which work in collaboration with the government 3. To understand how the government has set out implementation strategies in respect of provision of health services. 4. Assess how the Ministries have taken on board the implementation of health services provisions in the strategic plan and health sector strategic plan in annual basis 5. To determine the mechanisms for disbursement, planning, reporting and rehabilitation of funds from basket and block grants. 6. Review of hospital agreements will assist the team to understand the content of the agreement and implementation methodologies.

Regional Secretariats (RHMTs) and Local Government Authorities (CHMTs)	1. Annual Plans and Budget for years under study 2. Service agreement Negotiation Records 3. Annual Progress reports (Quarterly, annually?) 4. Monitoring and evaluation reports for health facilities working in collaboration with the government 5. RHMTs, CHMTs and Submitted reports from health facilities	1. To understand the level of involvement of private organization in council annual plans and budget. 2. To assess the negotiations results, composition of negotiation teams and reflection of the agreed terms and conditions in the final agreement. 3. To determine if the LGAs carry out its significant role of monitoring health facilities in their localities. Also to assess the degree of implementation of the LGAs annual plans and budgets as well as the challenges raised during the implementation of the annual plans. 4. To understand the mechanisms used by the LGAs in monitoring and evaluating the progress of health facilities, frequency of inspection and supervision as well and the recommendation given to the facilities. 5. Also to determine the reporting system 6. Also to determine the extent of implementation of the given recommendations.
Medical Stores Department (MSD)	6. MSD's annual plans and Budget 7. Medical distribution of procuring facilities	To determine the disbursement details and trend of the government in terms of procurement of medicines, medical supplies and equipment from MSD
CCBRT	1. The MoU (Service agreement) entered between CCBRT and the government.	To assess the extent to which the government and CCBRT, as a sampled health facility which works with the government in provision of health services,

		discharge their respective obligations as per agreement
	2. Technical reports submitted to the government.	To assess how resources provided by the government are being utilized by the facility.

Appendix 5: Officials who were interviewed during the audit together with the purpose of interviewing them

S/N	Title	Department	Type of information to be obtained
Ministry of Health, Community Development, Gender, Elders and Children			
1.	Director of Policy and Planning	Policy and Planning Division	Planning methodologies and budgeting of health services. List of private national, zonal and regional referral hospitals working with the government
2.	Director of Curative Services	Curative services Division (Public and Private Health Services Division)	Management of public and private health facilities. List of Councils Designated hospitals (CDH) and Voluntary Agencies organizations (VAO) Budget for CDH and VAO Seeking information in relation with those facilities which work with the government.
3.	PPP Unit Officer	Curative services division	Information in relation with projects / programmes which are implemented between the government and private organization.
4.	Quality assurance section	Curative services division	Information in relation to monitoring, supervision, inspections of health services as implemented as per the agreement.
5	Director for Administration and Human Resource Management	Directorate of Administration and Human Resource Management	Information on management of staff salaries and payroll management working in health facilities which have entered into the health agreement with the government
President's Office - Regional and Local government Authorities			
1.	Director for health and environment	Directorate of health and environment	information regarding to the progress of LGAs in management of health

2.	Local government Authorities director	Local government Authorities director	services delivery Disbursement of fund for health development projects
Local Government Authorities			
1.	Planning director	Planning directorate	Planning methodologies and budgeting of health services. Extent of Private facilities and other stakeholders involvement in Planning
2.	DMOs	Health department	Information on monitoring of health service activities in the council for the facilities that the council work with private organization
3.	DHMT	Councils Management	Information of the progress of the facilities, Information on how LGAs monitors the progress health facilities
Medical Stores Department			
1.	Director for Customer services	Customer Services Directorate	Government fund's disbursement for medicine and medical supplies procurement for health programs /projects in which he government work with the private sector
2.	Risk Management officer	Finance Directorate	Details on the disbursement of fund for procurement of medicine, medical supplies and medical equipment for health facilities
Health facilities			
1.	CEO		To understand the general overview on how the government work together with CCBRT in health service provision
2.	Alliance Director		To understand the specific areas which the government support

			CCBRT in health service provision Challenges that arise in such partnership.
3.	Human Resource Director		Information relating record to staff receiving salaries from the government and the modality the government disburse staff salary to the facility.
4.	Head of Finance		Information relating the use of funds generated by the facilities from cost sharing schemes.
5.	Head of pharmacy section		Trend of service received from MSD as well as exemptions status of imported medicines and medical consumables.

