THE UNITED REPUBLIC OF TANZANIA
NATIONAL AUDIT OFFICE

PERFORMANCE AUDIT REPORT ON THE REGULATION OF PRIVATE AND VOLUNTARY HEALTHCARE FACILITIES

CONTROLLER AND AUDITOR GENERAL
MARCH 2023

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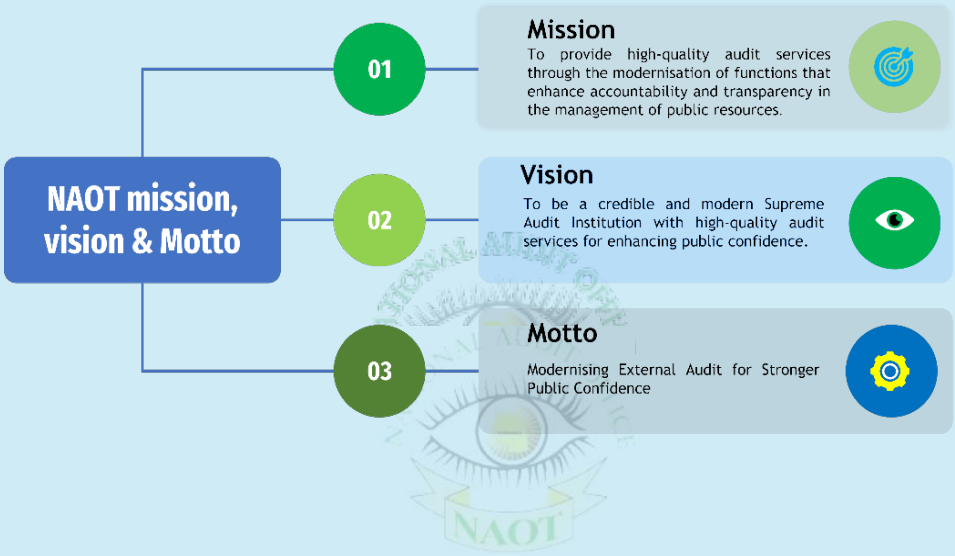
The statutory mandate and responsibilities of the Controller and Auditor General are provided for under Article 143 of the Constitution of the United Republic of Tanzania, 1977 and in Section 10 (1) of the Public Audit Act, Cap. 418.



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PREFACE

Section 28 of the Public Audit Act, CAP 418 [R.E. 2021] gives mandate to the Controller and Auditor General to carry out Performance Audit (Value-for-Money Audit) to establish the economy, efficiency and effectiveness of any expenditure or use of resources in the Ministries, Departments and Agencies (MDAs), Local Government Authorities (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 Her Excellency, the President of the United Republic of Tanzania, Hon. Dr. Samia Suluhu Hassan, and through her to the Parliament of the United Republic of Tanzania, the Performance Audit Report on the Regulation of Provision of Healthcare Services by Private and Voluntary Healthcare Facilities.

The report contains findings, conclusions, and recommendations that are directed to the the Ministry of Health (MoH).

The Ministry of Health (MoH) had the opportunity to scrutinize the factual contents of the report and comment on it. I wish to acknowledge that discussions with the Ministry of Health (MoH) have been useful and constructive.

My Office will carry out a follow-up audit at an appropriate time regarding actions taken by the the Ministry of Health (MoH) in implementing the recommendations given in this report.

In completing the audit assignment, I subjected the draft report to a critical review of subject matter expert, namely Prof. Mujinja Gamba Mussumi a retired Professor and Researcher at Muhimbili University of Health and Allied Sciences (MUHAS) who came up with useful inputs for the improvement of this report.

The report was prepared by Ms. Janeth Rutagengwa and Mr. Fundikira L. Ntabo (Team Members) under the supervision and guidance of Mr. Elisante Mshana (Chief External Auditor), Ms. Esnath N. Henry (Assistant Auditor General) and Mr. George C. Haule (Deputy Auditor General).

I would like to thank my staff for their commitment in preparing this report. I also acknowledge the audited entities for their cooperation with my Office, which facilitated the timely completion of the audit.

Charles E. Kichere
Controller and Auditor General
United Republic of Tanzania
March, 2023

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LIST OF ABBREVIATIONS & ACRONYMS

APHFTA	:	Association of Private Health Facilities in Tanzania
CCHP	:	Comprehensive Council Health Plan
CHMT	:	Council Health Management Team
DHQA	:	Director of Health Quality Assurance
DMOs	:	District Medical Officers
DPP	:	Director of Policy and Planning
FBO	:	Faith-based Organization
GPP	:	Good Pharmacy Practice
HFs	:	Healthcare facilities
HIV	:	Human immunodeficiency virus
HSSP	:	Health Sector Strategic Plan July 2009–June 2015
IPC	:	Infection Prevention and Control
LMICs	:	Low- and Middle-Income Countries
MCT	:	Medical Council of Tanzania
MoH	:	Ministry of Health
MUHAS	:	Muhimbili University of Health and Allied Sciences
NEMLIT	:	National Essential Medicines List Tanzania
NHIF	:	National Health Insurance Fund
PHAB	:	Public Health Accreditation Board
PHL	:	Private Health Laboratories
PHLB	:	Private Health Laboratories Board
PHSDP	:	Primary Healthcare services Development Programme
PORALG	:	President's Office Regional Administration and Local Government
PPP	:	Public Private Partnerships
RHMT	:	Regional Health Management Team
RMOs	:	Regional Medical Officers
STG	:	Standard Treatment Guidelines
TCSSC	:	Tanzania Christian Social Services Commissions
WHO	:	World Health Organization

EXECUTIVE SUMMARY

Background Information

According to the World Bank Report of 2018, private and voluntary healthcare facilities play a significant role in the provision of healthcare services in low- and middle-income countries (LMICs), and the number of Private hospitals is increasing rapidly.

Private Health sector involvement in the Tanzanian health system has grown relatively quickly over the past 20 years. This is, in part, responding to government policy changes (such as removing the ban on private practice in 1991). In Tanzania, at independence, the government assumed primary responsibility for the provision of healthcare to its people and made progress in developing a comprehensively structured healthcare delivery system from the national to the village level. The Government healthcare services have, however, been supplemented by the private healthcare services. Initially, not-for-profit healthcare providers, particularly church-owned facilities, dominated this sub-sector.

As such, the main objective of the audit was to assess whether the Ministry of Health (MoH) had an effective and efficient mechanism for the management of regulation of the provision of healthcare services provided by the private and voluntary healthcare facilities in the country.

The focus of the audit was on the measures taken by the government to ensure that Private and Voluntary Healthcare Facilities provided Quality Healthcare Services. This included examination of MoH Processes and Procedures for Registration of Private and Voluntary Healthcare Facilities, assessing the effectiveness and efficiency of the Compliance and Enforcement processes to ensure Quality of Healthcare Services, including whether there was any support which was provided to Private and Voluntary Healthcare Facilities to enhance the quality of Healthcare Services in these Facilities.

The audit covered the period of five financial years, from 2016/17 to 2021/22. The essence was to measure the trend of performance of the Regulatory Mechanism governing the provision of healthcare services by Private and Voluntary Healthcare Facilities.

Audit Findings

Insufficient Quality of Healthcare Provision in Private and Voluntary Healthcare Facilities

According to the audit findings, the provision of healthcare services by Private and Voluntary Healthcare Facilities did not meet the quality of healthcare services required. Thus, the Provision of Quality Healthcare services by Private and Voluntary Healthcare Facilities was Inadequate. Basing on the star rating assessment of 514 private healthcare facilities, only 18% attained the star rating of 3 and above.

For the case of Pharmacy Services, it was noted that they were insufficiently provided. The observation made in the fourteen (14) visited district councils, only four (4) district councils had attained the level of quality pharmaceutical services. The factors for insufficient pharmacy services were indicated by the presence of Unregistered Pharmacies, Inadequate qualified personnel, lack of dedicated area for dispensing drugs, poor handling of unexpired and expired medicine and lack of refrigerators/ cold rooms for storage of medications.

On the other hand, the laboratory services provided by the private healthcare facilities were found to be inadequate. That is, among the fourteen (14) visited districts, only six (6) districts were able to show the best quality of the laboratory services. The audit findings further revealed that, out of a total of one hundred thirty-two (132) visited attached laboratories, one hundred and five (105) attached laboratories, equivalent to 80%, had anomalies.

Moreover, it was noted that the weakness in the quality of services provided by private and voluntary healthcare facilities was contributed by the Shortage of Health workers for health across these Facilities. Further elaboration revealed that the shortage of medical personnel ranged from 43% to 73% across all professionals, including doctors, nurses, laboratory technicians and pharmacists.

Weakness in the Registration of Private Healthcare Facilities

PHAB managed to register private healthcare facilities by 87% of the private healthcare facilities that applied for registration. The timeliness for Registration of Healthcare Facilities and laboratories varied. In the case of registering a healthcare facility, it took an average of 28 to 269 days. The

main reasons for such variations in the registration timeliness, were lack of binding set timeliness, lack of client service charter and ineffectiveness of the online registration system.

Likewise, the audit findings revealed that there was a delay in issuing Notification letters after registration to Private and Voluntary Healthcare Facilities. It was noted that the issuance of notification to the successful applicant took 55 to 155 days. It was further provided that the pre-inspections which were conducted by the regulatory bodies were not adequately performed.

For the case of renewal of registration licenses by the Private and Voluntary healthcare facilities, it was found that these healthcare facilities did not renew their registration licenses on timely basis due to weakness in the management of inspection and supportive supervision in respect to the provision of private and voluntary healthcare services at the lower levels, such as districts.

Low Coverage of Supportive Supervision Provided to Private and Voluntary Healthcare Facilities

Supportive supervision provided at all levels by RHMT and CHMT was not sufficient to facilitate the improvement in the provision of private healthcare services. The coverage of the planned Supportive Supervision by CHMT was low. The observation made in the fourteen (14) visited Local Government Authorities (LGAs) revealed that LGAs succeeded to conduct supportive supervision by 4% to 55% to the Private and Voluntary Healthcare facilities.

The reason for low coverage of supportive supervision to the private healthcare facilities was due to non-implementation of the supportive supervision planning, low budgetary allocation for supportive supervision of private and voluntary healthcare facilities and planning of the supportive supervision gaps on the provision of healthcare services by private and voluntary healthcare facilities. Consequently, the quality of healthcare services provided was poor.

For the Planned Supportive Supervision to CHMTs by RHMTs in the visited regions, it was noted that supportive supervision attained only 41% of the requirements. The contributing factor for this situation could be attributed to the fact that the Ministry of Health (MoH) did not have adequate information on the results of supportive supervision done by CHMTs.

Low Coverage of Inspection Provided to Private and Voluntary Healthcare facilities

The audit findings noted that there was low coverage of inspection provided to private and voluntary healthcare facilities by MoH through PHAB and PHLB. PHAB did not manage to inspect 70% of the planned Private Healthcare facilities from 2016/17 to 2021/22. The audit findings further revealed that PHAB managed to conduct one hundred and eight (108) to four hundred sixty (460) of the planned inspections from 2016/17 to 2021/22.

On the other hand, PHLB only managed to inspect 4% to 13% of the registered Private Healthcare laboratories. Moreover, the Pharmacy Council did not inspect the attached Pharmacies in the Private and Voluntary Healthcare facilities.

Inadequacy Management of Prices for Medical Services by Private and Voluntary Healthcare Facilities

The display of the prices of medicines by the Private and Voluntary Healthcare Facilities was inadequate, and such display was found to be in a conspicuous place. It was also noted that the conspicuous display of prices in the private and voluntary healthcare facilities ranged between 13% and 65%. It was further provided that the Ministry of Health (MoH) only crosschecked the availability of displayed prices, and not whether the patients were charged the amount displayed on the boards.

Inadequate Conduct of Clinical Audits on the Provision of Healthcare Services

The Ministry of Health (MoH) through the Curative Department did not adequately conduct the clinical audits of the private and voluntary healthcare facilities. However, MoH started to conduct clinical audits in

public hospitals and not in private healthcare facilities. It was noted that this was due to lack of funds for implementing the intervention.

The impacts of not conducting clinical audits to private and voluntary healthcare facilities were, namely, failure to eliminate preventable medical errors at health facilities, failure to improve the quality of healthcare services provided, failure to identify the existing gaps in the management of patients and failure to build a culture of adherence to standards necessary for reducing malpractices.

Audit Conclusion

The Ministry of Health (MoH) has not ensure the General Public and Citizens that the provision of healthcare services by Private and Voluntary healthcare facilities is of good and acceptable quality. This was due to weakness in the regulation of Private and Voluntary healthcare facilities.

The MoH regulatory functions through the provision of procedures for registration, supportive supervisions, inspections, clinical audits and regulations of prices are not performed as intended. Moreover, the MoH coordination and reporting mechanisms for its regulatory functions are not functioning as they were supposed to be. This actually hampered the quality of healthcare services provided by the Private and Voluntary Healthcare facilities.

The inadequacies of the regulation of private and voluntary healthcare services resulted in more than 80% of the Private and Voluntary healthcare facilities failing to attain the 3 stars in the provision of healthcare services. This was a clear indication that the quality of healthcare services provided by these facilities are not at the level envisioned by the Ministry of Health.

Audit Recommendations

The Ministry of Health is urged to:

1. Strengthen the Registration System by ensuring that each stage of registration of Private health facility is allocated with standard time for completion and ensure that all actors abide to the set timeliness;

2. Develop a long-term comprehensive risk-based inspection plan through institutionalized compliance risk assessment of each registered private

and voluntary healthcare facility and use that as the basis for conducting inspections;

3. Regularly track the payment of fees and allocate a percentage of the collected fees based on the agreed terms to Regional Health Management Teams (RHMT) and Council Health Management Teams (CHMT) to aid in supportive supervision of Private and Voluntary healthcare facilities at lower levels;

4. In collaboration with PO-RALG strengthen the mechanism to plan, conduct and receive feedback on the supportive supervision conducted to Private and Voluntary Healthcare facilities at lower levels;

5. Strengthen the Clinical Audit System and ensure that the Clinical Audits are mandatory, planned and implemented to Private and Voluntary Healthcare facilities;

6. Devise a mechanism for a periodical reviews of Prices rendered by Private and Voluntary Healthcare Facilities; and

7. Establish a mechanism for effective implementation of regulatory activities through enhancement of the collaboration among different actors involved in the regulation of Private and Voluntary Healthcare facilities to reduce duplication of efforts and fragmentations.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Audit

According to the World Bank Report of 2018, private and voluntary healthcare facilities play a significant role in the provision of healthcare services in low- and middle-income countries (LMICs), and the number of private hospitals in these countries is increasing rapidly.

Private health sector involvement in the Tanzanian health system has grown relatively quickly over the past 20 years. This is, in part, responding to the government policy changes (namely; removing the ban on private practice in 1991). In Tanzania, at independence, the government assumed primary responsibility for the provision of healthcare to its people. On this, specifically, the government made progress in developing a comprehensively structured healthcare delivery system from the national to the village level. The Government healthcare services have, however, been supplemented by the private healthcare services. Initially, not-for-profit healthcare providers, particularly church-owned facilities, dominated this sub-sector.

As the private healthcare sub-sector continues to grow, questions are being raised regarding its capacity to effectively complement the public sector in attaining the health sector goals. Such questions include whether the government is providing an effective regulatory framework as well as whether the government is facilitating the environment for the effective delivery of quality and equitable private healthcare services. The argument raised here is that, if prices for healthcare services are not monitored and if competition between facilities fails to keep prices down, the poor and vulnerable will be denied access to appropriate healthcare services.

Given the fact that an estimated 40% of healthcare facilities in Tanzania are owned by the private sector (commercial, faith-based, or not-for-profit)[1], more efficient utilization and inclusion of the private health sector presents a significant opportunity to strengthen the Tanzanian health system as a whole.

1.2 Motivation of the Audit

This Audit was motivated by both the significance and importance of private and voluntary healthcare facilities to improve the health of the people as briefly presented below:

1.2.1 Importance of Private and Voluntary Healthcare Services to Public Health in Tanzania

According to the Blueprint for Regulatory Reforms to Improve the Business Environment report of 2018 by the Ministry of Industry and Trade, the Tanzanian Private Health Sector has grown over the years. It currently provides at least 40% of the healthcare services in the country through outlets of more than 2,000 healthcare facilities (Hospitals, Health Centres, and Dispensaries), over 900 Pharmacies and more than 8,000 Accredited Drugs Dispensing Outlets (ADDOS).

The private sector (for-profit and not-for-profit) is the principal supplier of health services in some geographic areas. According to Health Sector Strategic Plan July 2021 – June 2026 (HSSP V), in Dar es, Salaam, one hundred eleven (111), equivalent to 19% of the five hundred seventy two (572) healthcare facilities were recorded as the government owned facilities, leaving more than 80 per cent being private healthcare facilities. On the other hand, only eleven (11) of sixty three (63) healthcare facilities in Moshi Municipal Council are operated by the government, with more than 82 per cent of council healthcare services being provided by faith-based and for-profit health facilities. The private health sector has been in a critical situation in terms of the provision of

[1] According to 2013 census conducted by the Ministry of Health on Private Healthcare Facilities

human resources, specialized diagnostics and consultative services for extending the reach of government health services into the rural and hard-to-reach areas.

1.2.2 Shortage of infrastructure, Medical Personnel and Medical Supplies in Private and Voluntary Healthcare Facilities

According to the Health sector Performance Report 2019 by the Ministry of Health, the shortage of Human Resources for Health in the private healthcare facilities is estimated to be 52%. Apart from shortage of Human Resources for Health, the private healthcare facilities also fail to cope with the demands for services due to shortages supplies and equipment and limited revenues. Private and Voluntary Healthcare facilities, especially in the lower levels, are characterized by inadequate and unqualified personnel, poor physical infrastructure, poor equipment and inappropriate technology.

1.2.3 Unsatisfactory Regulation on the Provision of Healthcare Services by Private Healthcare Facilities

According to the World Bank's Tanzanian Private Health Sector Assessment Report of 2013, there is inadequate regulation and enforcement on the provision of Healthcare Services by the Private Healthcare facilities. The Unsatisfactory regulation of the Private Healthcare facilities, which was observed, included such factors as ineffective inspection and inadequate supportive supervision to enhance the provision of healthcare services by these facilities. As a result, Private Healthcare facilities mushroomed without having adequate capacity of delivering the Quality Healthcare Services.

1.2.4 High Cost of Medicare in Private and Voluntary Healthcare Facilities

According to Kirua et al., (2020), Prices of medicines for the management of pain, diabetes and cardiovascular diseases in private pharmacies had large variations in prices of the surveyed essential medicines sold in the private pharmacies in the sampled four (4) regions in Tanzania. The study also revealed that nearly half of the sampled medicines in the private sector pharmacies were sold at the prices that were higher than the reference

prices used for reimbursement by the National Health Insurance Fund (NHIF).

Similarly, there was a significant variance in the price of medicines both across the country (urban/rural) and across Health Sectors because of weak and/or lack of price control mechanisms. The last Government Survey on medicine Prices was conducted in 2004, and found that prices for a basket of key medications were 10% higher in urban public healthcare facilities than in rural public healthcare facilities, 30% higher in urban private healthcare facilities than in urban public healthcare facilities, and 32% higher in rural private healthcare facilities than in rural public healthcare facilities.

1.3 Design of the Audit

1.3.1 Audit Objective

The objective of the audit was to assess whether the Ministry of Health (MoH) has an effective and efficient mechanism for the management of regulation of the provision of healthcare services provided by private and voluntary healthcare facilities in the country.

1.3.2 Specific Objectives of the Audit

To address the main audit objective, the following specific audit objectives were used and aimed at assessing whether:

(a) Processes and procedures for registration of private and voluntary healthcare facilities are functioning adequately;

(b) Supportive supervision of private and voluntary healthcare facilities is adequately conducted;

(c) Inspections of private and voluntary healthcare facilities are adequately conducted;

(d) Clinical Audits of private and voluntary healthcare facilities are adequately conducted;

(e) Prices of medical services charged by private and voluntary healthcare facilities are adequately monitored; and

(f) Coordination and reporting mechanisms for regulation of Private and Voluntary healthcare facilities are adequately functioning.

1.3.3 Audit Scope

The main audited entity was the Ministry of Health which is responsible for the Regulation of Private and Voluntary Healthcare Facilities through the Private Health Facilities Board.

The focus of the audit was on the measures taken by the government to ensure that Private and Voluntary Healthcare Facilities provide Quality Healthcare Services. This included examination of MoH Processes and Procedures for Registration of Private and Voluntary Healthcare Facilities; assessing the effectiveness and efficiency of the Compliance and Enforcement processes to ensure that Private and Voluntary Healthcare Facilities provide Quality Healthcare Services; and determining the extent supportive supervision that is given to enhance the quality of Healthcare Services provided by Private and Voluntary Healthcare Facilities.

On the process and procedures for registration of Private and Voluntary Healthcare facilities, the audit focused on the application for registration, pre-inspection and verification, renewal of licenses, and payment of registration and license fees.

Under the aspect of Supportive Supervision to Private and Voluntary healthcare facilities, the audit focused on supporting supervision planning, implementation of supportive supervision and reporting, including feedback on supportive supervision.

With regards to the Inspection of Private and Voluntary Healthcare facilities, the audit focused on the planning, conduct, enforcement, and feedback of inspections, as well as the effectiveness of inspections in improving the quality of healthcare services delivered by private and voluntary healthcare facilities.