Appendix 6: Details on basket fund disbursement to CDHs from 2012/2013 to 2015/2016

QUARTERLY DISBURSEMENT OF FUNDS TO CDHs					
KIBOSHO CDH					
Financial year	**Quarters**	**Amount approved**	**Amount disbursed**	**Variance**	**Date of receipt**
2012/2013	1st	39,159,364		(39,159,364)	
	2nd	39,159,364		(39,159,364)	
	3rd	39,159,364	77,497,140	38,337,776	3-Jan-13
	4th	39,159,364	77,497,140	38,337,776	10-Jun-13
		156,637,455	**154,994,280**	**(1,643,175)**	**Not paid**
2013/2014	1st	39,159,364	-	(39,159,364)	
	2nd	39,159,364	-	(39,159,364)	
	3rd	39,159,364	78,318,728	39,159,364	17-Jan-13
	4th	39,159,364	78,318,728	39,159,364	24-Jun-13
		156,637,455	**156,637,456**	**1**	**Not paid**
2014/2015	1st	38,748,570	-	(38,748,570)	
	2nd	38,748,570	32,201,521	(6,547,049)	14-Nov-14
	3rd	38,748,570	32,201,521	(6,547,049)	23-Feb-15
	4th	38,748,570	64,403,042	25,654,472	27-Apr-15
		154,994,280	**128,806,086**	**(26,188,194)**	**Not paid**
2015/2016	1st	38,748,570		(38,748,570)	
	2nd	38,748,570	-	(38,748,570)	
	3rd	38,748,570	31,005,250	(7,743,320)	26-Feb-16
	4th	38,748,570	31,005,250	(7,743,320)	24-Jun-16
		154,994,280	**62,010,500**	**(92,983,780)**	**Not paid**
		623,263,470	502,448,322	(120,815,148)	81%
MACHAME CDH					
Financial year		**Amount approved**	**Amount disbursed**	**Variance**	
2012/2013	1st	34,806,728	-	34,806,728	
	2nd	34,806,728	-	34,806,728	
	3rd	34,806,728	15,803,364	19,003,364	27-Mar-13
	4th	34,806,728	-	34,806,728	6-Jun-14
		139,226,912	**15,803,364**	**123,423,548**	**Not paid**
2013/2014	1st	67,962,480	34,802,827	33,159,653	1-Aug-13
	2nd	67,962,480	-	67,962,480	
	3rd	67,962,480	-	67,962,480	
	4th	67,962,480	67,719,080	243,400	6-Jun-14