On prices rendered by Private and voluntary Healthcare Facilities, the audit examined monitoring of prices, transparency of the prices, application for charging maximum prices and review of the price structure of medical treatments rendered by private and voluntary healthcare facilities.

Regarding Clinical Audits, the audit examined the planning and conduct of clinical audits of Private and voluntary healthcare facilities.

Lastly, on coordination and reporting of the regulatory mechanisms to private and voluntary healthcare facilities; the audit examined the submission of the reports by private and voluntary healthcare facilities, involvement in the planning of comprehensive council plans and collaboration in conducting regulatory services to private and voluntary healthcare facilities.

Data were collected from MoH and the respective Boards, namely Private Hospitals Advisory Board and Private Healthcare Laboratory Board, which are responsible for the Regulation of Personnel and Facilities within the Private and Voluntary Healthcare Facilities. Also data were collected from such responsible regulatory institutions as Medical Council of Tanganyika, Pharmacy Council, and Tanzania Nursing and Midwifery Council.

Moreover, data were collected from the Regional Health Management Teams and District Health Management Teams. Both teams are responsible for the regulation of the Provision of Healthcare services by Private and Voluntary Healthcare Facilities.

The audit covered the period of five financial years, from 2016/17 to 2021/22. The essence for covering that duration of time was to enable the audit to measure the trend of performance of the Regulatory mechanism governing the provision of healthcare services by private and voluntary healthcare facilities.

1.3.4 Audit Assessment Criteria

To assess the effectiveness of the regulation mechanism on the provision of healthcare services by private and voluntary healthcare facilities, the audit criteria were drawn from legislations, standards, good practices and Strategic Plans. The following were the broader assessment criteria for each of the specific audit objectives:

(a) Quality of Healthcare Services Provided by Private and Voluntary Healthcare Facilities

According to the MoH Strategic Plan of 2016/17-2020/21, the Ministry of Health planned to ensure the increase in the number of private and voluntary healthcare facilities with a Star rating of above 3 in form of 2015/16 - Baseline; 2016/17(20%), 2017/18(50%), 2018/19(80%), 2019/20(90%); 2021/22(95%**).**

On the other hand, the Private Health Laboratories Strategic Plan of 2017/18 – 2021/22 requires Private Health Laboratories Board to ensure that 80% of the registered Private Healthcare Laboratories complied with the set standards by June 2022, such that by 2017/18(55%), 2018/19(65%), 2019/20(70%), 2020/21(75%) and 2021/22(80%).

Furthermore, the Pharmacy Council Strategic Plan of 2016/17-2020/21, states that the Pharmacy council is supposed to ensure that 80% of the registered premises are compliant with the GPP standards by June 2021.

Follow-up on the above, the Basic Standards for Healthcare Facilities Guidelines volume I-IV indicate that the Ministry of Health is supposed to ensure that no health professional personnel offers his/her professional practices in private and voluntary healthcare facilities without having a professional license from the appropriate organ.

According to PHAB Strategic Plan 2015/16-2019/20, the Ministry of Health (MoH) through PHAB planned to ensure that private healthcare facilities had 60% of the qualified staff.

The Guidelines to establish and operate a Private Hospital of 2018 established that a private healthcare facility may be registered if the applicant for such registration has complied with the Basic Standards for healthcare facilities as determined by the Guidelines and such other requirements relating to staff, infrastructure, equipment and location.

(b) Adequacy of Registration of Private Healthcare Facilities

According to the Private Hospitals Regulation Act of 1977, the Ministry of Health is supposed to ensure that no healthcare facility is established, operated, managed or cause to be managed unless the facility has been registered, operated by an approved organization, and has a certificate issued by the Ministry, and it complies with the set standard guidelines.

The Guidelines to establish and operate a Private Hospital of 2018 requires MoH through RHMTs and CHMTs to conduct pre-inspection of the applicant's registration, prepare and submit the reports for validation of a specific healthcare facility that seeks registration to the PHAB Board before registration of a healthcare facility.

Also, the Ministry of Health is supposed to ensure that private healthcare laboratories annually renew their licenses by submitting their applications for license renewal to the appropriate organ before the expiry date of the current licenses.

Thus, to ensure the life of the operating licenses, the MoH is supposed to ensure that private healthcare facilities renew their licence registration after every five years when the renewal for the registration of the private hospital is made.

Parallel to this, the Ministry of Health is supposed to ensure that every registered Private hospital pays annual licencing fees to the Board in each calendar year as set out.

(c) Effectiveness of Supportive Supervision Provided to Private and Voluntary Healthcare Facilities to ensure the Provision of Quality Healthcare Services

According to PHAB Strategic Plan, 2016/17-2020/21, CHMTs are supposed to conduct supportive supervision of private and voluntary healthcare facilities and ensure that each facility is at least visited once.

Also, the National Supportive Supervision for Quality Control Guideline of 2015 stated that RHMTs are supposed to conduct Quarterly supportive supervision of CHMTs and sampled healthcare facilities with regard to

private and voluntary healthcare facilities every quarter and submit reports to MoH and PO-RALG.

Further, the guideline stated that MoH is supposed to record actions and decisions and continue ongoing monitoring of weak areas and improvements, follow-up on prior visits and problems of private and voluntary healthcare facilities.

PHAB Strategic Plan 2016-2021 indicated that PHAB planned to conduct supportive supervision of RHMTs. The plan was to conduct supportive supervision to at least nine (9) regions annually. Moreover, the way of reporting is that Council Health Management Teams (CHMTs) are supposed to submit supportive supervision reports to RHMTs quarterly.

The guideline also emphasized that RHMTs are supposed to submit supportive supervision reports with regard to private and voluntary healthcare facilities to Po-RALG and copy to MoH every quarter.

(d) Effectiveness of Inspections Conducted to Private and Voluntary Healthcare Facilities to ensure the Provision of Quality Healthcare Services

According to the Private Hospitals (Regulations) Act of 1977, the Ministry of Health is supposed to conduct an inspection or cause to inspect private and voluntary healthcare facilities to ensure compliance with the set standards and regulations.

Guidelines for Developing and implementing institutional Risk Management Framework in the Public sector, 2012 provided that Ministry of Health is supposed to ensure that its inspection activities including inspection plans and priorities are informed by an adequate risk assessment process.

PHAB strategic plan 2016/17-2020/21, states that the Private Healthcare Facilities' Board is supposed to ensure that 70% of the private and voluntary healthcare facilities are inspected annually.

Furthermore, Pharmacy Council Strategic Plan 2016/17 - 2020/21, indicates that the Pharmacy council planned to ensure that 100% of registered Pharmacies are inspected at least once each year.

Similarly, the Private Health Laboratory's Strategic plan for 2017/18 – 2021/22, indicates that the PHLB planned to ensure that 100% of registered Private Health Laboratories are inspected at least once a year through conducting inspections at Zonal, Regional and District Levels.

Guidelines to Establish and Operate a Private Hospital of 2018 stated that MoH or any officer acting on behalf of the Board may suspend services of any private hospital if the Board is satisfied that the facility has repeatedly failed to comply with the Laws of the land and the requirements set during its registration.

(e) Affordability of Charged Maximum Determined Prices to Citizen

According to the Private Hospital (regulation) Act of 1991, MoH is supposed to ensure that private healthcare facilities charge the maximum determined prices through regulations and price checks and ensure that prices are posted in conspicuous places so they can be easily seen by patients.

Moreover, the Private Hospital Regulation Act of 1991 states that the Ministry of Health is supposed to monitor the prices of medical services charged by private and voluntary healthcare facilities. Also, it extended that private healthcare facilities may apply for charging a maximum price from the approved prices.

Similarly, the Private Hospital Regulation Act of 1991 stipulates that the price structure of medical treatment rendered by private healthcare facilities may be reviewed either on a national or in any area.

(f) The Effectiveness of Coordination of Regulatory Functions

PHAB Strategic Plan 2016-2021 requires RHMTs to submit supportive supervision reports regarding private and voluntary healthcare facilities to MoH and PO-RALG quarterly, while the Ministry of Health, through PHAB and RHMT, is supposed to involve the Private Sector during supportive supervision.

Moreover, the Health Sector PPP Policy Guideline of 2013 and CCHP Guideline of 2011 require LGAs to involve private healthcare facilities during planning and budgeting on the implementation of Comprehensive Council Health Plans.

1.3.5 Sampling, Methods for Data Collection and Analysis

Various methods for sampling, data collection and analysis were used by the Audit Team as presented below: -

(a) Sampling Techniques Used in the Audit

The Stratified sampling method was used during the selection of regions The number of registered private and voluntary healthcare facilities was used in calculating the sample size in each Region and Zone.

In the first stage, regions were stratified into seven geographical zones namely, Northern Zone, Eastern Zone, Western Zone, Central Zone, Southern Highlands Zone, Western Zone and Eastern Zone.

In the second stage, purposive sampling was used to select regions which were within the identified geographical zones. In this case, a region with the highest number of private and voluntary healthcare services was selected from each Zone. The reason is that the highest number of available private and voluntary healthcare facilities presents the highest risk of non-compliance and impacts.

Therefore, the audit visited the following regions as indicated in **Figure 1.1** The selected regions were Dar es Salaam, Kilimanjaro, Tabora, Mwanza, Mbeya, Ruvuma and Dodoma as indicated in **Figure 1.1** below.

Figure 1.1: Geographical Distribution of the Visited Regions

Source: *Auditors' sketching of the location of the visited regions (2022)*

Appendix 2(a) provides detailed analysis on the selection of the above-mentioned regions that were sampled.

Selection of Districts were Visited

The selection of visited districts was based on the number of private healthcare facilities available in each region in which two districts with many private and voluntary healthcare facilities were selected. The selected districts were those with the following characteristics:

- Urban settings; and
- Rural settings and distance from the regional headquarters.

The selected LGAs were Songea MC, Nyasa DC, Tabora MC, Igunga DC, Mwanza CC, Misungwi DC, Dodoma CC, Kongwa DC, Moshi MC, Moshi DC, Temeke DC and Ilala MC, Kyela DC and Mbeya CC.

Selection of Private Healthcare Facilities to be Visited

In each LGA, the audit team visited 10[2] Private healthcare facilities which fall under the four available categories, namely; Hospital Level I, (Council Level Hospitals), Hospital Level II (Regional Level Hospitals), Hospital Level III (Zonal Level Hospitals) and Hospital Level IV (National Level Hospital) depending on their availability in each LGA.

(b) Methods of Data Collection

The audit team gathered reliable and sufficient audit evidence through the corroboration of evidence to address the audit questions in order to achieve the objective of the audit through using different methods such as document reviews, interviews, and observations.

Documents Review

Different documents were reviewed to get comprehensive, relevant, and reliable information about the performance of the Ministry of Health in regulating Private and Voluntary Healthcare facilities. The other reason for conducting a document review was to corroborate information from interviews and physical observations. The main categories of documents which were reviewed included -Planning documents, Performance and Progress Reports, and Monitoring and Evaluation Reports. The reviewed documents were those which were prepared during the period covered by this audit, that is, from 2016/17 to 2021/22. The specific list of documents that were reviewed together with the reason for being reviewed is presented as **Appendix 3.**

[2]Some LGA had less than 10 Private Healthcare facilities.

Interviews

Interviews were conducted to obtain more information and further clarification on the information obtained through reviewed documents and observations made. Also, the interview was conducted to - get comprehensive, relevant and reliable information about the performance of the Ministry of Health in regulating Private Healthcare facilities. The details of the officials from the Ministry of Health, Visited RSS and LGAs who were interviewed are presented in **Appendix 4**.

Physical Verifications

The audit team verified the state of private and voluntary healthcare facilities in the country. The selection of areas for physical inspection depended on the outcome of the reviewed documents and interviews in the sampled regions and districts. Also, the audit team evaluated through physical verification the capacities of the councils to manage the provision of healthcare services by private health and voluntary facilities.

Furthermore, for the areas to be visited, the audit team was able to establish challenges facing the management of the provision of Healthcare services by private and voluntary healthcare facilities. The status of the healthcare facilities' infrastructures in the provision of healthcare services by the private and voluntary providers was verified and pictures were taken as evidence.

1.3.6 Methods of Data Analysis

The collected information was analysed using both qualitative and quantitative methods to obtain facts and sufficient information regarding the regulation of healthcare provision by private and voluntary healthcare facilities.

(a) Analysis of Qualitative Data

- Content analysis techniques are used to analyse qualitative data by identifying different concepts and facts originating from interviews or document reviews and categorising them based on their assertion.

- The extracted concepts or facts were either tabulated or presented as they are to explain or establish the relationship between different variables originating from the audit questions.
- The recurring concepts or facts were quantified depending on the nature of the data it portrays.
- The quantified information (concepts/facts) was then summed up or averaged in spreadsheets to explain or establish the relationship between different variables.

(b) Analysis of Quantitative Data

- Quantitative information with multiple occurrences was tabulated in spread sheets to develop point data or time series data and relevant facts extracted from the figures obtained.
- The tabulated data was summed up, averaged or proportionate to extract relevant information and relationships from the figures.
- The sums, averages or percentages were presented using different types of graphs and charts depending on the nature of data to explain facts for point data or establish trends for time series data and other quantitative information/data with single occurrence was presented as they are in the reports by explaining the facts they assert.

1.4 Data Validation Process

The Ministry of Health (MoH) was given the opportunity to go through the draft audit report and comment on the figures and information presented. MoH confirmed the accuracy of the figures and information which have be presented in the audit report.

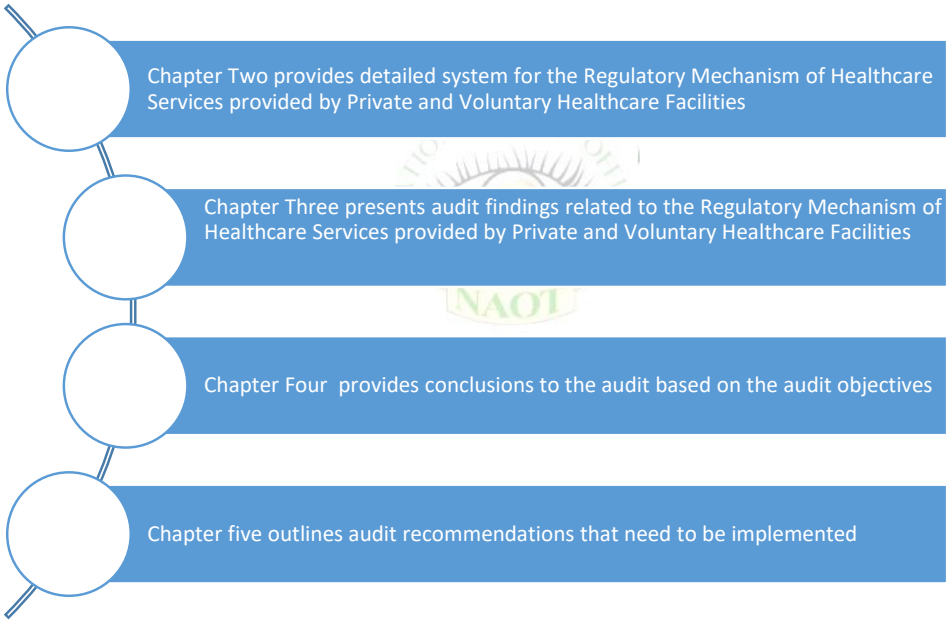
The information was also cross-checked and discussed with experts in the field of Health to confirm the validity of the information and facts presented in the audit report.

1.5 Standard Used for the Audit

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

1.6 Structure of the Performance Audit Report

The remaining parts of this report cover the following:



CHAPTER TWO

SYSTEM FOR REGULATING THE PROVISION OF HEALTHCARE SERVICES BY PRIVATE HEALTHCARE FACILITIES

2.1 Introduction

This chapter describes the system for Regulating the Provision of Healthcare Services by Private Healthcare Facilities in the country. Therefore, the legal framework, roles and responsibilities of key players, processes for regulatory mechanism of healthcare services by private healthcare facilities, and roles and responsibilities of key players involved in Implementing and monitoring Private Healthcare facilities are discussed here:

2.2 Policy, Legislation and Guidelines on the Provision of Private Healthcare Services

The following are Policies, Laws and Guidelines, which govern the provision of healthcare services by private healthcare Facilities.

2.2.1 Health Policy, 2007

The established policy describes that on ensuring the provision of private healthcare services by private healthcare facilities the government sets and monitors Healthcare service delivery by Private and Voluntary Healthcare providers to ensure that they meet standards at all levels.

2.2.2 Governing Laws

The governing laws for the provision of healthcare services by private healthcare facilities have been described in **Figure 2.1**

Figure 2. 1: Governing Laws

The Private Hospitals Act, 1977

- The Act provides the basic and guidelines required to govern the Regulation of private healthcare facilities in the country.

Private Health Laboratory Registration Act, 1997

- This act was enacted by the parliament of the United Republic of Tanzania with the purpose to regulate, manage and control establishment of private health laboratories.

Pharmacy Act of 2011

- The Act provides for the functions, management of the council to provide for regulations and control of pharmacy professionals and provides for other matters such as regulation of private and voluntary healthcare facilities

The Nursing and Midwifery Act, 2010

- The Act makes provisions for protection, promotion and preservation of the public health, safety and welfare through regulation and control of nursing and Midwifery Education and Practice.

***Source**: Auditors' Analysis from the Governing Laws (2022)*

2.2.3 Strategies and Guidelines

Health Sector Strategic Plan July 2009-June 2015 (HSSP III)

The expected results of the Health Sector Strategic Plan III with Private and Voluntary Healthcare Providers were such as: -

(i) Rational allocation of health funds is made to public and private healthcare providers, based on competencies and performance, using service contract mechanisms;
(ii) Mechanisms are in place for optimal mutual utilization of human resources for health in public and private healthcare facilities; and
(iii) Private healthcare facilities are involved to the maximum extent possible in health programs, and disease control programs using service agreements.

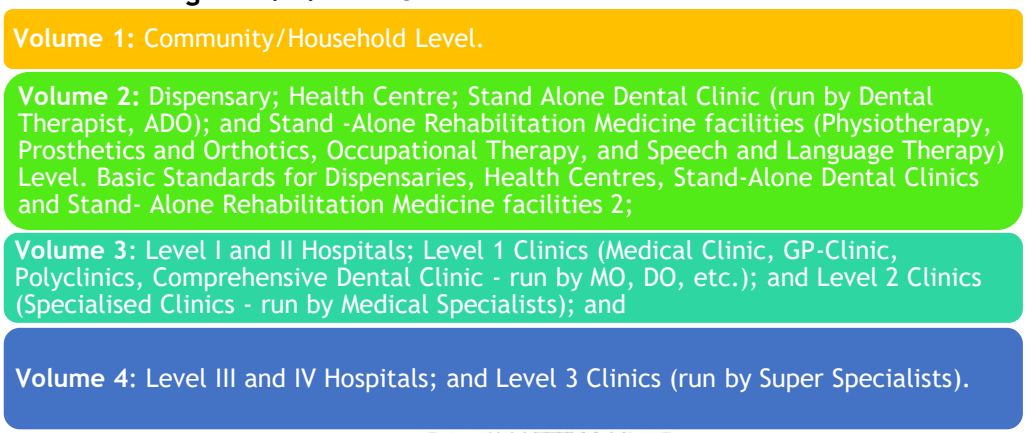
Primary Healthcare Services Development Programme - (PHSDP) (2007-2017)

In 2007 the Ministry of Health developed the Primary Healthcare Services Development Programme, better known as the (PHSDP) 2007-2017 (MoH, 2007). The objective of (PHSDP) was to accelerate the provision of primary healthcare services for all by 2017 through PO-RALG, Local Government Authorities (LGAs) and Ward Development Committees.

A Guideline for Basic Standards for Healthcare Facilities

The required standards for the establishment of private healthcare facilities are described in **Figure 2.2** below.

Figure 2. 2: Basic Standards for Healthcare Facilities



***Source**: Auditors' Analysis from Basic Standards for Healthcare Facilities (2022)*

Standard Treatment Guidelines (STG) and National Essential Medicines List Tanzania Mainland (NEMLIT), 2013

The Standard Treatment Guidelines and National Essential Medicines List Tanzania Mainland aim at providing health practitioners with standardized guidance in making decisions about appropriate healthcare for specific conditions found in Tanzania.

2.3 Roles and Responsibilities of Key Actors

2.3.1 The Ministry of Health (MoH)

Roles of the Ministry of Health in Private Healthcare service provision include:

(i) Setting and administering all registration procedures;
(ii) Setting laws and regulations that govern private healthcare provision;
(iii) Monitoring and regulating effectively private healthcare provision in terms of quality of services rendered;
(iv) Reviewing the price structure of medical treatment rendered by private healthcare providers; and

(v) Providing health education through seminars and workshops (i.e., communication and co-ordination linkage).

The Ministry of Health implements those activities through the following Boards, Departments and Councils;

a) Directorate of Curative Services (DCS)

The curative services department plays a direct role in the management of tertiary healthcare services in the country. Its main roles include:

(i) To formulate, review and oversee the implementation of curative health policies, laws, Regulations and guidelines;
(ii) To oversee the provision of general and specific curative services; and
(iii) To coordinate the provision of pharmaceutical and diagnostic services in the provision of curative services.

b) Private Health Laboratories Board (PHLB)

This is the Government Institution under the Ministry of Health which registers and manages all Private Health Laboratories in Tanzania (Mainland). Its main roles include:

(i) Monitoring and regulating all Private Health Laboratories to ensure better provision of Private Health Laboratory services; and

(ii) Performing Inspection to better Implementation of Private Health Laboratories Regulation Act No. 10 of 1997.

c) Private Hospitals Advisory Board (PHAB)

The Private Hospitals Advisory Board is the statutory Board under the Ministry of Health established under the Private Hospitals Regulation Act of 1977and its Amendment Act of 1991. The office of the Registrar is the operation unit of the Board, and its main roles include:

(i) Registration and approval of Private and Voluntary Healthcare facilities;

(ii) Monitoring and regulating all Private Healthcare facilities to ensure better provision of Private Healthcare services;

(iii) Performing Inspection to better Implementation of Private Hospitals Act of 1977;

(iv) Conducting support supervision to Private Healthcare facilities; and

(v) Collaborating with other professional bodies, LGAs and councils in monitoring compliance of policies and Guidelines.

d) **Health Quality Assurance Unit**

The Health Quality Assurance Unit at the Ministry of Health (MoH) performs the following activities: -

(i) Preparing and disseminating Quality Assurance Policy Guidelines in healthcare provision;
(ii) Assessing the Quality of healthcare provision in the country;
(iii) Collecting and disseminating national and international experiences (evidence-based best practices), techniques and data references with regards to quality assurance in healthcare provision; and
(iv) Serving as the Secretariat (National Quality Improvement Secretariat) to the National Quality Improvement Committee.

e) Medical Council of Tanganyika

The Medical Council of Tanganyika is vested with the legal powers to oversee medical and dental practice in Tanzania. In particular, the Council has been empowered to ensure safe and effective practice for medical doctors and dentists.

f) Tanzania Nursing and Midwifery Council (TNMC)

TNMC is vested with the legal powers to oversee nursing and midwifery practices in Tanzania. In particular, the Council has been empowered to ensure safe and effective practice for nursing and midwifery.

g) Pharmacy Council of Tanzania

Pharmacy Council of Tanzania is responsible for maintaining the high standards of pharmacy education and evaluating the competency of intern pharmacists and overseas before registering to ensure pharmacists have the skills and knowledge to deliver effective healthcare that meets the changing needs of the community.

2.3.2. Regional Secretariats

Regional Secretariats are responsible for the management and administration of Public services at regional level. According to the National Guidelines Section 4.1.2, the RHMTs are responsible for supportive supervision of the Ministry of Health Services in their respective regions. In addition, the RHMTs supervise the selected health facilities to verify information provided by the CHMTs that supervise the respective level.

2.3.3. Local Government Authorities (LGAs)

LGAs are responsible for the management and administration of Public services at Council level. According to the Ministry of Health National Supportive Supervision Guidelines Section 4.1.3, at the lower levels, the Council Health Management Team (CHMT) is supposed to conduct supportive supervision to supervise all HFs irrespective of ownership including Private and Voluntary Healthcare facilities. The CHMTs are responsible for conducting pre- inspection for registration of Private and Healthcare facilities for approval by the District Medical Officers (DMO) and submit to the Ministry of Health through PHAB and PHLB.

2.3.4. Other Stakeholders Involved in the Provision of Private and Voluntary Healthcare Services

The stakeholders involved in the Provision of Healthcare Services by private and voluntary healthcare facilities are as shown in **Table 2.1** below.

Table 2. 1: Other Stakeholders Involved in the Provision of Healthcare Services

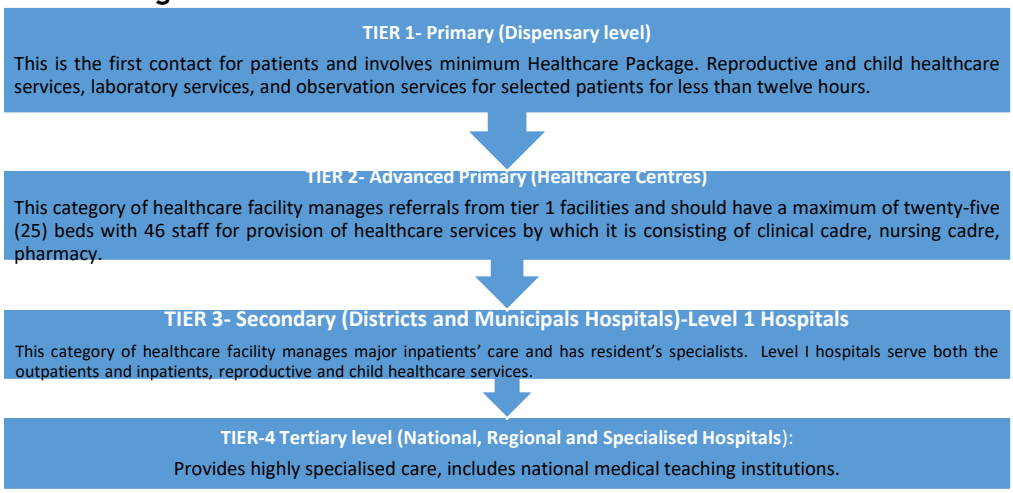
Name of the Stakeholder	Responsibility of the stakeholder
Faith-Based Organizations (FBO)	Collaborate with the MoH and PO-RALG in the Provision of healthcare services from dispensary to the referral hospitals levels.
Christian Social Services Commission (CSSC)	Coordinates and regulates the functions of church-based Healthcare Service Providers.
Private Sector	Collaborate with the Ministry of Health and PORALG in the delivery of healthcare services from the dispensary to the referral level.
Non-Governmental Organizations	NGOs is directly and indirectly involved in the provision of healthcare services.
Association of Private Healthcare Facilities in Tanzania (APHTA)	An umbrella that involves hospitals, health centers, dispensaries, clinics, laboratories, pharmacies/Accredited Drug Dispensing Outlets (ADDOs) and maternity homes in the delivery of public health.

***Source*:** *Auditors' Analysis from on roles of Stakeholders (2022)*

2.4 Organization of Private Healthcare Delivery System in Tanzania

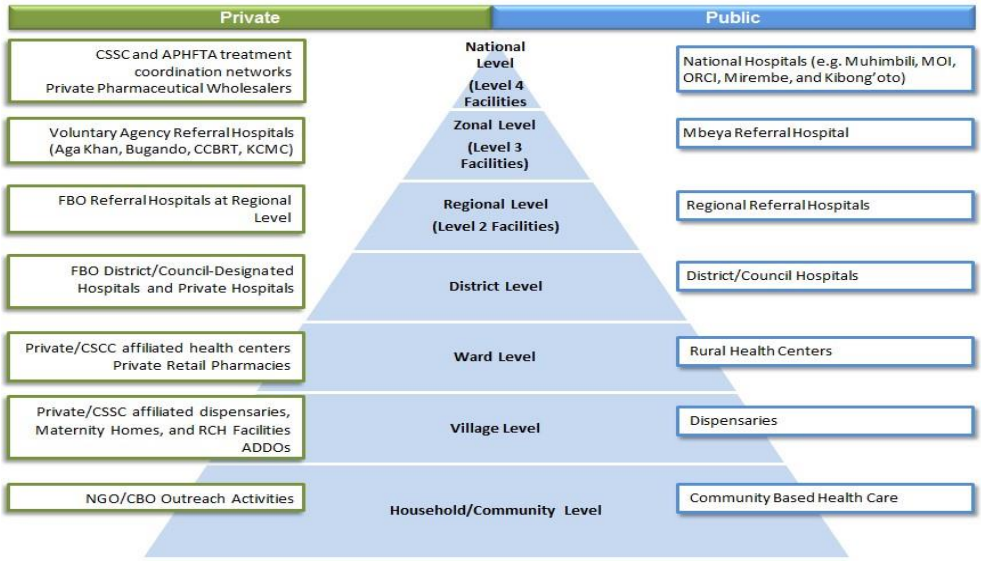
The structure of the healthcare delivery in Tanzania is based on the referral system between four tiers of care described in **Figure 2.3 and 2.4.**

Figure 2. 3: Tiers for the Provision of Healthcare Services



Source: *Auditors' Analysis from on the Guideline for Basic Standards for Healthcare Facilities (2022)*

Figure 2.4: Tanzania Healthcare Delivery System



Source: *USAID Tanzania Private Healthcare Assessment Report (2013)*

2.5 Efforts Made to Improve Regulations on the Provision of Healthcare Services

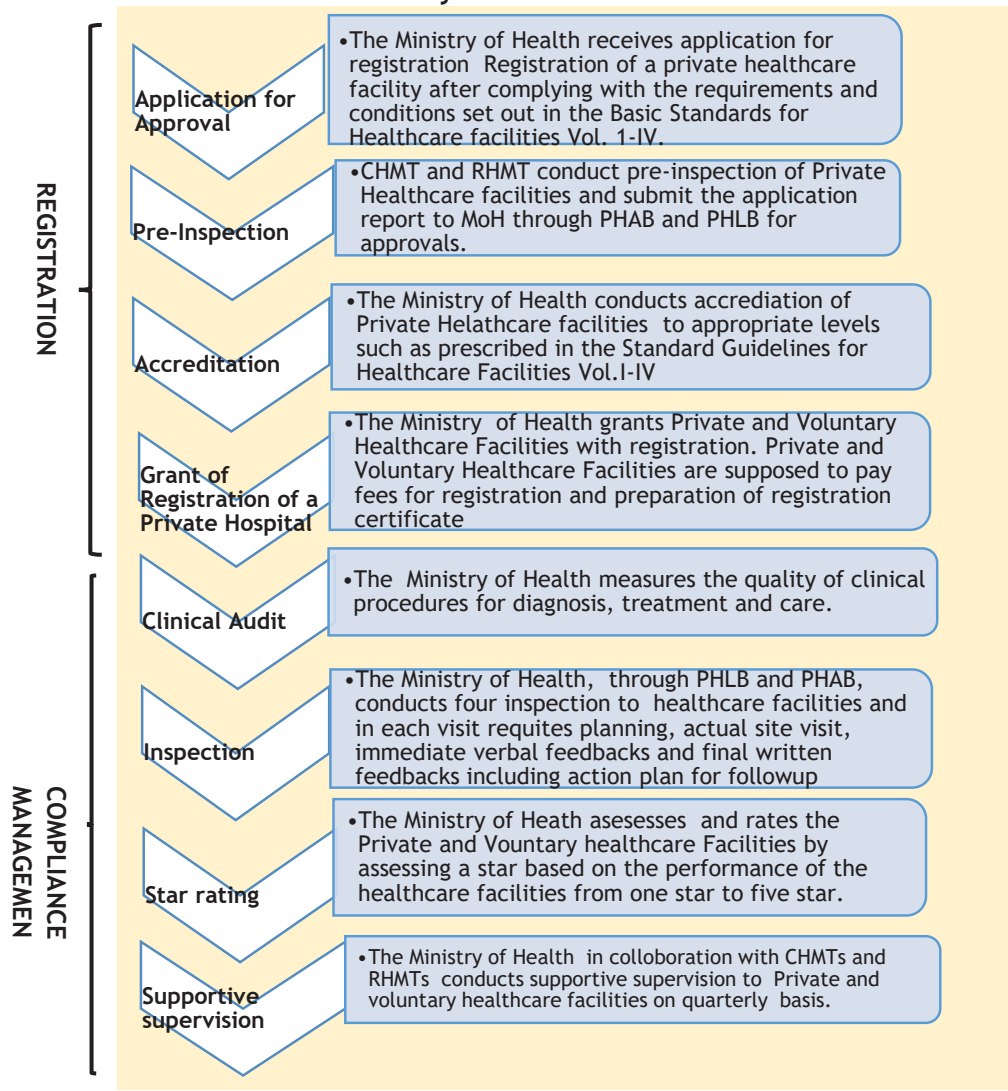
Since 1977 the Government of Tanzania has made several efforts to improve the performance of healthcare facilities, both private and government owned.

The Ministry of Health (MOH) has put an effort to improve the system for regulating the private healthcare facilities in the country by developing and establishing policies, Acts, Regulations, Strategic Plans and Guidelines from 1977 to 2018 as shown in **Appendix 5**.

2.6 System and Process Description for Regulating Private and Voluntary Healthcare Facilities

The regulatory framework for the Provision of healthcare services by private and voluntary healthcare facilities comprises of two major activities. These activities are the registration conducted before the facility is issued with the license, and compliance monitoring for ensuring compliance with standards which is done when the facility is operating. The process for registration includes Application for approval, Pre-Inspection and Accreditation. Also, the quality assurance activities on provision of healthcare services involves activities such as Star Rating, Inspections, Supportive Supervision and Clinical Audits.

Figure 2.5: Process for Regulating the Provision of Healthcare Services by the Private and Voluntary Healthcare Facilities



***Source**: Auditors Analysis from Ministry of Health Standard Guidelines for Healthcare Facilities Vol. I-IV, Ministry of Health Supportive Supervision Guideline (2022)*

2.7 Resources for Regulation of Private Healthcare Facilities

Private Hospitals Advisory Board and Private Health Laboratories Board are responsible for the regulation of Private healthcare facilities. Below are the budgeted and allocated financial resources for both Boards.

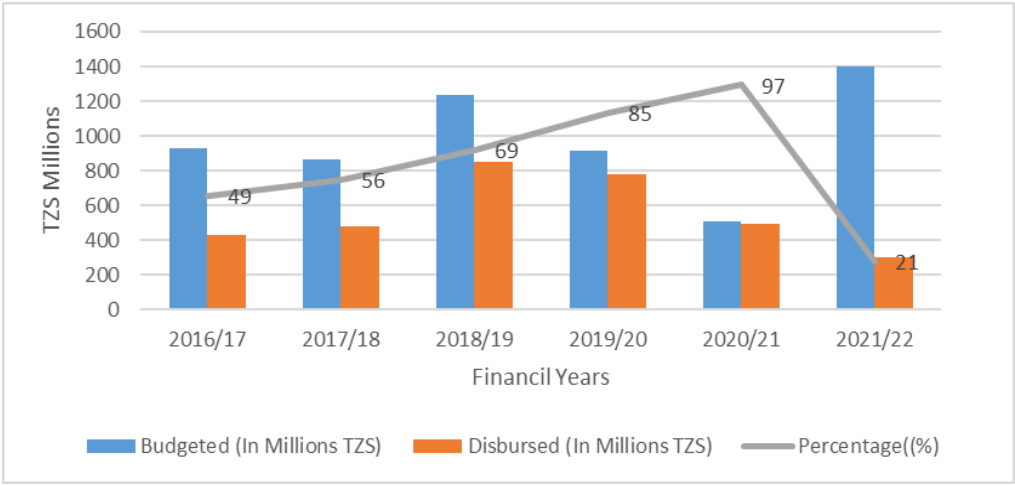
a) Resources for Private Healthcare Facilities Advisory Board

The following were the resources allocated to Private Health Laboratories Board.

(i) Financial Resources for Private Healthcare Facilities Advisory Board

The Ministry of Health has been allocating financial resources to regulate the provision of healthcare services by Private and Voluntary Healthcare Facilities as shown in **Figure 2.6.**

Figure 2. 6: Comparison of the Budgeted and Disbursed Funds for Private Hospitals Advisory Board



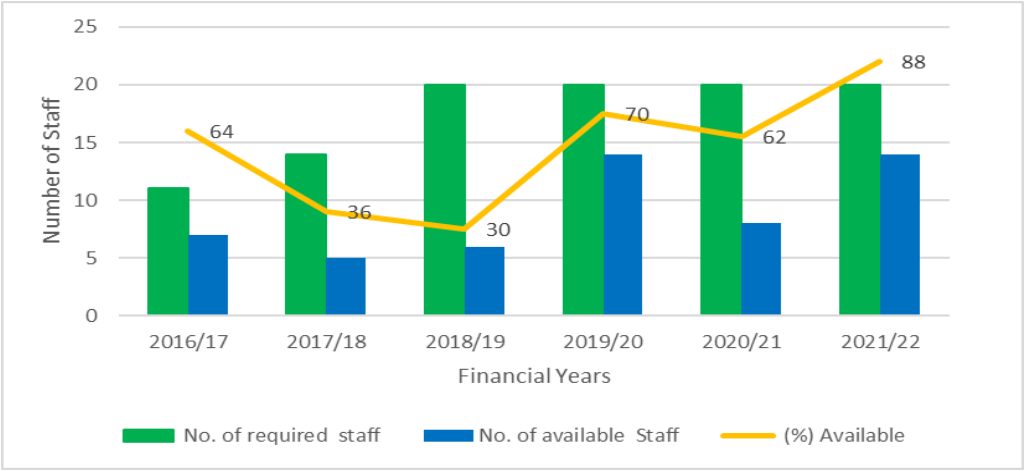
Source: *Annual Financial Reports (2016/17-2021/22)*

From **Figure 2.6,** it can be noted that in the last six years, the disbursement of funds to PHAB ranged between 21% in 2021/22 to 97% in 2020/21.

(ii) Human Resources for Private Hospitals Advisory Board

Several efforts were made by PHAB to improve the internal capacity in terms of human resources to enhance the execution of its duties to regulate the provision of healthcare services by private healthcare facilities as shown in **Figure 2.7.**

Figure 2.7: Human Resources for Private Hospitals Advisory Board



***Source**: PHLB Approve Establishment Post-IKAMA (2016/17-2021/22)*

Figure 2.7 indicates that the human resources that were available for Private Hospitals Advisory Board increased from 30% in 2018/19 to 88% in 2021/22.

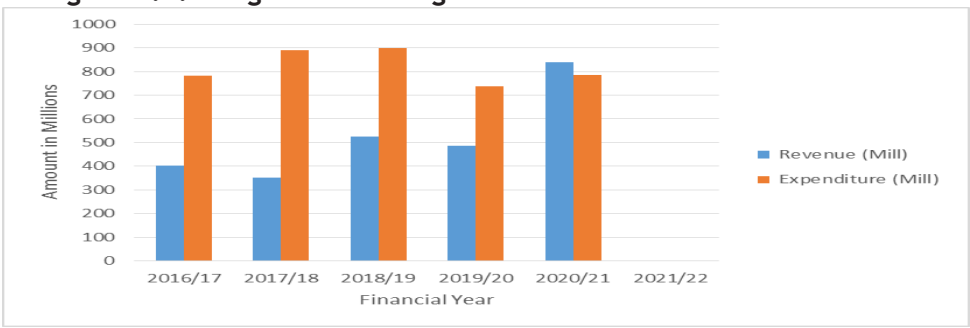
b) Resources allocated to Private Health Laboratories Board

The following were the resources allocated to Private Health Laboratories Board.

(i) Financial Resources for Private Health Laboratories Board

PHLB has been allocated funds from the Ministry of Health to regulate the provision of healthcare laboratory services in the country as shown in **Figure 2.8.**

Figure 2.8: Budget for the Regulation of Private Health Laboratories



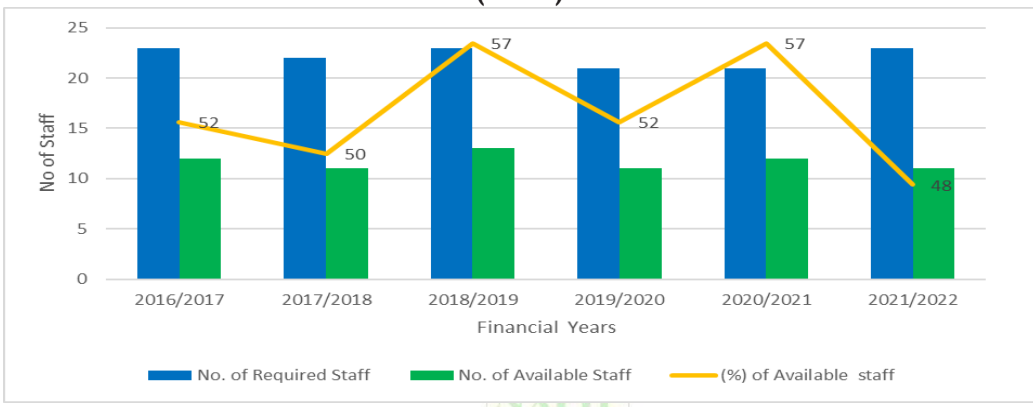
***Source**: Auditors' Analysis of the PHLB Annual Financial Reports (2016/17-2021/22)*

From **Figure 2.8,** it can be noted that in the last six years, the allocation of funds to PHLB ranged between 55% in 2020/21 to 100% in 2021/22.

(i) Human Resources for Private Health Laboratories Board

Private Healthcare Laboratories Board has been putting efforts to improve internal capacity in terms of human resources to fulfil the role of regulating the provision of laboratory healthcare services in the country as shown in **Figure 2.9.**

Figure 2.9: Human Resources for Private Healthcare Laboratories Board (PHLB)



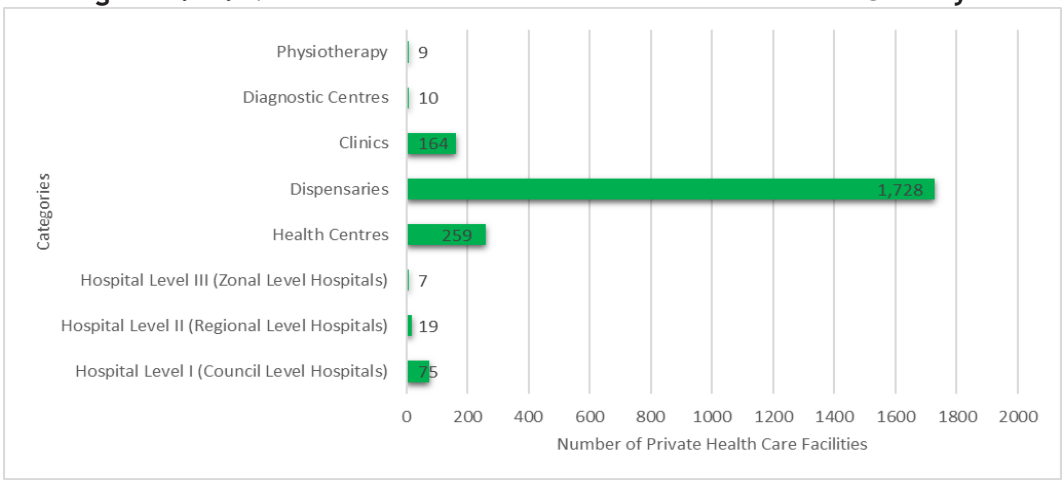
Source: *PHLB Approve Post Establishment IKAMA (2021)*

From **Figure 2.9,** it can be noted that the human resources available for Private Health Laboratories Board ranged between 48% in 2021/22 to 57% in 2018/19.

c) Number of Private Healthcare Facilities in the Country

Figure 2.10 shows that the number of registered and operating private healthcare facilities at all levels in the country as of June 2021 was 2,271.