		271,849,920	**102,521,907**	**34,559,427**	**Not paid**
2014/2015	1st	57,249,600	115,191,134	(57,941,534)	15-Jul-14
	2nd	57,249,600	115,191,134	(57,941,534)	12-Nov-14
	3rd	57,249,600		57,249,600	
	4th	57,249,600	14,312,400	42,937,200	3-Jun-15
		228,998,400	**128,806,086**	**-15,696,268**	**Not paid**
2015/2016	1st	42,040,800	-	42,040,800	
	2nd	42,040,800	-	42,040,800	
	3rd	42,040,800	10,304,928	31,735,872	23-Mar-16
	4th	42,040,800	10,304,928	31,735,872	30-Jun-16
		168,163,200	**20,609,856**	**147,553,344**	**not paid**
SUMVE CDH					
Financial year	**Quarters**	**Amount approved**	**Amount disbursed**	**Variance**	**Date of receipt**
2012/2013	1st	30,248,425		30,248,425	
	2nd	30,248,425		30,248,425	
	3rd	30,248,425	30,248,425	-	30-Jan-13
	4th	30,248,425	90,745,275	(60,496,850)	19-Jun-13
		120,993,700	120,993,700	-	
2013/2014	1st	26,405,000	-	26,405,000	
	2nd	26,405,000	-	26,405,000	
	3rd	26,405,000	62,930,227	(36,525,227)	10-Jan-14
	4th	26,405,000	42,689,772	(16,284,772)	9-Jun-14
		105,620,000	105,619,999	1	
2014/2015	1st	23,400,000	-	23,400,000	
	2nd	23,400,000	23,400,000	-	23-Dec-14
	3rd	23,400,000	-	23,400,000	
	4th	23,400,000	70,200,000	(46,800,000)	8-Jun-15
		93,600,000	93,600,000	-	
2015/2016	1st	17,578,560	-	17,578,560	
	2nd	17,578,560	-	17,578,560	
	3rd	17,578,560	35,157,120	(17,578,560)	22-Apr-16
	4th	17,578,560	35,157,120	(17,578,560)	12-Jul-16
		70,314,240	70,314,240	-	
		390,527,940	390,527,939	1	100%

KOLANDOTOCDH					
2012/2013	1st	39,159,363.75	-	39,159,364	
	2nd	39,159,363.75	-	39,159,364	
	3rd	39,159,363.75	15,803,364	23,356,000	27-Mar-13
	4th	39,159,363.75	32,916,253	,243,111	6-Jun-14
		156,637,455	**48,719,617**	**,560,253**	
2013/2014	1st			-	
	2nd			-	
	3rd			-	
	4th			-	
			156,637,455	**56,637,455**	
2014/2015	1st			-	
	2nd			-	
	3rd			-	
	4th			-	
			128,806,086	**128,806,086**	
2016/2016	1st			-	
	2nd			-	
	3rd			-	
	4th			-	
			62,010,500	**62,010,500**	

Note: Nyangao CDH could not provide adequate details thus the amounts disbursed could not be verified or analyzed. Kolandoto CDH provided details for only financial year 2012/2013.

Appendix 7

RESPONSES TO AUDIT RECOMMENDATIONS FROM MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT GENDER, ELDERS AND CHILDREN

S/N	RECOMMENDATION	PORALG'S MANAGEMENT RESPONSE	PLANNED ACTION TO BE TAKEN IN ORDER TO IMPLEMENT THE RECOMMENDATION	TIME FRAME
1.	**PLANNING FOR HOSPITAL AGREEMENTS**			
1.1.	***The Ministry of Health, Community Development Gender, Elders and Children should:***			
i.	Prepare and disseminate the guidelines for developing and implementation of hospital agreements;	Agreed	Guidelines for Health facilities service agreements which have been developed, awaiting for printing and dissemination.	By end of December 2017
ii.	Review and update the existing agreement templates to include indicative prices of health services:	Agreed to review SA Templates	1) All Service agreement Templates (General, CDHs, Regional and Zonal Referral hospitals) have been reviewed to align with current health service needs and situation. 2) Vetting conducted by Attorney General's office for 3 Templates, except CDH Template. 3) Revised Service Agreements Templates for referral hospitals at Regional level and General Service agreement has been submitted	Done Follow-up of CDH SA template from Attorney General's office by end of April 2017

			to PORALG for implementation. 4) Approved prices of health service (cost sharing and NHIF prices) which are also used in service agreements are available to implementers. This will be enhanced by sending a soft copy to hospital agreement implementers.	By end of June 2017
iii.	Conduct assessments of private Hospitals' capacity before entering into agreements with the private hospitals and accredit them to Zonal Referral Hospital.	Agreed	The MOHCDGEC is in a process of conducting an initial assessment for 3 private Zonal Referral Hospitals (Bugando, KCMC and CCBRT) and 10 upgraded FBO Regional hospitals.	By the end of June 2017
2.0	**IMPLEMENTATION OF HOSPITAL AGREEMENTS**			
2.1	***The Ministry of Health, Community Development Gender, Elders and Children should:***			
i.	In collaboration with Ministry of Finance and Planning, timely disburse funds to facilities and at the amounts agreed in the agreements;	Agreed, only if funds are disbursed timely and as budgeted.	1) Will depend on disbursed of funds from the Ministry of Finance	By end of June 2018
ii.	Develop a mechanism of regularly reviewing	Agreed, if funds for development	MOHCDGEC will ensure a period review of	By end of June 2018

	the implemented Zonal Referral Hospital agreements;	of tools for regular review and dissemination are made available	implemented Zonal Referral Hospitals agreements.	
iii.	Enhance transparency during preparations of annual action plans and budgets by involving Zonal Referral Hospitals throughout the process.	Agreed	1) The planning process including annual action plans and budgets for Zonal Referral Hospitals is conducted in collaboration with owners of hospitals and MOHCDGEC.	By end of April, 2017
3.0	**MONITORING AND EVALUATION OF THE COUNCIL DESIGNATED AGREEMENT**			
3.1	***The Ministry of Health, Community Development Gender, Elders and should:***			
i.	Monitor the implementation of Zonal Referral Hospitals Agreements by conducting supportive supervisions and inspections and report on their performance;	Agreed, if funds for printing, dissemination of joint supportive supervision guide and actual supportive supervision are made available	1) Supportive Supervision Guideline has been reviewed to incorporate implementation of agreements. Awaits printing and dissemination. 2) Actual Supportive supervision and inspection will be conducted depending on availability of funds	By end of June 2018
ii.	Coordinate all matters related to planning and implementation of Zonal Referral Hospitals Agreements and strengthen its reporting system on their performance.	Agreed	The MOHCDGEC coordinates all Zonal Referral Hospital Agreements and reporting through the existing mechanisms of the MOHCDGEC directorates (Curative, Preventive Services, Policy and Planning, Quality	By end of June 2018

			Assurance)	
iii.	Evaluate the currently implemented Zonal Referral Hospital Agreements so as to assess the extent of their implementation and their impacts to health service delivery in the country;	Agreed, If funds are made available for conducting evaluation and assessments of Zonal Hospitals	As 1.1 (a) Above Furthermore the MOHCDGEC will conduct general evaluation of implementation of Service Agreements at Zonal referral hospitals and assess their impact to health service delivery in the country every after 3 years	By end of June 2020
iv.	Assess capacity to Zonal Referrals Hospitals regularly to check if the facilities are providing services as per their level of accreditation;	Agreed, If funds are made available for the remaining 2 Zonal Hospitals	1) The MOHCDGEC will continue performing periodic assessment for Zonal Referral Hospitals to ensure adequate health service provision as per agreement. 2) For health facilities under Regional and LGAs periodic assessment is under PORALG responsibilities	By end of June 2018
v	Involve all agreements' stakeholders in the development and implementation process of the Zonal Referral Hospital Agreements.	Agreed	The MOHCDGEC will make sure that the developed Service agreement guideline is adhered too. That all stakeholders in the Zonal Referral Hospital Agreements are involved	By end of June 2018

Appendix 8

Responses to Audit Recommendations from the President's Office – Regional and Local Government Authorities (PORALG)