Figure 2.10: Number of Private Healthcare Facilities in the Country



***Source**: Auditors' Analysis from the 2021 Registration Records of the Private Healthcare Facilities (2022)*

CHAPTER THREE

AUDIT FINDINGS

3.1 Introduction

This chapter presents audit findings on regulatory mechanisms of Private and Voluntary Healthcare Facilities. Specifically, the chapter focuses on the findings relating to the regulatory mechanisms of healthcare services provided by private and voluntary healthcare facilities such as the registration and verification procedures, inspection, supportive supervision, clinical audits and prices for medical and healthcare services. Below are the detailed audit findings.

3.2 Insufficient Quality of Healthcare Provision in Private and Voluntary Healthcare Facilities

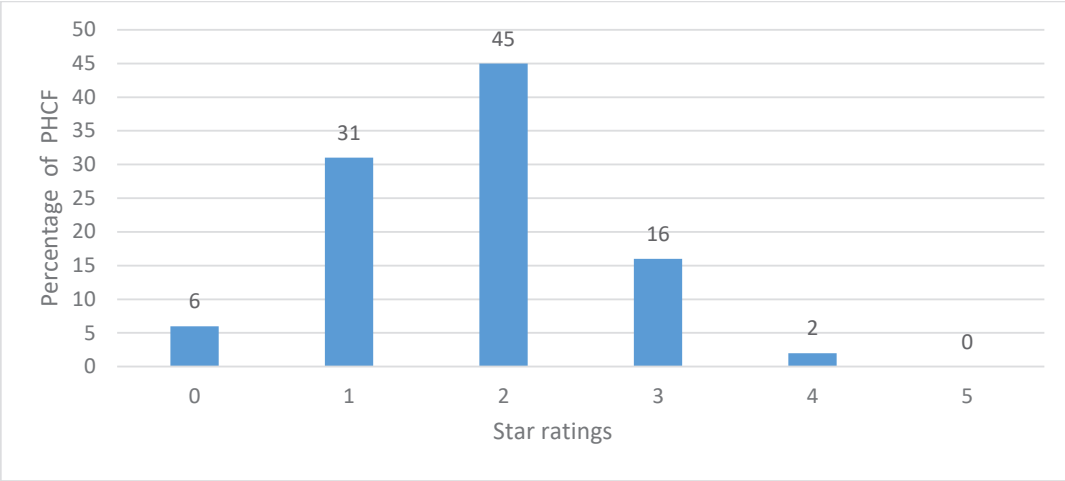
Private and voluntary healthcare facilities are required to meet the required standards based on the registration guidelines before the approval for registration is granted by their respective bodies. Furthermore, private and voluntary healthcare facilities are required to maintain the assessed cadre according to the requirements for registration during the operation period. The audit has noted the following anomalies regarding the provision of healthcare services in the private and voluntary healthcare facilities, laboratories and pharmacy services.

3.2.1 Inadequate Provision of Quality Healthcare Services by Private and Voluntary Healthcare Facilities

According to HSSP IV, the quality-of-service delivery in Tanzania's Health Sector is measured through the attainment of at least three stars. The Star Rating assessment provides a national overview of the status of healthcare facilities and guides further priority setting for identifying bottlenecks for healthcare facility quality improvements to be addressed.

The Ministry of Health's Medium Term Strategic Plan (2016/17-2020/21) indicates that MoH planned to have at least 20% in (2016/17), 50% in 2017/18, 80% in (2018/19), 90% (2019/20) and 95% (2020/21) of three-star and above healthcare facilities respectively. The audit analysed the star rating of the assessed 514 Private healthcare facilities to ascertain the quality of healthcare services and found that only 18 % attained the star rating of 3 and above by June 2022 and above as depicted in **Figure 3.1.**

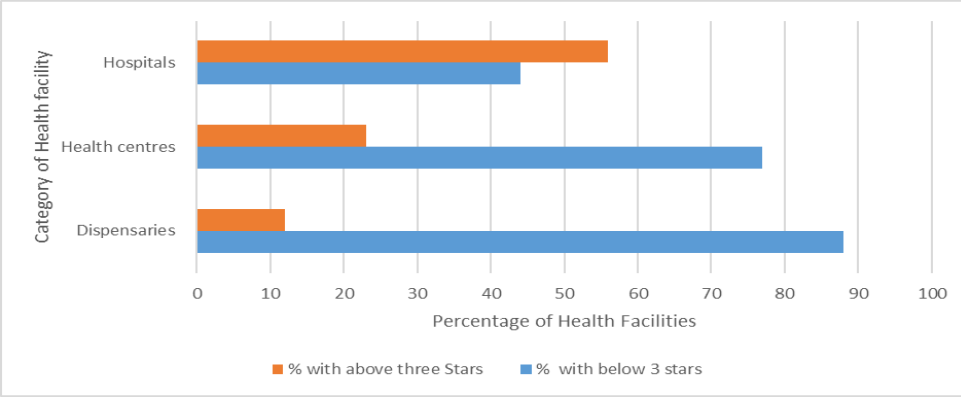
Figure 3.1: Star Rating of Private Healthcare Facilities



Source: *Auditors' Analysis of the Third Round Star Rating Report (2021)*

From **Figure 3.1,** it was noted that more than 82% of the assessed private healthcare facilities had less than 3 stars which indicate that the healthcare facilities attained the minimum required standard. The audit further analysed the star rating of the private health facilities per each level of the facility and noted that dispensaries had 88% of facilities with less than 3-stars followed by health centres which had 77% of facilities and hospitals had 44% of facilities under each category as depicted in **Figure 3.2.**

Figure 3. 2: Star Rating of Private Healthcare Facilities Per Category



Source: *Auditors' Analysis of the Third-Round Star Rating Report (2021)*

From **Figure 3.2,** it can be noted that during the third round of the star rating analysis, dispensaries performed lower than health centres and hospitals in the quality ratings. The audit reviews of the star rating reports revealed that the lower rating mainly contributed to low performance in the 12th domain of Quality Care which had Clinical Services and Clinical Support Services such as pharmaceutical services and laboratory services.

(i) Insufficiently Provided Pharmaceutical Services

Pharmacy Council through its Strategic Plan of 2016/17 - 2020/21 planned to ensure that 80% of the registered premises were compliant with the Good Pharmacy Practice (GPP) Standards by June 2022.

The audit noted that the Pharmacy Council did not conduct a review of the compliance of the attached pharmacies with Good Pharmacy Practice Standards from 2016/17 to 2021/22, and thus there was no information on the number of Pharmacies with Good Pharmacy Practices.

The audit further noted through the visits to healthcare facilities in the regions that there were healthcare facilities with anomalies in the pharmaceutical services as shown in **Table 3.1.**

Table 3.1 shows the number of healthcare facilities with anomalies in the pharmaceutical services across the regions. As it is further indicated in **Table 3.1,** all pharmacies in the visited healthcare facilities in the Tabora and Ruvuma regions had anomalies with 100% inadequate pharmaceutical services. For the Kilimanjaro region, the anomaly in the pharmaceutical services was about 70%, while the anomalies for the Dodoma, Mbeya, Mwanza and Dar es Salaam regions were 89%, 80%, 78% and 75% respectively.

Table 3.1: Number of Pharmacies with Anomalies in the Visited Healthcare Facilities per each Region

Name of the Regions	Number of Visited Healthcare Facilities	Number of Attached Pharmacy with Anomalies	% of Inadequate Pharmaceutical Services
Tabora	17	17	100
Ruvuma	19	19	100
Dodoma	18	16	89
Mbeya	20	16	80
Mwanza	18	14	78
Dar es Salaam	20	15	75
Kilimanjaro	20	14	70

***Source**: Auditors' Analysis of field observation in Private and Voluntary Healthcare Facilities across Regions (2022)*

On the other hand, the audit compared the results across sampled and visited LGAs to establish the extent of pharmaceutical services.

Table 3.2 shows the situation in the visited healthcare facilities per district. The audit further noted, during the field observations, that out of the one hundred thirty-two (132) visited healthcare facilities, one hundred and eleven (111), equivalent to 84% of all visited healthcare facilities in the selected LGAs had anomalies in the provision of pharmaceutical services.

Table 3.2: Number of Pharmacies with Anomalies in the Visited Healthcare Facilities in the Selected LGAs

Name of the LGAs	Number of Visited Healthcare Facilities	Number of Attached Pharmacy with Inadequate Services	Percentage of HCF with inadequate Services
Kongwa DC	8	8	100
Igunga DC	7	7	100
Tabora MC	10	10	100
Misungwi DC	8	8	100
Nyasa DC	9	9	100
Songea MC	10	10	100
Kyela DC	10	9	90
Moshi Dc	10	9	90
Dodoma CC	10	8	80
Temeke Mc	10	8	80
Ilala CC	10	7	70
Mbeya CC	10	7	70
Mwanza CC	10	6	60
Moshi MC	10	5	50

***Source**: Auditors' Analysis of Healthcare Facilities Records and Physical Observations (2022)*

From **Table 3.2,** it can be noted that in the six visited LGAs of Igunga DC, Kongwa DC, Misungwi DC, Nyasa DC, Songea MC and Tabora MC, 100 percent of the attached pharmacies in the visited private healthcare facilities had anomalies.

The audit further noted that the common occurring irregularities with regard to pharmaceutical services in the visited healthcare facilities were the presence of unregistered pharmacies with unqualified personnel, lack of designated areas for dispensing drugs as well as improper handling of unexpired and expired medicines.

These factors are discussed below.

a) Presence of Unregistered Pharmacies and Drug Outlets in the Private Healthcare Facilities

According to section 34 of the Pharmacy Act of 2011, a person shall not sell, dispense, or sell any medicinal products except in the premises licensed under the pharmacy act.

Through the visits conducted by the audit team to all one hundred thirty-two (132) private healthcare facilities, it was noted that these facilities dispensed medicine and drugs without the approval of the pharmacy council. This was evidenced by the fact that none of the visited facilities had the registration certificate from the Pharmacy Council of Tanzania.

The presence of unregistered pharmacies and drug dispensing outlets was due to the fact that the Pharmacy Council had not inspected these attached pharmacies. This act actually conflicted its mandates in regulating the private healthcare facilities. This has been contributed by the Pharmacy Council only registers autonomous pharmacies and not the attached pharmacies and the available attached pharmacies are evaluated and operated concurrently with the establishment of the healthcare facility by PHAB, which prevents the responsible council (Pharmacy council) for the registration of pharmacies from conducting inspections.

b) Unregistered and Unqualified Drug-Dispensing Personnel

Sections 16, 24 and 28 of the Pharmacy Act, 2011 require that pharmacists, pharmaceutical technicians, and pharmaceutical assistants must be registered, enrolled, and enlisted by the Council to practice.

The audit noted through the visits to healthcare facilities that out of seventy-seven (77), equivalent to 58% of the one hundred thirty-two (132) visited healthcare facilities, were operated by unregistered and unqualified pharmacists and ALDOs. The consequences of the pharmacy being operated by the unqualified drug dispensing personnel could result in the wrong dispensing of drugs.

c) Lack of a Dedicated Area for Dispensing Drugs

The audit noted through the review of the star rating reports that one hundred twenty-seven (127), equivalent to 37% of the three hundred forty-six (346) healthcare facilities, did not have dedicated areas for dispensing drugs. Furthermore, the audit noted through visits to healthcare facilities that out of the one hundred thirty-two (132) healthcare facilities, eleven (11) healthcare facilities, equivalent to 15% did not have dedicated areas for dispensing drugs.

d) Improper Handling of Unexpired and Expired Medicine

The best practice of drug handling requires pharmacies to set procedures for handling expired drugs and ensure that the expired drugs and unexpired drugs are properly handled and separated.

The audit observed through visits that there was improper handling of expired and unexpired medicine in healthcare facilities. Out of the visited one hundred thirty-two (132) healthcare facilities, forty-three (43), equivalent to 33% did not properly handle the expired and unexpired drugs.

The audit review of the records showed that the unexpired medicines were not separated from the expired medicines. Improper handling of Unexpired and Expired Medicine could result in poor quality of medicines, stock damage and expirations which in turn would lead to poor quality of health services.

Photo 3.1 was taken at one of the visited Pharmacies, the audit found improper handling of drugs.

***Photo 3. 1**: Drugs arrangements in a Pharmacy. The Photo was taken on 10th August 2022 by the Auditors during field observations in the dispensary in Mwanza City Council*

e) Inadequacies in the Provision of Laboratory Services

Private Health Laboratories Strategic Plan of July 2017 – June 2022 planned to ensure that 80% of registered Private Health Laboratories complied with the set standards by June 2022.

The implementation report of 2022 of the PHLB inspection reports revealed that all Private Laboratory Facilities had weaknesses to meet the required set standard including a lack of qualified laboratory personnel and the presence of unregistered private health laboratories.

The audit noted through the reviews of the PHAB and PHLB inspection reports conducted to healthcare laboratories between 2016/17 to 2020/21 that the Private healthcare Laboratories had weaknesses in providing laboratory services. These weaknesses were the presence of unregistered attached Laboratories, unqualified laboratory professionals and non-renewal of Laboratories Licenses.

The audit noted, through the visits conducted to the healthcare facilities across the regions and LGAs, that the services for one hundred and five (105), equivalent to 88% of the one hundred thirty-two (132) visited attached healthcare laboratories, were not adequate. **Table 3.3** depicts observations in the visited healthcare facilities per the selected regions.

The audit noted that the healthcare facilities in the Kilimanjaro region had the most attached healthcare laboratories with anomalies whose inadequacy in terms of laboratory services stood at 95%. Compared to other selected regions, the healthcare facilities in the Mbeya region had the least attached healthcare laboratories with anomalies whose inadequacy in laboratory services stood at 50%.

Table 3.3: Situation of the Laboratory Services in the Visited Healthcare Facilities per each Selected Region

Name of the Regions	Number of Visited Healthcare Services	Number of Visited Attached Laboratory with Inadequate	Percentage of HCF with Inadequate Laboratory Services
Kilimanjaro	19	18	95
Mwanza	20	18	90
Tabora	17	15	88
Ruvuma	20	17	85
Dar es Salaam	20	15	75
Dodoma	18	13	72
Mbeya	18	9	50

***Source**: Auditors' Analysis of Healthcare Facilities Records and Physical Observations (2022)*

Table 3.4 reveals the situation of the attached laboratory services in the visited LGAs. From the observations, the audit noted that fewer laboratories in Kyela DC had few weaknesses. On the other hand, it was observed that 100% of the laboratories in the six (6) other LGAs of Moshi MC, Mwanza CC, Misungwi DC Kongwa DC, Igunga DC and Nyasa DC had inadequate laboratory services. However, both Dodoma CC and Mbeya CC were observed to have 50% each in terms of the number of visited attached laboratory inadequate laboratory services.

Table 3.4: Situation of the Attached Laboratory Services in the Visited Healthcare Facilities per the Selected LGAs

Name of the Districts	Number of Visited Healthcare Services	Number of Visited Attached Laboratory with Inadequate Services	Percentage of HCF with Inadequate Laboratory Services
Igunga DC	7	7	100
Kongwa DC	8	8	100
Misungwi DC	10	8	100
Moshi MC	9	10	100
Mwanza CC	10	10	100
Nyasa DC	10	9	100
Moshi DC	10	8	80
Songea MC	10	8	80
Tabora MC	10	8	80
Temeke Mc	10	8	80
Ilala CC	10	7	70
Dodoma CC	10	5	50
Mbeya CC	10	5	50
Kyela DC	8	4	40

***Source**: Auditors' Analysis of Healthcare Facilities Records and Physical Observations (2022)*

From **Table 3.4,** the audit noted that out of the one hundred thirty-two (132) visited attached laboratories, one hundred and five (105), equivalent to 80%, had anomalies. Laboratories with anomalies ranged between 40% in Kyela and 100% in the six other LGAs of Moshi MC, Mwanza CC, Misungwi DC, Kongwa DC, Igunga DC and Nyasa DC.

The audit further analysed the common occurring anomalies across the private healthcare facilities as discussed hereunder.

a) Presence of Unregistered Attached Laboratories

According to the Private Health Laboratories Regulations Act of 1997, no person can establish, operate, manage or cause to be managed or operated a private health laboratory facility unless the facility complies with the standard guidelines set out in the First Schedule to these Regulations, and that the facility has been registered and a certificate issued by the Board.

The audit noted, through the review of the submitted PHLB inspection reports from 2016/17 to 2021/22 that unregistered attached laboratories existed.

Further, the audit noted from the field visits in the healthcare facilities that out of the one hundred thirty-two (132) private healthcare facilities, sixty-five (65), equivalent to 49%, operated their laboratories without registration from the Private Healthcare Laboratories Board. The presence of unregistered laboratories indicated a lack of assurance of the quality of the services provided by the laboratories to patients.

b) Non- Renewal of Laboratory Licences

According to Section 11(2) of the Private Health Laboratories Regulations of 2005, the registration shall be renewed annually upon payment of the respective fees.

The audit noted through the review of the inspection reports of the Private Health laboratories that there were attached private healthcare laboratories that did not renew their licences.

Similarly, the reviews of the Star Rating Reports of 2017, 2018 and 2022 revealed that one of the weaknesses that faced the private and voluntary healthcare facilities was the non-renewal of laboratory licences.

Further, the audit observed through the visits conducted to healthcare facilities that out of the one hundred thirty-two (132) visited healthcare facilities, thirty-two (32), equivalent to 25% did not renew their licences as required and operated with expired licences. The audit noted that the main reason for the non-renewal of licences was low coverage of the inspections by PHLB.

c) Unqualified Laboratory Professionals

According to Health Laboratory Technologist, Registration and Regulation Act, 1997; a registered health laboratory means any duly qualified person who is for the time being authorized to practice the health laboratory profession by that person being registered or licensed under the provisions of the act.

The audit noted through the review of the inspection report of PHLB (2016/17-2021/22 that there were healthcare laboratories that operated without having qualified registered laboratory technologists or technicians.

Similarly, in the reviews of the star rating reports of 2017, 2018 and 2022, it was noted that one of the key impediments to the provision of laboratory services was the presence of unqualified laboratory technologists.

The audit noted, through the visits conducted to healthcare facilities that out of the one hundred thirty-two (132) visited healthcare facilities across the selected regions, sixty-five (65) of the attached healthcare laboratories, equivalent to 49%, operated without having qualified laboratory technologists. Operating without qualified laboratory technologists was likely to contribute to the provision of low-quality healthcare services through these attached healthcare laboratories.

3.2.2 Private and Voluntary Healthcare Facilities Operated with Insufficient Healthcare Workers

PHAB in its Strategic Plan (2015/16-2019/20) planned to ensure that private healthcare facilities had 60% of the qualified staff.

However, the audit noted, through the review of the Ministry of Health Annual Progress Reports, that the shortages of Human Resources for Health in the private healthcare facilities ranged between 84 and 87 per cent, with hospitals having more shortages than other facilities.

Table 3.5 shows the availability of healthcare workers in the Private and Voluntary Healthcare Facilities. As it is indicated in Table 3.5, hospitals had a shortage of 87%, health centres had a shortage of 86% and dispensaries had a shortage of 84%.

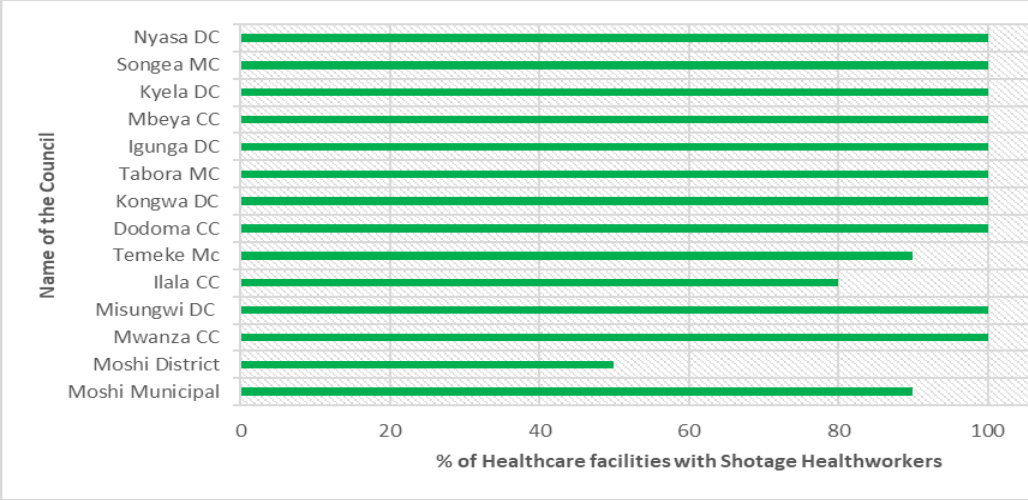
Table 3. 5: Availability of Health Workers in the Private and Voluntary Healthcare Facilities

Level of Facilities	Required No. Staff	Available №. of Staff	Shortage №. of Staff	%age Shortage
Hospitals	26,004	3,251	22,753	87
Health Centres	5,400	758	4,642	86
Dispensaries	11,487	1,842	9,645	84

***Source**: Auditors' Analysis of the Ministry of Health Annual Progress Reports (2022)*

Similarly, the audit noted from the reviews of the star rating reports of 2017, 2018 and 2021 that healthcare facilities had a significant shortage of medical personnel in all levels. The audit analysed the health workers for health in the visited healthcare facilities in the selected LGAs, and the results are as depicted in **Figure 3.3.**

Figure 3.3: Percentage of the Available Health Workers in the Visited Private Healthcare Facilities



***Source**: Auditors' Analysis from Private Healthcare Facilities workers files (2022)*

From **Figure 3.3**, it can be noted that the visited Private and Voluntary Healthcare Facilities were all understaffed, and the number of understaffed healthcare facilities ranged between 50% and 100%.

For example, in Moshi DC 50% of the visited Private Healthcare Facilities had a deficit of health workers, while 100% of the healthcare facilities in the eleven (11) of the visited LGAs had less than the required number of health workers.

Table 3.6 indicates the comparison of the required and available health workers in the visited healthcare facilities. The audit noted through the analysis that the shortage of medical personnel ranged between 60% and 73% across all professionals of doctors, nurses, laboratory technicians and pharmacists.

Table 3. 6: Comparison of Required and Available Healthcare Workers for each Cadre in the Visited Facilities

Name of the Professional	Required No. Healthcare Workers	Available №. of Healthcare Workers	Shortage №. Of Healthcare Workers	% Shortage Healthcare Workers
Doctors	240	96	144	60
Nurses	960	300	660	69
Laboratory tech	360	156	204	57
Pharmacist	240	65	175	73

***Source**: Auditors' Analysis from the Private Healthcare Facilities and HR files (2022)*

From Table 3.6, it can be noted that the shortage of doctors was 60%, Nurses 69%, laboratory personnel 57% and pharmacy personnel was 73%.

Consequences of private healthcare facilities operating without sufficient health workers for healthcare would likely results into following:-

a) Impairment of the Quality of Healthcare Provision

According to the WHO Global strategy on human resources for the health workforce of 2030, Health professionals play a central and critical role in improving access to and quality healthcare for the population.

Health professionals provide essential services that promote health, prevent diseases, and deliver healthcare services to individuals, families, and communities. Any shortage of health professionals, in turn, impacts the provision of healthcare services.

b) Constraints the Ability of the Healthcare System to Respond to Key Health Delivery of Health Services

The health workforce is the backbone of a good functioning health system that is critical in accelerating progress towards Sustainable Development Goals (SDGs).

The shortage of health workers in the Private and Voluntary Healthcare Facilities, as stakeholders in improving and responding to health challenges such as Malaria, TBs and HIVs, would likely constrain the health system in responding to these challenges.

To ensure that the private and voluntary healthcare facilities operate sufficiently, the Regulation of private health providers was entrenched in the country's statutes, which define the conditions and requirements for private healthcare provision. The observed anomalies were the results of inadequate regulatory initiatives such as low coverage of inspection, inadequate supportive supervision and non-conduct of clinical audits as discussed in Sections 3.4, 3.5, and 3.6 of this report respectively.

3.3 Ineffective Registration of Private Healthcare Facilities

The Private Hospitals Advisory Board is mandated to register all screened applications of private and voluntary healthcare facilities. The audit noted the following with regard to the registration of private healthcare facilities:

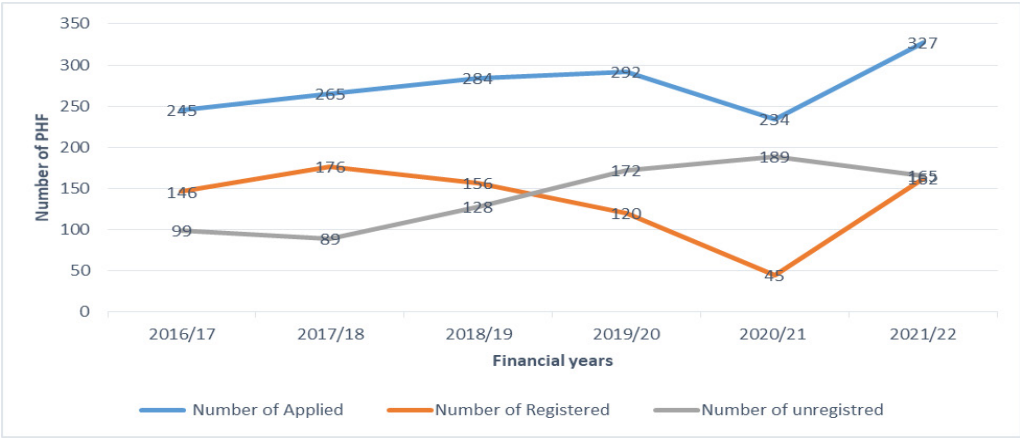
3.3.1 Not all applied Private Healthcare Facilities were registered.

According to the Private Hospitals Regulation Act of 1977, the Ministry of Health is supposed to ensure that no healthcare facility is established, operated, managed, or cause to be managed unless the facility has been registered, operated by an approved organization, and has a certificate issued by MoH and complies with the set standard guidelines.

The audit review of the PHAB Annual Implementation Reports of 2016/17-2021/22 revealed that PHAB managed to register between 19% and 87% of the private healthcare facilities that applied for registrations. The audit noted that the lowest registration of healthcare facilities in the year 2018/19 was due to healthcare facilities not meeting the required minimum registration criteria.

Figure 3.4 depicts the comparison of the applied, registered and rejected Private Healthcare facilities in the selected regions. It can be noted that in the financial year 2016/17, PHAB managed to register one hundred forty-six (146), equivalent to 60% of the two hundred forty-five (245) applied private healthcare facilities. In the financial year 2017/18, PHAB managed to register one hundred seventy-six (176), equivalent to 66% of the two hundred sixty-five (265) applied private healthcare facilities, and in the financial year 2020/21, PHAB managed to register only forty-five (45), equivalent to 19% of the applied two hundred thirty-four (234) private healthcare facilities.

Figure 3. 4: Comparison of the Applied, Registered and Unregistred PHCF 2016/17-2021/22



Source: *PHAB Annual Implementation Report (2016/17-2021/22)*

From **Figure 3.4,** it can be noted that there were more applied healthcare facilities than the number of registered healthcare facilities.

The audit noted through the review of PHAB Board meetings' minutes that the issues that led to the rejection of registration of the application were mainly related to infrastructure, insufficient health workers, and lack of tools and equipment.

Table 3.7 depicts the category of issues which resulted in the rejection of the application of private and voluntary healthcare facilities.

Table 3.7: Reasons for Rejection of Registration of PHCF

Financial Year	Insufficient Infrastructure	Insufficient Health Workers	Absence of the Required Tools and Equipment
2016/17	✓	✓	✓
2017/18	✓	✓	✓
2018/19	✓	✓	✓
2019/20	✓	✓	✓
2020/21	✓	✓	✓
2021/22	✓	✓	✓

Source: *Auditors' Analysis from Private Hospital Advisory Board Minutes (2016/17-2021/22)*

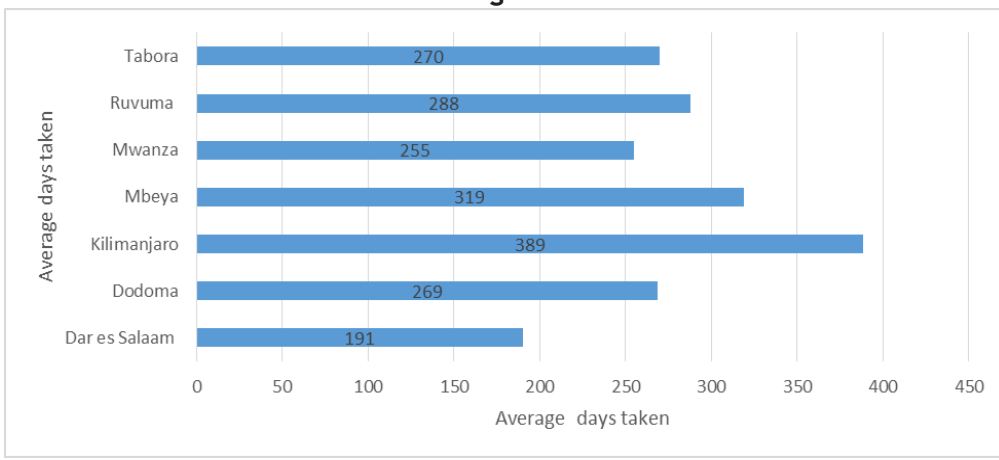
From **Table 3.7,** it can be noted that the main factors that lead to the rejection of registration of a healthcare facility were infrastructure, insufficient health workers and the absence of the required tools and equipment.

3.3.2 Varied Timeliness for the Registration of Private and Voluntary Healthcare Facilities

The audit analysed the average time taken from application to approval of registration of private healthcare facility per each region and noted that the timeliness varied.

Figure 3.5 depicts the average time taken to register a Private Healthcare Facility per each of the selected regions.

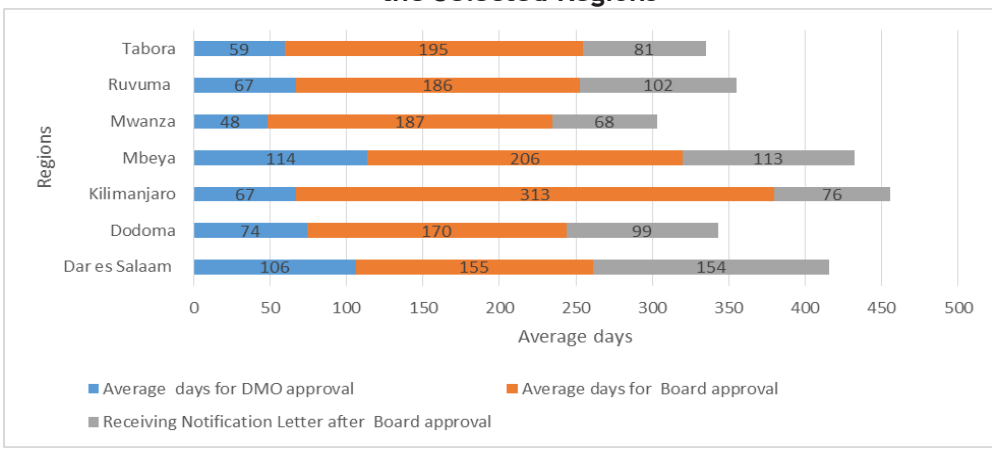
Figure 3.5: Average Time Taken to Register a Private Healthcare Facility in Regions



***Source**: Auditors' Analysis of PHAB Registration Data (2022)*

From **Figure 3.5,** the audit noted that it took an average of 191 days for a healthcare facility in the Dar es Salaam region to be registered while it took an average of 389 days for a healthcare facility in Kilimanjaro to be registered. The audit further analysed the average time taken on each stage of registration of healthcare facilities per each of the selected regions.

Figure 3.6: Average Time Taken Between Stages for Approvals Per Each of the Selected Regions



Source: *Auditors' Analysis of PHAB Registration Data (2022)*

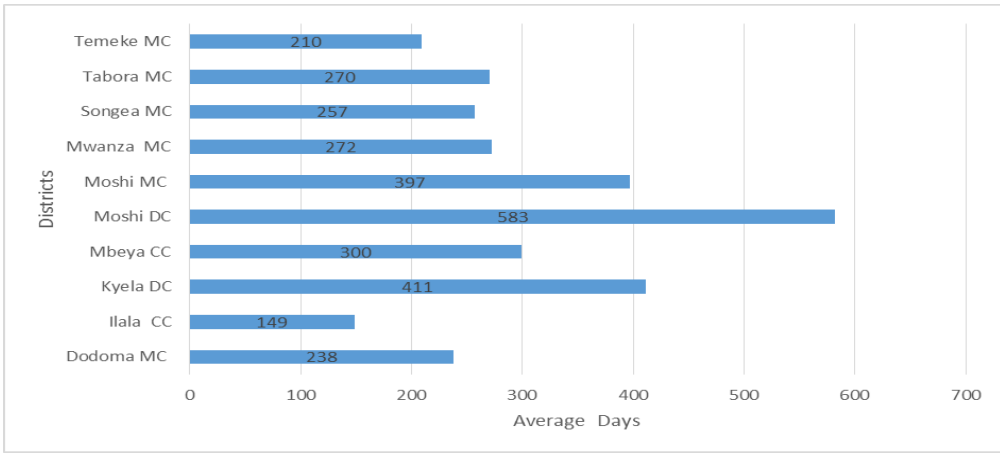
Figure 3.6 depicts the average time taken to register a health care facility per each in the visited regions. The approval from medical officers was lower in Mwanza as it took only 48 days and highest in Mbeya where it took an average of 114 days. Further, the average time to receive approval from the Board was higher for facilities in Kilimanjaro as it took 313 days and lowest in the Dar es Salaam Region, where took 155 days.

It took an average of 144 days to receive DMO approval in the Mbeya Region which was considered the longest time when compared with the time taken in other visited regions. With regards to receiving Board approval, it took an average of 313 days for a private healthcare facility to receive approval in Kilimanjaro which was considered the longest compared to the time taken in other visited regions. For receiving notification for registration, it took an average of 113 days for a healthcare facility located in Mbeya, which was the longest time compared to a healthcare facility located in other selected regions.

The audit further analysed the registration timeliness for the private healthcare facilities across the visited LGAs. **Figure 3.7** depicts the average time taken to register a private healthcare facility located in the visited LGAs.

The audit noted that the average time to register a healthcare facility varied significantly across the visited LGAs. It took an average of 583 days for a healthcare facility located in Moshi DC to be registered and 149 days to register a healthcare facility that was located in Ilala MC.

Figure 3.7: Average Time Taken to Register a Private Healthcare Facility in LGAs



Source: *Auditors' Analysis of PHAB Registration Data (2022)*

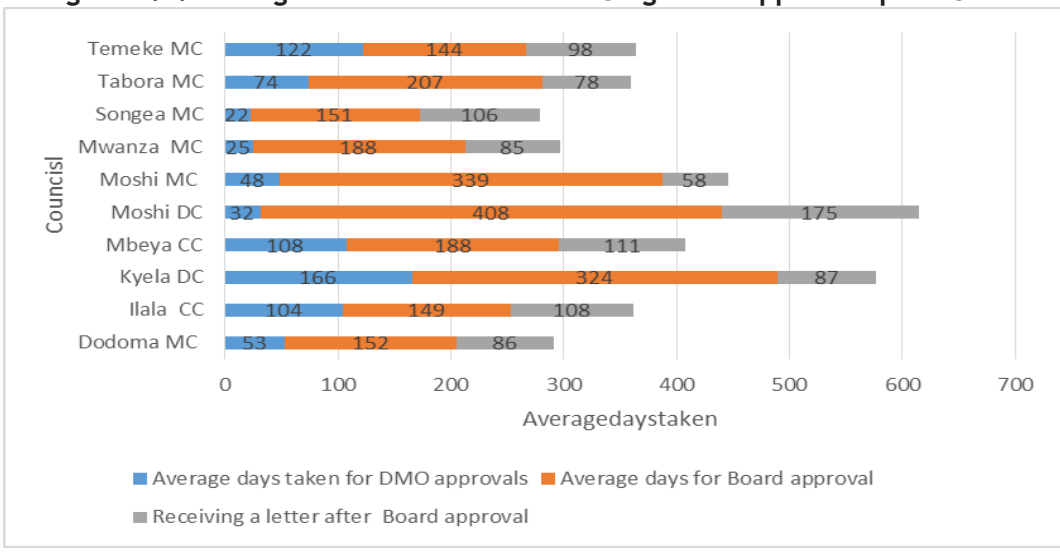
Figure 3.7 indicates that the average time taken for a healthcare facility to be registered since its application ranged from 149 to 583 days. A healthcare facility located in Moshi DC took more time, which was 583 days, to be registered than a private healthcare facility located in other LGAs. Further, the audit noted that it took an average of 149 days for a healthcare facility located in Ilala CC to be registered which was the shortest time of the thirteen (13) visited LGAs.

The audit also analysed the average time taken between stages of approvals in each visited LGAs.

Figure 3.8 depicts the average time taken to register a private healthcare facility across districts. The audit noted that the time taken for each stage varied significantly across the LGAs.

With regards to DMO approvals, the audit noted that it took an average of 22 to 166 days for a healthcare facility to be registered, and for Board approvals, it took an average of 114 to 339 days for a healthcare facility to receive approval from the PHAB board, while it took an average of 85 to 175 days for a healthcare facility located across the LGAs to receive a notification letter for registration.

Figure 3.8: Average Time Taken Between Stages for Approvals per LGAs



***Source**: Auditors' Analysis of PHAB Registration Data (2022)*

From **Figure 3.8,** it can be noted that DMO in Songea MC took an average of 22 days to approve a private healthcare facility application while a DMO in Kyela DC took the average of 166 days which was the longest time taken to approve the application.

Similarly, with regards to receiving Board approval since application, it can be deduced that it took an average of 144 days for a healthcare facility in Temeke Municipality to receive a Board approval, while a healthcare facility in Moshi DC received Board approval after an average of 408 days which was the longest to be approved by the Board.

Meanwhile, with regards to receive a notification after Board approval, the audit noted that it took an average of 58 days for a healthcare facility located in Moshi MC which was the shortest and 175 days for a private healthcare facility located in Moshi DC which was the longest time to receive a notification from the Board.

3.3.3 Delays in issuing Notification Letters to Private Healthcare Facilities after Registration

According to the Guide for Establishing Private Hospitals, the Registrar is supposed to inform the applicant the decision of the Board within fourteen (14) days after the Board's meeting.

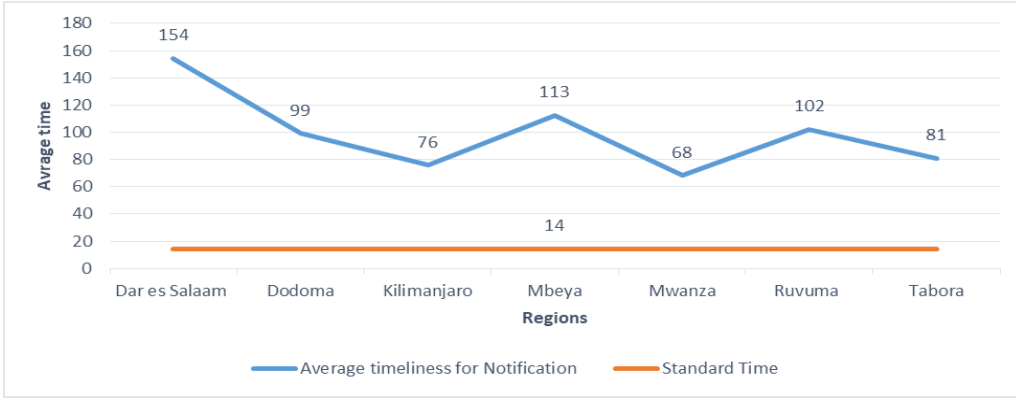
The Board sits quarterly and receives applications for operating private healthcare facilities approved by the District Medical Officer and the Regional Medical Office.

The audit noted through the review of two hundred and three (203) files of private healthcare facilities from seven (7) regions that on average private healthcare facilities received notification for the board decision in more than fourteen (14) days.

Figure 3.9 indicates the average time taken to provide notification letters to private healthcare facilities.

The audit noted that PHAB took an average of 68 to 154 days to issue notification letters to private healthcare facilities in the visited region. It also took an average of 154 days for healthcare facilities located in the Dar es Salaam region to be issued with a notification letter, while it took an average of 68 days for private healthcare facilities to be issued with a notification letter for registrations.

Figure 3.9: Average Time taken to Issue Notification Letters to PHFs for the Registration of Private Healthcare Facilities in the Selected Regions



***Source**: Auditors' Analysis from Private Healthcare Facilities registered from (2016/17-2020/21)*

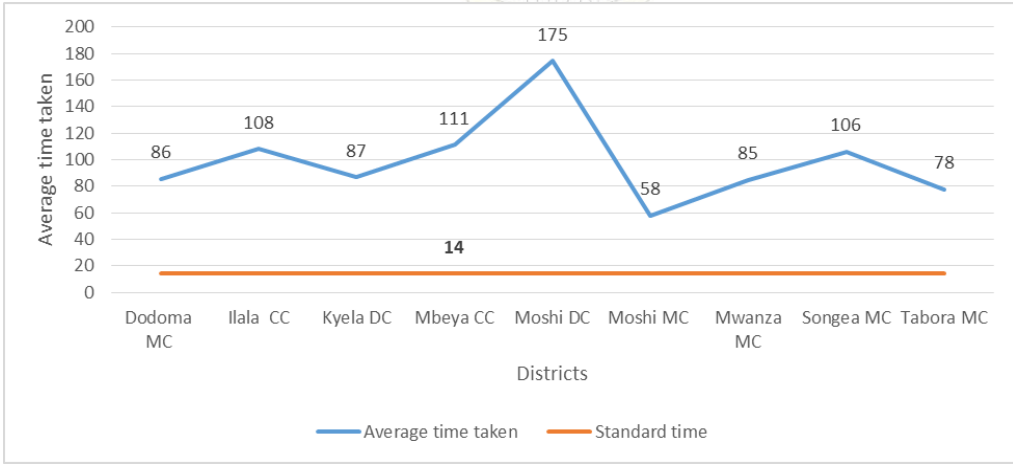
From **Figure 3.9,** it was noted that on average private healthcare facilities in Dar es Salaam were the most delayed in receiving the notification letter for their registration with an average of 154 days while those in the Mwanza regions were issued with a notification letter on the average of 68 days.