S/N	RECOMMENDATION	PORALG'S MANAGEMENT RESPONSE	PLANNED ACTION TO BE TAKEN IN ORDER TO IMPLEMENT THE RECOMMENDATION	TIME FRAME
2	**PLANNING FOR COUNCIL DISIGNATED HOSPITAL AGREEMENTS**			
1.1	***The President's Office - Regional and Local Government Authorities through Regional Secretariats and Local Government Authorities should:***			
i.	Carry out needs assessments prior entering into agreements with private hospitals;	Management will adhere to Auditors recommendations; it will be taken care on the next coming Service agreement.	Issue the Government note/letter that will emphasize, The LGA's not to enter into services agreement with the private facilities to the place where there are Government services. That will ensure no duplication of the services. The notes will also strictly prohibit the renew of the services agreement to parties where there is Government services	30 June, 2017
ii.	Conduct inspections to private hospitals in order to assess the capacity before accrediting them to Council Designated Hospitals and signing the Hospital Agreements;	Management will adhere to Auditors recommendations; capacity need assessment report section will be part of the services agreement.	The Government is now reviewing template for the facilities services agreement. PO – RALG will write to MoHCDCE to ensure the template accommodate the section of capacity assessment report that will be major area for the decision making.	30 June, 2017
2.0	**IMPLEMENTATION OF THE COUNCIL DISIGNATED HOSPITAL AGREEMENT**			
2.1	***The President's Office - Regional and Local Government Authorities through Regional Secretariats and Local Government Authorities should:***			
iv.	Develop a mechanism of regularly reviewing the implemented Council Designated Hospital agreements;	Management agreed with the auditors' recommendation. Most of the Agreement were not reviewed	On the new designed template will provide the clause for the annual review, PO RALG will write to MoHCDGCE to accommodate the clause for the midyear review and the end of	30 June, 2017

			the agreement evaluation that will determine the next agreement.	
v.	In collaboration with President's Office Public Service Management consider harmonizing employment and payment of staff working with Council Designated Hospitals.	Management of PO RALG agreed with the auditors comments	PO RALG in collaboration with MoHCDGEC will write to President's Office Public Service Management considers harmonizing employment and payment of staff working with Council Designated Hospitals.	30 June, 2018
vi.	Enhance transparency during preparations of annual action plans and budgets by involving Council Designated Hospitals throughout the process.	Management agreed with the auditors comments, the preparation of the budget will be transparence and participatory, it has been stipulated under the CCHP guideline 2011.	PO RALG will issue a letter to remind the stakeholder's involvement and transparency to both parties during planning and the execution of the budget. This will be taken into account during supportive supervision to Region and LGA's	30 June, 2018
3.0	**MONITORING AND EVALUATION OF THE COUNCIL DESIGNATED HOSPITAL AGREEMENTS**			
3.1	***The President's Office - Regional and Local Government Authorities through Regional Secretariats and Local Government Authorities should:***			
i.	Monitor the implementation of Council Designated Hospitals Agreements by conducting supportive supervisions and inspections and report on their performance;	Management adhere Auditors recommendation	This will be done on quarterly bases and the performance report will be issued. It will be verified on the next performance audit.	30 June, 2018
	Coordinate all matters related to planning and implementation of Council Hospital Agreements and strengthen its reporting system on their performance;	Management of PO RALG adhere to auditors comment	All this are coordinated through the PO RALG structure in collaboration with the MoHCDGEC. The coordination will be done throughout the year and the reporting system will be strengthening. It will	30 June, 2018

			be verified on the next audit.	
ii.	Evaluate the currently implemented Council Hospital Agreements so as to assess the extent of their implementation and their impacts to health service delivery in the country;	Management adhere with the auditors comments.	PO RALG in collaboration with the MoHCDGEC will organize, and conduct the impact evaluation and see the contribution of Council Hospital Agreement toward improving health services delivery in the country.	30 June, 2018
iii.	Assess capacity to Council Hospitals regularly to check if the facilities are providing services as per their level of accreditation;	Management adhere to auditors comments	In collaborating with MoHCDGEC, Through supportive supervision and monitoring of CDH services, this will be checked on annual bases. The report will be used to upgrade the accreditation or downgrade the accreditations.	30 June, 2018
iv.	Involve all agreements' stakeholders in the development and implementation process of Council Hospital Agreements.	Management agreed with the auditors comments, the development and implementation process will be transparence and participatory.	PO RALG will issue a letter to remind parties to involve stakeholders during development and the implementation of CDH agreement. This will be taken into account during supportive supervision to Regions and LGA's. It will be verified on the next Audit.	30 June, 2018