The audit further analysed the extent of issuing a notification letter after approval from the Board in LGAs.

Figure 3.10 depicts the average time taken in issuing a notification to private healthcare facilities in LGAs. The audit noted that on average none of the private healthcare facilities received the notification letter within the stipulated timeliness of 14 days in all LGAs. It can be deduced that the average time to be issued with a notification letter ranged between 78 days to 175 days.

On an average of 58 days, a private healthcare facility in Moshi MC was issued with a notification letter. However, on an average of 175 days, which was the longest time, a private healthcare facility in Moshi DC was issued with a notification letter.

Figure 3.10: Average Time taken in Providing Notification letters to PHFs in LGAs



Source: *Auditors' Analysis from Private Healthcare Facilities registered from (2016/17-2020/21)*

From **Figure 3.10,** it was indicated that Moshi DC healthcare facilities were issued with a notification on average of 175 days. On the other hand, Moshi MC took an average time of 58 days, which was shorter than the time taken by all healthcare facilities in other visited LGAs.

The following were the reasons for Varied Timelines on the registration of Private Healthcare Facilities across the regions and districts:

(a) Non-conducting of PHAB Board Meetings

PHAB, through its strategic plan of 2016/17-2021/22, was supposed to conduct Quarterly Board Meetings for the approval of applications for registration of Private Healthcare Facilities. During the Board meetings, the issues discussed and deliberated are such as approval and registration of Private and Voluntary Healthcare Facilities.

However, the Audit noted through the reviews of Board Meetings' Minutes from 2016/17 - 2021/22 that PHAB did not manage to conduct all four Board Meetings in all years under audit, except in 2021/22.

Table 3.8 depicts the status of Board Meetings conducted by PHAB from 2016/17 to 2021/22.

Table 3. 8: Status of the Planned Board Meetings

Financial Year	Number of Meeting Required	Number of Meeting conducted	Meetings not Conducted
2016/17	4	3	1
2017/18	4	3	1
2018/19	4	2	2
2019/20	4	3	1
2020/21	4	4	-
2021/22	4	3	1

***Source**: Auditors' Analysis from the Private Hospital Advisory Board Minutes (2016/17-2021/22)*

The audit noted that in 2016/17, 2017/18, 2018/19, and 2021/22 PHAB conducted three (3) meetings annually out of the required four (4) meetings. The situation which resulted in the submitted application not to be approved until the subsequent quarter and thus impacted the registrations. The audit review of the board packs revealed that no reasons for not holding the meetings which were provided.

(b) Ineffective Registration System

The review of the registration files shows that information on all the registered healthcare facilities from PHAB was obtained. It was further noted that PHAB was using a manual system form for the registration of private healthcare facilities in each stage up to 2020.

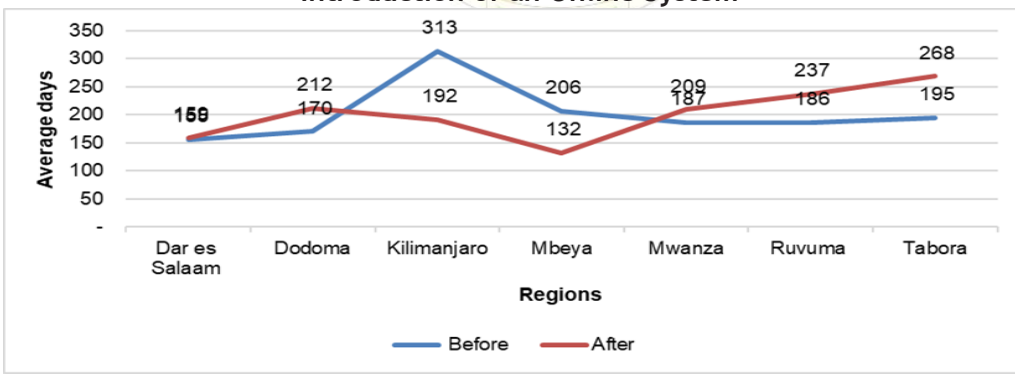
The PHAB management attributed the varied timelines to the use of the manual system because it was difficult to monitor the registration stages at lower levels before reaching the PHAB Board.

However, the audit comparison of the timelines from application dates to Board approval before and after the establishment of the online registration system indicates that there was no significant difference before and after the establishment of the online system.

Figure 3.11 indicates the average time taken for the PHAB Board to approve a Healthcare Facility before and after the establishment of the online system for registration across the regions.

The audit noted that the time taken for the application to be approved by the Board did not differ significantly before and after the establishment of the online system for the application. On average it only improved in Kilimanjaro and Mbeya regions by 221 days and 74 days respectively and remained significantly higher than before the establishment of the online system for the application.

Figure 3.11: Comparison of the Time Taken Before and After the Introduction of an Online System



***Source**: Auditors' Analysis of PHAB Registration data (2022)*

From **Figure 3.11,** it can be noted that the approval time by the Board since the application improved in two regions of Kilimanjaro and Mbeya after the introduction of the online system. Furthermore, it can be noted that in four regions timelines for registration increased in Mwanza (22 days), Dodoma (42 days), Ruvuma (51 days), Tabora (83 days) and Dar es Salaam (4 days) even after the introduction of the new system.

This result indicates that despite the introduction of the online system for registration, there were no improvements in the time taken for an application to be approved by the Board. The audit noted that the main reason for this could be due to a lack of standard timelines for registration of a healthcare facility in each stage of the registration process.

(c) Lack of Standard Timeliness for the Registration of Private Healthcare Facilities

The audit noted that there was no standard time for registration of Private Healthcare Facilities in all five stages of registration of private healthcare facilities except for registration issuance of notification after Board approvals.

The audit noted that the reason for the lack of standard timelines for the registration of healthcare facilities was the fact that PHAB had not developed the client service charter.

(d) Absence of Client Service Charter

Section 4.2 of the Guide on Preparation and Implementation of Client Service Charters for the Public Service required the Ministry of Health through PHAB to set standards for service delivery in the charter. The Service Charter is a tool that facilitates transparency, accountability, and efficient service delivery as it indicates the list of services provided and the duration for processing such services by the responsible officers or units.

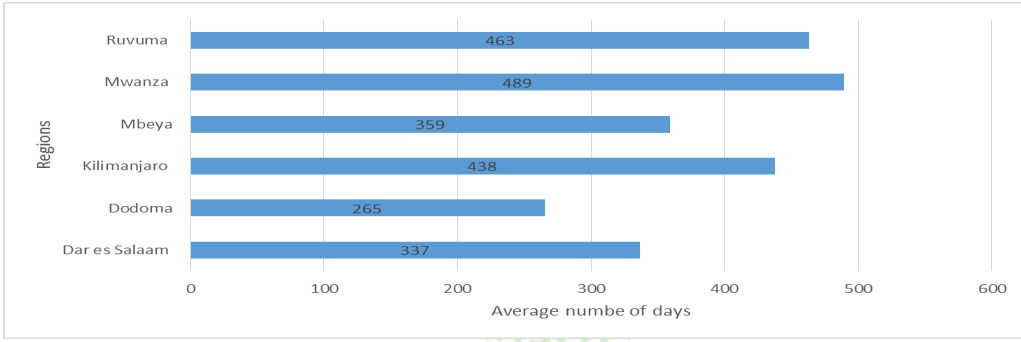
The audit noted that PHAB did not have a client service charter to be used in setting the agreed timeliness between the client and the service provider in this case the Private Healthcare Facility and PHAB. Upon enquiry, the audit noted that PHAB never had a plan for developing a client service charter from 2016/17-2021/22.

According to interviews with officials, the absence of the Client Service Charter resulted in Private Healthcare Facilities not being aware of the number of days that would be taken to complete the process for registration of healthcare facilities.

3.3.4 Varied Timeliness in the Registration of the Private Healthcare Laboratories

The audit reviewed the files for private laboratories registration to assess the average time for registration and noted that there was a varied timeline to register a private healthcare facilities. **Figure 3.12** stipulates the average time taken to register a private Healthcare laboratory. The audit noted that it took an average of 438 days in the Kilimanjaro region, 489 days in the Mwanza region, 359 days in the Mbeya region, 337 days in the Dar es Salaam region and 265 days in the Dodoma region to register a Private Healthcare laboratory.

Figure 3.12: Average Time taken to Register a Private Healthcare Laboratory



***Source**: Auditors' Analysis from PHLB registration files (2016/17-2021/22)*

From **Figure 3.12,** the analysis shows that the average time taken to register a private healthcare laboratory was the shortest in the Dodoma region which took 265 days and longest in the Mwanza region which was 489 days.

The audit further analysed the time taken to register a private healthcare laboratory for each stage of registration across the regions.

Figure 3.13 depicts the comparison of timeliness for each application stage across the regions. The audit noted that the average time to register a private healthcare laboratory in each stage of registration varied. Stage one which was the approval from the DMO indicates that the Ruvuma region took the shortest time of 20 days. In the Mwanza region, approval of the private healthcare laboratory took the longest time of 100 days.

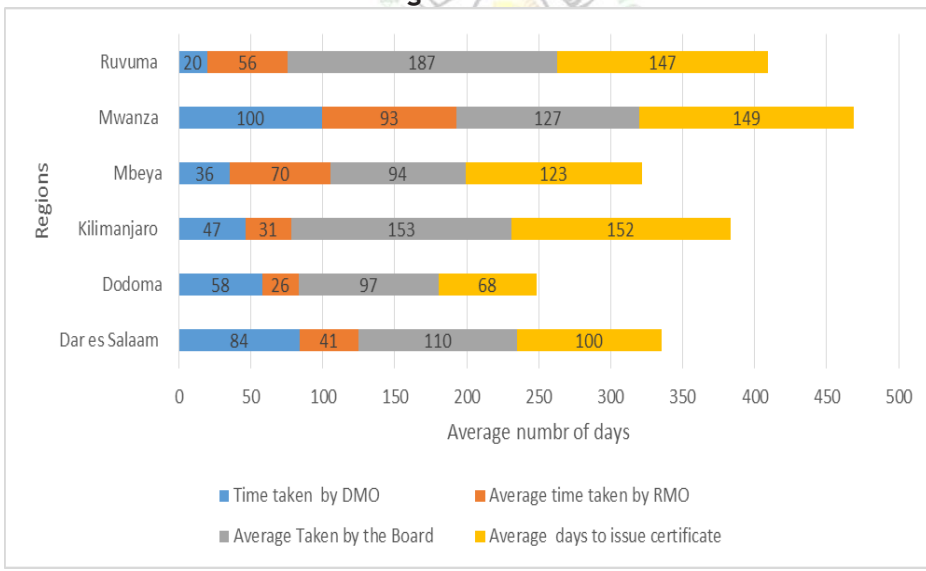
Similarly, with regard to approval by the Regional Medical Officers, it can be noted that it took an average of 31 days for RMOs to approve the private

laboratory in the Kilimanjaro region which was the shortest, and the longest average time was observed in Mwanza which on average the RMO spent an average of 93 days.

Further, with regard to the average time taken by the Board to approve a private healthcare facility. The audit noted that it took an average of 94 days for a private healthcare facility in the Mbeya region to receive approval and this was the shortest time while the longest average time to register a private healthcare laboratory was observed in the Kilimanjaro region where the private healthcare laboratory took an average of 153 days to receive an approval from the Board.

Meanwhile, with regards to average days taken to receive a certificate, the audit noted that the longest average time was for a private healthcare facility in the Kilimanjaro region which took an average of 152 days and the shortest was in the Dodoma region which took an average of 68 days.

Figure 3.13: Varied Approval Stages in Regions Varied Time of Registration at Regional Level



***Source:** Auditors' Analysis from the Private Health Laboratory (2022)*

Figure 3.13 shows that the average timeliness for the registration of a private healthcare facility varied considerably across the regions per each stage of the application for a private healthcare facility. The audit further analysed the

timeliness for registration of a private healthcare laboratory in districts from application to the date of receiving the certificate.

Varied Timeline for the Registration of Private Health Laboratories at LGA Levels

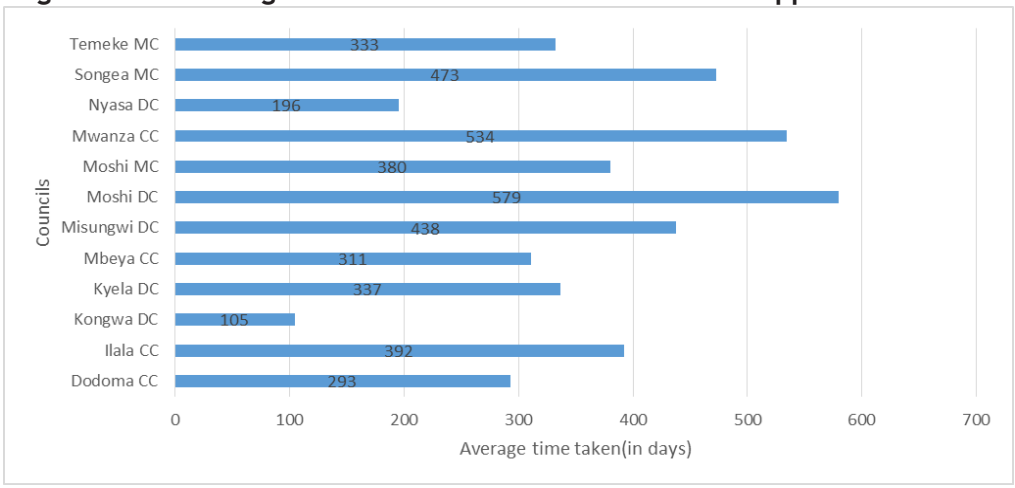
The audit analysed the timelines for receiving notification and the audit team noted that the timelines to receive a registration certification since the application varied across the LGAs.

Figure 3.14 stipulates a comparison of the average time taken by a private healthcare laboratory to receive a certificate of registration since the date of applications in the visited LGAs.

The audit noted that the average time taken to receive a certificate varied substantially across visited LGAs. It can be noted that it took an average of 579 days for a private healthcare facility in Moshi DC to receive a registration certificate and this was the longest time.

Meanwhile, it only took an average of 105 days for a Private Healthcare Laboratory located in Kongwa DC to receive a certificate of registration.

Figure 3.14: Average time to receive a certificate since applications in LGAs



Source: *Auditors' Analysis of the Private Healthcare Laboratory files (2022)*

Figure 3.14 shows that, the average time taken for a private healthcare laboratory to receive a certificate varied considerably in the visited LGAs.

The audit further analysed the time taken to register a Private healthcare laboratory at each stage in the visited LGAs. **Figure 3.15** depicts the average time taken to register private healthcare laboratories across the LGAs.

The audit noted an average time to register a private healthcare laboratory in each stage of registration in LGAs and across each stage.

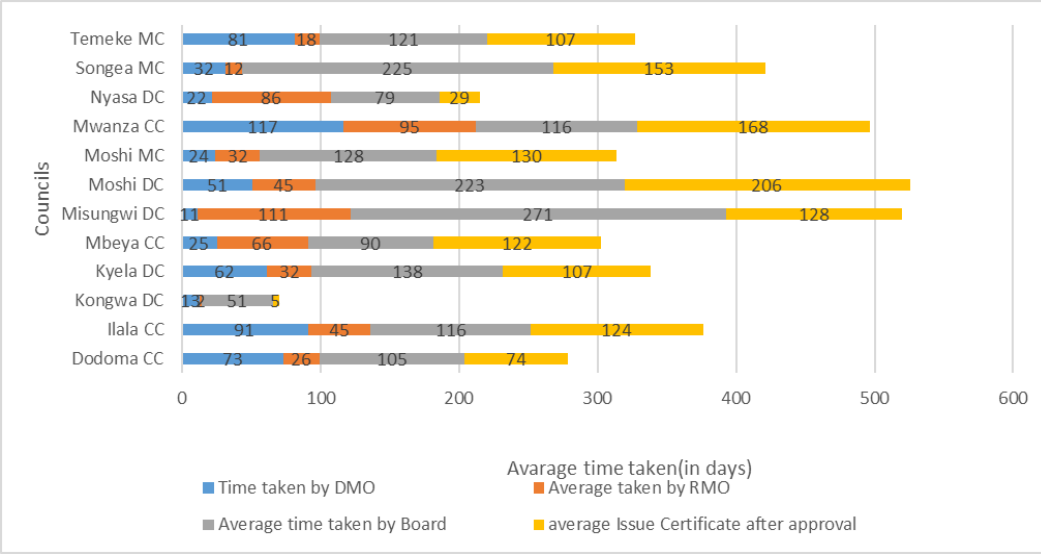
In stage one, which was the approval from the DMO indicates that on average Misungwi DC took less time of 11 days to approve an application of a Private Healthcare Laboratory, while Mwanza CC took the longest time which was an average of 117 days.

Further, in the second stage which was the approval by RMO, the audit noted that it took an average of 5 days for applications in Kongwa DC to be approved by the RMO which was the shortest time, while the longest time was observed in Misungwi DC in which the application of private healthcare laboratory from this LGA on average was approved by the RMOs after 111 days.

With regards, to the third stage of application which was the approval by the Board, the audit noted that it took an average of 271 days for a private healthcare facility in Misungwi DC to receive approval from the private health laboratory Board and was the longest time. It was also noted that the shortest time was observed in Nyasa DC in which the applied Private Healthcare Laboratories received approval on an average of 79 days.

Lastly, with regards to the average time taken to be issued with a certificate, the audit noted that the shortest time was observed in Dodoma CC where it took an average of 74 days, and the longest time was observed in Moshi DC where on average it took 206 days for Private Healthcare Laboratory to receive a certificate.

Figure 3.15: Comparison of Average Time Taken at Each Stage of Registration of a Private Healthcare Laboratory in the Visited LGAs



Source: *Auditors' Analysis of Healthcare Laboratories Registration Data (2022)*

Figure 3.15 shows that, on average the time taken for the registration of private healthcare laboratories varied considerably across LGAs per each stage of the application.

Reasons for varying time for the registration of private healthcare laboratories

(a) Ineffective Private Healthcare Laboratory Registration System

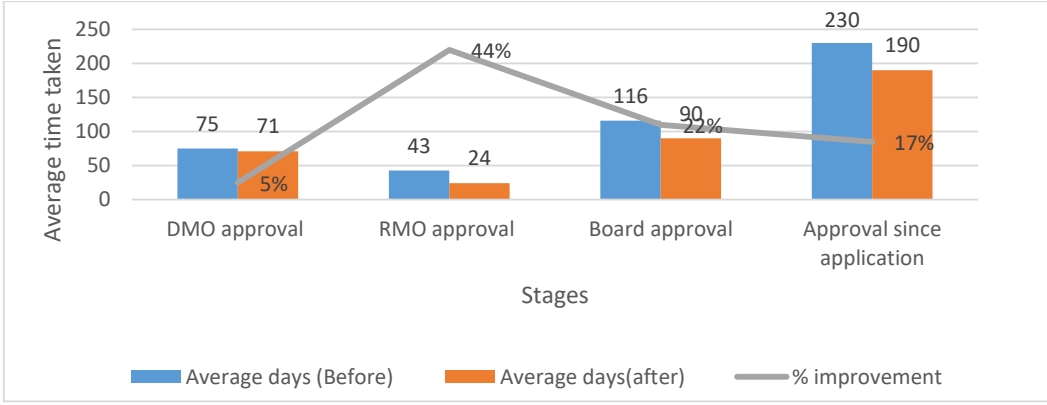
According to interviews with officials at PHLB, the main reason for varied timeliness in the registration of healthcare facilities was the use of the manual system for registrations and thus the introduction of the new system known as the Health facilities registration system which was introduced in 2020 and became effective in 2022 will curb the varied timeliness.

However, the audit noted that the online registration system was yet to curb the difference in time for registration across LGAs, regions, and stages for registration. The audit comparison of the stage of registration before and after the introduction of the new system revealed that there was no significant improvement on the time taken to register and approve a healthcare laboratory.

Figure 3.16 depicts the comparison of the average time taken before and after the introduction of the registration system (HFRS). It can be noted that the time taken for each stage improved slightly from the time taken before the introduction of the registration system.

The average time taken to receive approval from the DMO decreased from 75 days to 71 days, the average time taken for RMO approval improved from 43 days to 24 days, the average time taken for Board approvals after RMO approval from 116 days to 90 days and average approval since application improved from 230 days to 190 days.

Figure 3.16: Comparison of Average Time Taken Before and After the Online System per each Stage of Registration



***Source**: Auditors' Analysis of the PHLB registration Data (2022)*

From **Figure 3.16,** the audit noted through percentage analysis that the introduction of the registration system slightly improved each stage of the application. The stage which improved more was the time taken for approvals by the Regional Medical Officers which was 44%, while the least was the DMO approval which only improved slightly by 5%.

(b) Lack of Standard Time for Registration of Private Healthcare Laboratory

The audit noted that there was no standard time for registration of Private Healthcare Laboratories in all five stages of registration of private healthcare laboratories. The audit noted that the reason for the lack of standard timeliness for the registration of healthcare facilities was the fact that PHLB had not developed the client service charter.

(c) Absence of Client Service Charter

Section 4.2 of the Guide on Preparation and Implementation of Client Service Charters for the Public Service required the Ministry of Health through PHAB to set standards for service delivery in the charter.

The Service Charter is a tool that facilitates transparency, accountability, and efficient service delivery as it indicates the list of services provided and the duration for processing such services by the responsible officers or units.

The audit noted that the PHLB had not developed a client service charter to be utilized in establishing the timeliness between the customer and the service provider.

According to official interviews, the lack of a Client Service Charter caused Private Healthcare Facilities to be unaware of how many days would be taken to complete the registration procedure for healthcare facilities. The audit noted that from 2016/17 to 2021/22, PHLB never had plans to develop a client service charter.

Consequently, delays in providing the notification letters to private healthcare facilities of the decision of the board may result in the following:

(a) Could Hamper the Time for the Commencement of Operation of the Private Healthcare Facilities

Delays in assuring applicants of registration of private healthcare facilities could delay the operation of healthcare facilities. This poses a risk to the PHFs to operate without registration for the period of late notification. Also, there is a delay in the provision of healthcare services that are expected to be provided in the respective society.

(b) PHF Operate Without Registration for the Period of Late Registration

Delays in issuing the notification put a risk of healthcare facilities to commence operation of private healthcare facilities without being certain of being considered for registration or not. Private Healthcare facilities could be tempted to provide services without registration as all the essential items for a health facility are present in their locality.

a) PHF Owners incur Additional Operational Costs

Delays in issuing the notification make the owners of the facilities to incur operational costs because it is mandatory for owners to employ permanent health workers before applying for registration and also incurs other costs to run the facility such as utilities.

3.3.5 Non-Renewal of Registration of Private and Voluntary Healthcare Facilities

According to the Guidelines for establishing and operating a Private Hospital of 2018, the Ministry of Health is supposed to ensure that private healthcare facilities renew their registration after every five years when the renewal for the registration of the private hospital was done.

The audit review of the registration files of the private and voluntary Healthcare Facilities did not find any facility that has renewed its licence of registration in the last five years. The audit noted that the reasons for the non-renewal of licenses was inadequate inspection and lack of a monitoring system for Private and Voluntary Healthcare facilities.

The following were the reasons that affect the Private Healthcare Facilities from Renewal of the Registration: -

(i) Low Coverage of Inspection by PHAB

The audit team noted that the reason for the non-renewal of registration was low coverage of inspection by PHAB as discussed in section 3.3. It can be noted that it can take up to 7 years for a private healthcare facility to be inspected and thus make it easier for the Private Healthcare facility to operate without the currency of registrations.

(ii) Lack of a Comprehensive database for Private and Voluntary Healthcare Facilities

The audit team noted that there PHAB did not have a comprehensive list of all healthcare facilities up to June 2020 after the development of the Private Healthcare Facility online database. Similarly, the audit noted that the online

system does not have the mechanism to remind owners of the due date for renewing their licences without conducting visits.

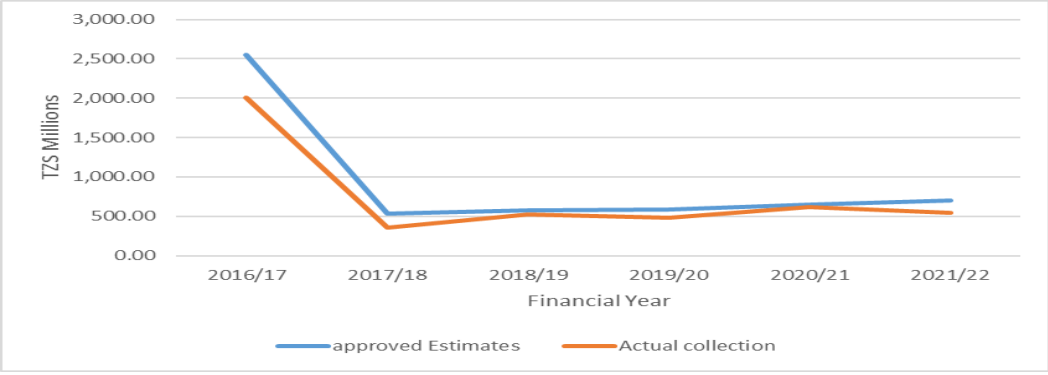
Non-renewal of the registration for Private Healthcare Facilities could result in the following: -

(i) **Not Met the Collection Targets**

Inadequate Collection of Licensing Fees which was contrary to section 9.1 of the Private Hospital Guideline which requires the Ministry of Health to ensure that every registered private hospital pays annual licensing fees to the Board in each calendar year as set out as mentioned below.

The audit noted that from 2016/17 - 2021/22 the Ministry of Health did not meet the required collections each year. It can be noted that in the financial year 2017/18 the collection was the lowest compared to others as shown in **Figure 3.17.**

Figure 3.17: Comparison Between Annual Estimates Vs Annual Collected by the Ministry of Health



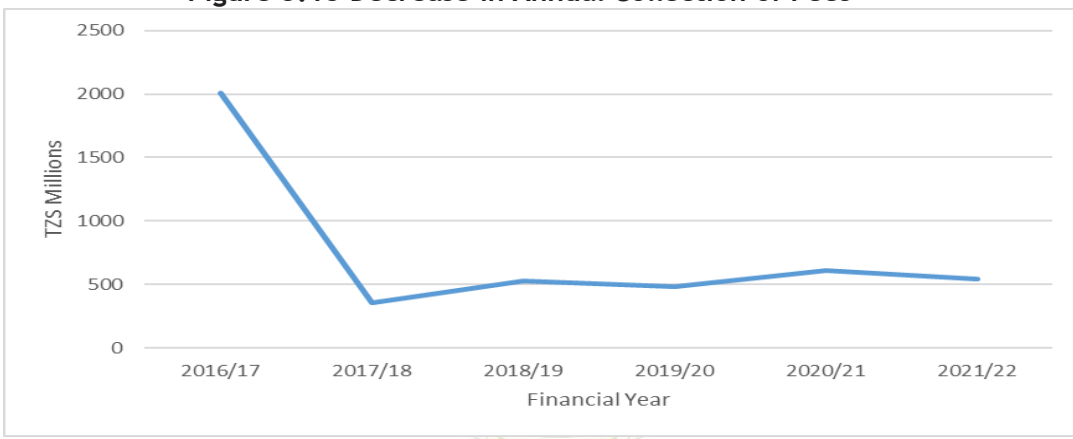
***Source:** Auditors' Analysis of the Annual Budget and Reports (2016/17-2021/22)*

Figure 3.17 shows that from the financial year 2016/17 to 2021/22, the Ministry of Health through PHAB did not adequately meet the planned collection of fees. However, in the financial year 2017/18, the difference noted between the collections was 34% compared to the planned one. The least difference was identified to be in the financial year 2020/21 whereby the difference noted was 5% between the actual collected and planned collection.

(ii) Decrease in the Amount of the Collected Fees.

The audit team reviewed the annual implementation reports annual collections that have been done by PHLB regarding renewal of registration and noted that there was a decreasing annual collection from the financial year 2016/17 to 2021/22 as shown in **Figure 3.18.**

Figure 3.18 Decrease in Annual Collection of Fees



***Source:** Auditors' Analysis of the Annual Budget and Reports for PHLB (2022)*

Figure 3.18 shows that the annual collection decreased from financial year 2016/17 to 2021/22. The difference between the highest collection and the lowest collection was 70% which shows the large variation from the expected original collected amount. This was the result of weak enforcement in renewing the Private Healthcare facilities licences and payment of annual registration fees.

(iii) ***Lack of Assurance on the Services Provided by Private Healthcare Facilities***

The audit noted that lack of renewal of registration may lead to the unapproved provision of healthcare services by healthcare facilities as it is required by the private health facility registration guidelines. Also, the board will not be aware of the practice provided by the healthcare facilities where it is required by the guideline for the registration of healthcare facilities that they should submit on renewal of registration a certificate of good performance issued by the Registrar of Private Hospitals.

3.4 Inadequate Supportive Supervision to Private and Voluntary Healthcare Facilities

According to PHAB Strategic Plan of 2016/17-2020/21, for Key Result 3 PHAB was supposed to support RHMTs and CHMTs to oversee the operation of Private Healthcare facilities and CHMTs were supposed to conduct quarterly supportive supervision to Private and Voluntary Healthcare facilities.

Through the review of Supportive Supervision Reports the following anomalies were noted:

3.4.1. Irregular Supportive Supervision to Private and Voluntary Healthcare Facilities by CHMTs

According to the Private Hospitals Advisory Board's strategic plan of 2016/17-2020/21, CHMTs were supposed to conduct quarterly supportive supervision to Private and Voluntary Healthcare facilities. CHMTs are supposed to conduct supportive supervision of private and voluntary healthcare facilities and ensure that each facility is visited at least once each quarter.

The audit team reviewed the annual implementation reports for supportive supervision in fourteen (14) visited LGAs and identified that the LGAs did not adequately conduct supportive supervision to Private and Voluntary Healthcare facilities as shown in **Table 3.9.**

Table 3.9: Supportive Supervisions to Private and Voluntary Healthcare Facilities Conducted by CHMTs

Region	Name of the LGAs	Average % Planned (in six years)	Average % Implemented (in six years)	% Gap
Kilimanjaro	Moshi MC	50	28	22
	Moshi DC	67	33	34
Dar es salaam	Ilala CC	67	38	29
	Temeke MC	50	25	25
Mwanza	Mwanza CC	33	10	23
	Misungwi DC	33	55	0
Mbeya	Mbeya CC	0	12	0
	Kyela DC	34	4	30
Ruvuma	Songea MC	84	4	80
	Nyasa DC	84	9	75
Dodoma	Dodoma CC	67	10	57

Region	Name of the LGAs	Average % Planned (in six years)	Average % Implemented (in six years)	% Gap
	Kongwa DC	67	20	47
Tabora	Tabora MC	83	10	73
	Igunga DC	67	19	48

Source: *Auditors' Analysis from CCHP and Supportive Supervision reports (2016/17 - 2021/22)*

It was noted that in the visited fourteen (14) LGAs, all the LGAs did not adequately attain the planned number of supportive supervisions whereby they managed to attain an average of 15.3% in from 2016/17-2021/22.

However, despite the inadequate implementation of planned number of supportive supervisions, the audit team noted that there was an average gap of 43.3% in the visited facilities and that was contributed by the highest gap identified in two (2) LGAs, namely, Nyasa DC which had a gap of 75% and Songea MC which had gap of 80%.

The following were the reasons for the low coverage of supportive supervision such as the Implementation of the planned supportive supervision by CHMTs.

a) Inadequate Planning of Supportive Supervision by CHMTs

The audit team reviewed the number of healthcare facilities against the planned supportive supervision to be conducted in each visited LGAs and noted that the fourteen (14) visited LGAs did not adequately plan for the supportive supervision in their private healthcare facilities from 2016/17 to 2021/22. The planning status for supportive supervision in fourteen (14) visited LGAs shows that five (5) out of fourteen (14) visited LGAs did not completely plan for supportive supervision of Private and Voluntary Healthcare Facilities as mentioned in **Table 3.10.**

Table 3.10: Number of Private Healthcare Facilities Vs Planned Number for Supportive Supervision

Region	LGAs	Average Number of Facilities in Six years	Average Number of planned Supportive supervision in Six years
Kilimanjaro	Moshi DC	40	26
	Moshi MC	38	0
Mwanza	Mwanza CC	28	20
	Misungwi DC	9	0
Mbeya	Mbeya CC	38	0
	Kyela DC	13	5
Ruvuma	Songea MC	28	17
	Nyasa DC	9	6
Tabora	Tabora MC	15	13
	Igunga DC	13	13
Dar es salaam	Ilala MC	49	32
	Temeke MC	118	49

Source: *Auditors' Analysis on CCHP, Registered Healthcare Facilities (2022)*

Table 3.10 shows that Temeke MC was among the fourteen (14) visited LGAs that managed to plan an average of forty-nine (49) supportive supervision. This has resulted into lack of monitoring schedules that could guide and enforce supportive supervision experts to cover all the private healthcare facilities.

b) Small Budget for Supportive Supervision for Private and Voluntary Healthcare Facilities by CHMTs

The audit team reviewed the council health management plans (CCHP) to assess the budget set for supportive supervision and noted that in seven (7) regions, there was a fluctuation of budget allocation in six years (2016/7 to 2021/22) despite the available number of private healthcare facilities as shown in **Table 3.11**.

The audit noted that five (5) out of fourteen (14) LGAs did not budget for the supportive supervision to Private and Voluntary Healthcare Facilities from 2016/17-2021/22.

Table 3.11: Budget Allocation for Supportive Supervision to Private Healthcare Facilities in Respective CHMTs

Region	LGAs	Average Amount (In Million TZS) 2016/17 - 2021/22
Dodoma	Dodoma CC	7
	Kongwa DC	41
Kilimanjaro	Moshi DC	6
	Moshi MC	3
Mwanza	Mwanza CC	0
	Misungwi DC	0
Mbeya	Mbeya CC	0
	Kyela DC	0
Ruvuma	Songea MC	2
	Nyasa DC	14
Tabora	Tabora MC	15
	Igunga DC	37
Dar es Salaam	Ilala MC	103
	Temeke DC	18

***Source**: Auditors' Analysis from CCHP and list of registered Private Healthcare Facilities (2022)*

Table 3.11 shows that unbudgeted supportive supervision was identified in the Mwanza region in Mwanza CC and Misungwi DC while in the Mbeya Region, it was noted in Mbeya CC and Kyela DC and Ilala MC in the Dar es Salaam region.

The lack of budget for supportive supervision was due to non-prioritization by CHMTs to conduct supportive supervision of private healthcare facilities in their respective LGAs.

c) PHAB did not Allocate 10% of the Collected Fees to CHMTs

According to the PHAB strategic plan which was contrary to the PHAB strategic plan of 2016/17-2021/22 which required PHAB to support regulations at a lower level (the CHMT) PHAB by allocating 10% of the collected fees.

The audit noted through the review of annual reports that the Private Healthcare Advisory Board (PHAB) inadequately managed to remit 10% of the collected fees to regional offices to be used for supportive supervisions.

Table 3.12 below stipulates the percentage allocation of 10% of the collection to CHMTs. The audit noted that PHAB remitted a 2% which was equivalent to TZS

85,000,000 out of TZS 3,599,000,000 of the collected fees from 2016/17 to 2021/22.

Table 3.12: The Percentage Allocation of 10% of Collection to CHMTs

Financial Year	Amount Collected in TZS Millions	Remitted to CHMTS in TZS Millions	% Remitted
2016/17	No records	No records	No records
2017/18	900	0	0
2018/19	644	0	0
2019/20	709	44	6
2020/21	600	21	4
2021/22	746	20	3

Source: *Auditors' Analysis from PHAB Revenue Data (2022)*

From **Table 3.12,** it can be noted that from 2016/17 to 2021/22 the rate of allocation of collected fees in the country decreased from 6% in 2018/19 per cent to 3% in 2021/22.

However, it was noted that during the board meeting conducted in Q2 of 2017/18, there was a discussion to remind the registrar to complete the procedure for allocating the funds to respective LGAs based on the amount they collected. However, it was noted that at the end of the year no fund was allocated.

The audit team noted that in the fourteen (14) visited LGAs, only Ilala MC of the LGAs was noted to receive the remittance from PHAB for supportive supervision but noted to be only in 2021/22 while the rest of the visited LGAs there was no any amount of funds that was disbursed as remittance from the collected fees to facilitate supportive supervision.

d) RHMT did not Adequately Supervise their Respective CHMTs

The audit noted that RHMTs did not adequately conduct supportive supervision of their respective CHMTs as indicated in **Table 3.13.** This was contrary to the National Supportive Supervision for Quality Control Guideline of 2015 which states that RHMTs are supposed to conduct Quarterly supportive supervision to CHMTs at every quarter and submit reports to the Ministry of Health and PO-RALG.

The audit team noted that only the Dodoma Region managed to conduct supportive supervision in four quarter while the Mwanza and Dar es Salaam regions managed to conduct supportive supervision above 2 quarters annually. However, the remaining four (4) regions of Tabora, Kilimanjaro, Ruvuma and Mbeya managed to conduct supportive supervision in less than 2 quarters annually as shown in **Table 3.13.**

Table 3.13: Supportive Supervisions Conducted by RHMTs to CHMTs 2016/17-2021/22

Region	Expected Quarters for Supportive supervisions. (A)	Quarters of conducted Supportive supervisions in six years. (B)	Average quarter for supportive supervision annually (B/6 Years)	Percentage Conducted Supportive Supervision annually.
Average less than 4 times a year				
Dodoma	24	22	4	91
Dar es Salaam	24	20	3	63
Mwanza	24	15	3	63
Average less than 2 times a year				
Tabora	24	12	2	50
Kilimanjaro	24	6	1	25
Ruvuma	24	5	1	21
Mbeya	24	5	1	21

Source: *Auditors' Analysis from RHMTs' Supportive Supervision and Reports (2016/17- 2021/22)*

From **Table 3.13,** it shows that in the visited seven (7) regions the minimum percentage for supportive supervision was observed to be 21% in the Ruvuma and Mbeya regions and the maximum percentage for supportive supervision by RHMTs to CHMTs was 91 which was observed in the Dodoma region. Inadequate supportive supervision to CHMTs hindered the RHMTs in understanding on whether the CHMTs conducted visits to the respective Private and Voluntary Healthcare Facilities.

e) Inadequate Tracking of the Implementation of Supportive Supervision

According to section 4.1.1 of the National supportive supervision Guideline, 2017 it is stated that supervisors at the national level will have the major task of looking at how the health policy and policy guidelines are being translated into

achievable objectives at all levels. National level supervisors will primarily be responsible for supportive supervision of the National and supervise RHMTs.

However, section 2.3.1 of Functions of Regional Health Management System, 2014 on function for RHMTs on Plan and Report it is stated that it should prepare required reports and submit timely to PORALG and copy to MoHCDGEC as well as other relevant authorities.

The audit team noted through the interview with the Ministry of Health officials that all the information that was obtained from supportive supervision conducted at lower levels of LGAs and Regional level was not shared to the Ministry of Health.

The audit further revealed that Regional Health Management Teams (RHMT) did not submit supportive supervision reports on private and voluntary healthcare facilities to the Ministry of Health from 2016/17 to 2021/22. Despite the fact that the Private Healthcare Facilities were registered by the Ministry of Health (MoH), MoH did not get feedback on how the registered healthcare facilities are operating and this makes it difficult to track the implementation of the recommendations issued during supportive supervision.

The reasons for inadequate tracking of the implementation of supportive supervision include: -

(i) Overlapping Channel for Regulating Private Healthcare Facilities

The audit team reviewed the correspondence files and guidelines from CHMT, RHMT and the Ministry of Health to identify whether the reporting of supportive supervision is well channelled and noted that there was unclear channel of the supportive supervision reports toward the Ministry as shown in **Table 3.14.**

Table 3.14: Status of Registration and Supportive Supervision of PHF

Ministry	Registration of PHF	Responsible for supportive supervision	Plans, Budgeting and Funding	Reporting on Supportive Supervision
Ministry of Health	v	X	X	X
PO-RALG	x	CHMT, RHMT	V	V

Source: *Auditors' Analysis from the Ministry of Health, LGAs and Regional correspondences (2022)*

Key
V=Responsible for
X=Not Responsible for

Table 3.14 shows that the private healthcare facilities are registered by the Ministry of Health (MoH) but they were not involved in the information concerning the supportive supervision of the healthcare facilities.

However, it was noted that PO-RALG is responsible for total engagement with the conducted supportive supervision from a responsible team of supportive supervision, planning, budgeting, and funding and also reporting of the supportive supervision conducted from the lower level.

This could lead to the risk of lack of information and the actual status of the quality of health services provided by private healthcare facilities. None reporting of the supportive supervision reports hinders the Ministry of Health from receiving first-hand information on the state of the provision of healthcare services by private and voluntary healthcare facilities.

(ii) Lack of Reporting Mechanism by Healthcare Facilities to LGAs

National Supportive Supervision for Quality Control Guideline of 2015, Function of Regional Health Management Team Guidelines requires the Ministry of Health to record actions and decisions and continue ongoing monitoring of weak areas and improvements, follow-up on prior visits and problems of private and voluntary healthcare facilities.

According to Interviews with officials of Private Healthcare facilities, the reasons for inadequate reporting were due to lack of data collection tools such as registers and minimal training of Private Health personnel on data collection standards and requirements.

The administration of the respective facility was not aided with capacity building on how the reporting should have been done to the respective LGA and also, they are not provided with the essential formats and documentation tools for reporting the quality status of the private healthcare facility.

This hindered the respective LGA in monitoring the quality of healthcare services. It also affected the LGA on the inability of assessing the risk areas during planning on how they are going to conduct the supportive supervision instead of conducting it on a random basis.

3.5 Inadequate Inspection of Private and Voluntary Healthcare Facilities

According to the Private Hospitals (regulations) Act of 1977], the Ministry of Health is supposed to conduct inspection or cause to inspect Private and Voluntary Healthcare facilities to ensure compliance with the set standards and regulations. The Ministry of Health was supposed to conduct inspections through PHAB, PHLB and Pharmacy Council. The audit noted the following with regard to the inspection of private and voluntary healthcare facilities;

3.5.1 Low Coverage of Inspection to Private and Voluntary Healthcare Facilities

According to PHAB strategic plan 2016/17-2020/21, The Private Hospitals Advisory Board was supposed to ensure that 70% of the private and voluntary healthcare facilities were inspected annually.

The audits noted through the review of the private healthcare inspection reports that PHAB did not manage 70% of the planned Private Healthcare facilities.

Table 3.15 depicts the comparison between the number of registered Private Healthcare facilities and the number of inspected Private Healthcare Facilities on the annual basis.

The audit noted that from 2016/17 to 2021/22, PHAB did not manage to inspect 70% of the registered private healthcare facilities as per strategic plan 2016/17-2020/21. The percentage of inspected private healthcare facilities ranged between 0% and 52% as indicated in **Table 3.15** below.

Table 3.15: Inspections Conducted by PHAB in the Private and Voluntary Healthcare Facilities.

Financial Year	Cumulative Number of HCF Registered	Number of Inspected PHCF	Percentage (%)
2016/17	240	0	0
2017/18	481	248	52
2018/19	806	108	13
2019/20	1165	121	10
2020/21	1309	172	13
2021/22	1474	460	31

***Source**: Auditors' Analysis of PHAB inspection reports (2016/17-2021/22)*

From **Table 3.15,** it can be noted that the inspection was lower than the required number of inspections which made it possible for private healthcare facilities to operate without being inspected for a long period.

Private Health Facilities in Few Regions were Inspected

According to PHAB's strategic plan of 2016/17-2021/ 22, PHAB planned to conduct inspections of at least 9 regions annually. The audit noted through the review of inspection reports that PHAB did not manage to inspect at least nine (9) regions on annual basis. **Table 3.16** below depicts the regions which were visited by PHAB for inspection of Private healthcare facilities.

It can be noted that few regions were visited for inspections in which Private Healthcare facilities in twenty-three (23) regions had never been inspected from 2016/17-2021/22, while in the three (3 regions of Morogoro, Mwanza and Arusha were visited once and only Dar es Salaam regions were visited twice.

Table 3.16: Frequency of Inspection in Regions

Frequency	Number of Visited Region	Regions
0	23	Not visited at all
1	3	Morogoro, Arusha and Mwanza.
2	1	Dar es Salaam

***Source**: Auditors' Analysis from Inspection reports (2016/17-2021/22)*

From **Table 3.16,** it can be noted that Private Healthcare facilities in 23 regions had never been subjected to the inspection conducted by PHAB.

The audit further analysed the extent of inspection in the visited regions. **Table 3.17** depicts the extent of inspection of Private Healthcare facilities in the visited regions. The audit noted that only the Dar es Salaam region was inspected twice in 2019/20 and 2021/22 in which PHAB managed to conduct an inspection to all Private Healthcare facilities available in the regions.

Table 3.17: Trend of Inspection Conducted to Private Healthcare facilities in the Visited Regions

Region	Percentage of Inspected Facilities Annually					
	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Dodoma	0	0	0	0	0	0
Kilimanjaro	0	0	0	0	0	0
Dar es Salaam	0	0	0	100	0	100
Tabora	0	0	0	0	0	0
Ruvuma	0	0	0	0	0	0
Mbeya	0	0	0	0	0	0
Mwanza	0	0	0	0	0	66

***Source**: Auditors' Analysis of PHAB Inspection Reports (2016/17-2021/22)*

From **Table 3.17,** it can be noted that the trend of inspected private healthcare facilities in the visited regions was neither increasing nor decreasing in the visited regions. It can further be noted through the review of the submitted inspection reports that no inspection had ever been conducted by PHAB in Tabora, Ruvuma, Mwanza, Kilimanjaro, and Dodoma regions.

The audit further analysed the extent of inspection by PHAB in the visited LGAs.

Table 3.18 stipulates the frequency of inspection conducted by PHAB from 2016/17-2021/22 in the visited LGAs.

The audit noted that the visited healthcare facilities in Ilala CC and Temeke MC located in the Dar es Salaam region were visited twice while Mwanza CC and Misungwi DC were visited once and the rest of the Private healthcare facilities in the visited LGAs had never been subjected to the inspection conducted by PHAB.

Table 3.18: Frequency of Inspection Conducted by PHAB in LGAs

Name of the LGA	Frequency of Inspection 2016/17-2021/22
Temeke MC	Twice
Ilala CC	Twice
Mwanza CC	Once
Dodoma CC	Never
Igunga DC	Never
Kongwa DC	Never
Kyela DC	Never
Mbeya CC	Never
Misungwi DC	Never
Moshi DC	Never
Moshi MC	Never
Nyasa DC	Never
Songea MC	Never
Tabora MC	Never

Source: *Auditors' Analysis of the Inspection reports (2022)*

From **Table 3.18,** it can be noted that PHAB rarely conducted an inspection to private and voluntary healthcare facilities and thus there were healthcare facilities in LGAs that had never been subjected to inspections.

The following are the reasons for the Low Coverage of Inspections in Private and Voluntary Healthcare Facilities.

a) **Lack of Comprehensive Annual Inspection Plan**

The audit review noted through the review of the PHAB strategic plan that PHAB planned to inspect 70 per cent of the private healthcare facilities on annual basis. The audit noted through the review of submitted PHAB annual plans of 2019/20-2021/22 that the annual plans that indicated the coverage of inspection were not comprehensive.

The audit noted through the review of the PHAB annual plan that the plans did not set the inspection milestones/targets expected to be attained in a particular period of the year and also, lacked the set timeframes as to when inspections were expected, type of inspection to be conducted the extent of coverage and did not show which facilities were planned to be inspected.

Further, type of inspection means for inspection of the selected facilities and number of staff for conducting inspection were not identified the only information which was included in the developed annual plans was the regions to be visited and the budget set for the inspections.

b) Un-conducted Risk Analysis of the Private and Voluntary Healthcare Facilities

According to the Guidelines for Developing and implementing institutional Risk Management Framework in the Public Sector of 2012, the Ministry of Health is supposed to ensure that its activities including inspections are guided by adequate risk assessment procedures.

The Ministry of Health was supposed to ensure that it carries out a risk assessment on the compliance of Private and Voluntary healthcare facilities so as to understand the extent of noncompliance of each healthcare facility and use that information for planning of inspection of the healthcare facilities.

The audit noted that no risk analysis had ever been conducted during the planning for inspection by the Ministry of Health. Similarly, there was no planning that indicated that the private and voluntary healthcare facilities were ranked with the level of risks they posed.

Also, the Ministry of Health did not document its planning to show that it systematically took risk factors into account. Risk-based inspection planning would have significantly decreased inspections level for low-risk private and voluntary healthcare facilities without at least affecting the expectation of worsening the safety of patients.

c) Insufficient Enforcement Actions to Address Non-Compliance with the Statutory Requirement

According to the guidelines to establish and operate a private hospital of 2018, the Ministry of Health or any officer acting on behalf of the Board may suspend services either by permanent close, or temporary close and issue a warning of any Private hospital if the Board is satisfied that the facility has repeatedly violated the laws of the land and the requirements set during its registration.

The audit noted through the review of the inspection reports from PHAB inspection enforcement of non-compliance with statutory requirements was very minimal.

Table 3.19: Action Taken on Inspected Private Healthcare Facilities

Financial Year	No of HFC inspected	Number of Permanent closed HCF	Number of temporary closed	Warned
2016/17	0	0	0	0
2017/18	248	14	3	20
2018/19	108	-	-	-
2019/20	121	24	0	1
2020/21	172	12	10	39
2021/22	460	8	0	0

***Source**: Auditors' Analysis of PHAB Inspection Reports (2016/17-2021/22)*

From **Table 3.19,** it can be noted that **in** 2018/19 out of the one hundred and eight (108) Health Care facilities inspected no action was taken even a warning while in 2021/22 out of the four hundred sixty (460) inspected facilities no Healthcare facilities were even warned.

An interview conducted with the PHAB official pointed out that for the private health facilities not complied with the statutory requirement action taken like penalties and warnings were conducted but no evidence was issued to auditors.

3.5.2 Low Coverage of Inspection Conducted by PHLB

According to the Private Health Laboratory's strategic plan of July 2017 – June 2022, PHLB planned to ensure that 100% of registered Private Health Laboratories were inspected at least once a year through conducting of inspections at Zonal, Regional and District Levels.

The audit noted that the Private health laboratories Board did not manage to inspect 100% of the registered attached laboratories at least once annually from 2016/17-2021/22 as indicated in its strategic plans.

Table 3.20 stipulates the coverage of inspection on the attached Private Laboratories. The audit noted that in 2016/17 PHLB managed to inspect 6% of the registered private healthcare laboratories in 2017/18 no inspection was conducted in 2018/19 only 6% of the registered private in 2019/20 conducted 4%, in 2020/21 conducted 4% while in 2021/22 it only conducted 13% of the planned inspection the registered attached healthcare laboratories.

Table 3.20: Coverage of Inspections Conducted by PHLB in the Attached Private Laboratories Healthcare Facilities

Financial Year	Cumulative registered Attached Laboratories	Number of Inspected Attached Laboratories	Percentage Inspected Attached Laboratories
2016/17	1618	100	6
2017/18	1723	0	0
2018/19	1854	120	6
2019/20	1967	85	4
2020/21	2151	81	4
2021/22	2232	291	13

Source: *Auditors' Analysis of the PHLB Inspection Reports (2022)*

From **Table 3.20,** it can be noted that the percentage number of inspected Healthcare laboratories ranged between 6% and 13% from 2016/17-2021/22. The following were the reasons for the low coverage of inspection in the visited regions.

a) Lack of Comprehensive Annual Inspection Plan

The audit review noted through the review of the PHLB strategic plan that PHLB planned to inspect 100% of Private Health facilities laboratories.

The audit noted from the submitted PHLB annual plans of 2019/20-2021/22 that the annual plans that indicated the coverage of inspection were not comprehensive. The audit noted through the review of the PHLB that the annual plan did not set the inspection milestones/targets expected to be attained in a particular period of the year and also, lacked the set timeframes as to when inspections were expected, type of inspection to be conducted the extent of coverage and did not show which facilities were planned to be inspected.

Further, the type of inspection means for inspection of the selected facilities and the number of staff for conducting inspection was not identified, the only information which was included in the developed annual plans was the regions to be visited and the budget set for the inspections.

b) Un-conducted Risk Analysis of the Private Healthcare Laboratories

According to the Guidelines for Developing and implementing institutional risk Management Framework in Public sector 2012, the Ministry of Health is supposed to ensure that its activities including inspections are guided by adequate risk assessment procedures.

The Ministry of Health was supposed to ensure that it carries out risk assessment on the compliance of Private and Voluntary health care facilities so as to understand the extent of noncompliance of each healthcare facility and use that information for planning of inspection of the healthcare facilities.

The audit noted that no risk analysis had ever been conducted during the planning for inspection by the Private Healthcare Laboratories Board (PHLB). Similarly, the audit noted that there was no planning that indicates that the private and voluntary health care facilities were ranked with the level of risks they pose.

Also, the Ministry of Health did not document its planning to show that it systematically took risk factors into account. Risk-based inspections planning would have significantly decrease inspections level for low-risk objects, without at least expectation worsening the safety of patients.

c) No Collaboration was Observed Between PHAB and PHLB During the Inspections

The audit noted that there was no collaboration between different actors who regulate the private healthcare facilities. Despite the fact that both PHAB, PHLB and Pharmacy Council are under the Ministry of Health and regulate the private and voluntary and Healthcare facilities but there was no collaboration during the conduct of inspections.

This indicates that the inspections conducted by the Ministry of Health are fragmented as each supervising entity visited the Private and Voluntary healthcare facility on its own.

The reason given for the uncoordinated inspection was the lack of agreements on joint inspections between different supervising entities which could had helped the ministry in inspecting a large number of healthcare facilities using minimal available resources.

3.5.3 The Pharmacy Council did not Conduct the Inspections in the Attached Pharmacies

Section 52 (1) of the Pharmacy Act of 2011 indicates that the Pharmacy Council is responsible for inspecting all drug outlets and ensuring that they abide to rules and regulations.

Similarly, according to the Pharmacy Council Strategic plan of 2016/17-2020/21, the pharmacy council planned to ensure that 100% of registered Pharmacies are inspected at least once each year. These include the attached pharmacies and accredited drug dispensing outlets (ADDOS).

The audit noted through the review of inspection reports of the pharmacy council that it did not manage to conduct an inspection to 100% of the attached pharmacies from 2016/17 to 2021/22.

Similarly, the audit noted through the visits of the Private healthcare facilities in the regions and districts that none of the visited private and voluntary healthcare facilities was subjected to inspection by the Pharmacy Councils.

3.6 Inadequate Regulation of Prices of Medical Services Rendered by Private and Voluntary Healthcare Facilities

According to WHO, Price setting and price regulation in healthcare, Guidelines Price setting and regulation serve as instruments to control volumes of services while providing incentives for quality, coverage, and efficiency. The following were observed concerning the regulation of prices of medical services rendered by private and voluntary healthcare facilities.

3.6.1. Insufficient Control of Price Transparency of Medical Services

According to the Private Hospital Act of 1991, the Ministry of Health is supposed to conduct price checks and ensure that prices are posted in conspicuous places so they can be easily seen by patients. Transparent price information on the charges of private healthcare facilities was intended to help consumers to anticipate their health costs and reduce the possibility of unexpected expenses.

The audit noted that the Ministry of Health did not ensure that the price of medical prices were posted in conspicuous places in private and voluntary healthcare facilities as in **Photo 3.2**

Photo 3.2: Compliance of Price display. This Photo was taken at St. Joseph Hospital in Moshi MC showing the proper way of displaying the price for transparency to Patients.

Table 3.21 depicts the display of the Price of Medical Services in the visited healthcare facilities across regions.

The audit noted that the display of prices by private healthcare facilities differed across regions, in Tabora MC only 20% of the visited healthcare facilities displayed the prices while the healthcare facilities in Dar es Salaam displayed more prices in the conspicuous places by 65%.

Table 3.21: Extent of Price Display by Health Facilities Across Regions

Name of the Region	Number of visited PHCF	Number Displayed Prices	% of Private Healthcare facilities displayed Prices
Dar es s Salaam	20	13	65
Kilimanjaro	19	12	63
Dodoma	18	9	50
Ruvuma	17	9	50
Tabora	20	9	45
Mbeya	20	7	35
Mwanza	18	6	33

***Source**: Auditors' field observations (2022)*

Further, the audit analysed the display of prices in the visited districts. **Table 3.22** depicts the extent of the display of price in the visited healthcare facilities across LGAs.

Table 3.22: The Extent of Price Display of Medical Services Across LGAs

Name of the LGAs	Number of Health Facilities Visited	Number of Facilities displayed Prices	% of Private Healthcare facilities displayed
Moshi MC	10	7	70
Temeke MC	10	6	60
Ilala MC	10	7	60
Moshi DC	9	5	50
Mwanza CC	10	5	50
Dodoma CC	10	5	50
Kongwa DC	8	4	50
Mbeya CC	10	5	50
Songea MC	10	5	50
Nyasa DC	7	4	40
Igunga DC	10	4	40
Kyela DC	10	2	20
Tabora MC	10	5	20
Misungwi DC	8	1	13

***Source**: Auditors' field observations (2022)*

From **Table 3.22,** it can be noted that the number of facilities that displayed prices were higher in Ilala CC and Temeke MC located in Dar es Salam and lower in Misungwi DC located in the Mwanza region in which only 13% of the visited healthcare facilities displayed the prices for medical services rendered by Private and Voluntary Healthcare.

The audit noted that the reasons for not displaying prices were due to low enforcement of section 16(1) of the Private Hospital Act of 1991 which states that any person who is responsible for managing the private hospital and fails to display prices shall be guilty of an offence and shall be liable on conviction to a fine or imprisonment for a term not exceeding twelve months, the audit noted that none of the hospitals that did not display prices was subjected to that. Non-display of prices in a conspicuous place impacts the transparency of medical prices, and thus could result on unexpected price increases and unreasonable charges.

3.6.2 Monitoring of Medical Prices was Not Conducted

According to the Private Hospital Act of 1991, the Ministry of Health is supposed to monitor the prices of medical services charged by Private and voluntary healthcare facilities to generate reliable information on the price, availability and affordability of selected important medical services and price components with the ultimate goal of improving access to affordable health services for all.

The audit noted that the Ministry of Health's monitoring of prices for medical services was not conducted from 2016/17 to 2021/22. The audit noted that the last price monitoring of medical services was conducted as a survey by WHO/HAI in 2012. However, the audit noted that the survey was focused on prices of medicines only and not prices of other medical services such as consultations, diagnostics, surgery, and other medical services. This indicates that the Ministry of Health did not have information on the medical prices rendered by Private and Voluntary Healthcare facilities from 2016/17 to 2021/22.

Officials at the Ministry of Health and the visited LGAs pointed out price monitoring was conducted during the inspection and supportive supervision, however, the audit noted through the review of the available supportive supervision checklist, and supportive supervision reports that this was not always the case. The review of the inspection reports indicates that the Ministry only

crosschecked on the availability of displayed prices and not whether patients were charged the correct amount as displayed in the boards.

3.6.3 Non-reviews of Price Structure of Medical Services

Section 13(ii) of the Private Hospital Regulation Act of 1991 requires the Ministry of Health to review the prices structure of medical treatment rendered by private healthcare facilities may be reviewed either on a national or in any particular area or areas.

The audit noted that the price structure of medical treatment was not reviewed from 2016/17-2021/22. The audit noted through the interviews with officials at the Ministry of Health that the Ministry depends on the reviews of prices from the NHIF prices list as the guidance of the structure of medical services in the country.

However, the audit noted that the NHIF prices list was also not updated since July 2016 contrary to section 5.4.1 of the NHIF Quality Assurance Manual which required the health service committee to review the benefits package after every three years. Non- reviews of the price structures could result into consumers of health services to pay more for the services that do not reflect the dynamics of markets

3.7 Clinical Audits were Not Conducted to Private and Voluntary Healthcare Facilities

According to the guideline for Clinical Audits of National Guideline for Clinical Audit, version 1 of 2020 and the Ministry of Health strategic plan of 2016/17-2021/22, the Ministry of Health planned to ensure that the system for clinical audits is established to both public and private healthcare facilities. The audit noted the following with regards to the implementation of Clinical Audits in Private and Voluntary Health care facilities.

3.7.1. The Ministry of Health did not Adequately Conduct Clinical Audits to Private and Voluntary Healthcare Facilities

According to the Ministry of Health strategic plan of 2016/17 to 2021/22, the Ministry planned to conduct Clinical Audits in all healthcare facilities by June 2022. The clinical audits are conducted so as to ascertain the quality-of-care services provided by the healthcare facilities. The Ministry of Health was

supposed to conduct clinical audits to referral hospitals and other lower-level hospitals.

The audit noted that the clinical audits were not adequately conducted to private and voluntary health facilities. The audit review of the National Base line Clinical Audit report of July 2022, indicated that, the Ministry of Health conducted clinical audits to a selected Public healthcare facility, the Ministry of Health clinical audit covered all (5) five National Hospital, Mloganzila, KCMC, Muhimbili National Hospital, MOI and Bugando, (4) three National specialised hospital (Kibong'oto, Mirembe, JKCI and Ocean Road), 28 Regional Referral Hospital and 15 District Hospitals.

The following were the reasons for conducting clinical audits of Private healthcare facilities by the Ministry of Health: -

a) Lack of Long a Term Plan for Clinical Audits at the Ministry of Health

The audit noted, through the review of the Ministry of Health strategic plan 2016/17-2020/21, that even though the Ministry had planned to ensure that clinical audits were conducted in all healthcare facilities in the country, however there were no long-term strategies on how these could be achieved.

The audit reviews of the Curative Department Annual Plans from 2016/17-2021/22 revealed that there were no strategies set on achieving the envisioned goal of ensuring that all healthcare facilities in the country were subjected to clinical audits. Moreover, the audit noted, through the review of the Curative Department's budgets from 2016/17-2021/22, that the clinical audits were not budgeted for and as a result, the clinical audits remained uncertain.

b) Delays in Completion of the National Clinical Audit Guideline

The audit noted, through the reviews of the Ministry of Health Medium-Term Strategic Plan of 2016/17-2020/21, that the National Clinical Audit Guidelines were supposed to be completed in June 2018, but the guidelines were completed and signed in November 2020, which indicates the delays of almost two years. The delays in the completion of the clinical audit guidelines impacted the implementation of the clinical audit system because the guidelines were an important guiding tool in establishing the clinical audit system.

c) Non- functioning of National Steering Committees for Clinical Audits

According to the Guidelines for clinical Audits of 2020, the National Steering Committee for Clinical Audits was supposed to hold at least biannual meetings to execute its mandate. The audit noted that the National Steering Committee for Clinical Audits had never met to execute its mandate on clinical audits as no meeting minutes were availed to the audit team.

The impact of the non-functioning of the National Steering committee for Clinical Audit was such as failure to have effective coordination of clinical audits in the Health Sector.

3.7.2. Insufficient Conduct of Clinical Audits by CHMTS

According to the National Guidelines for Clinical Audits of 2018, the team of Auditors from District levels shall be responsible to audit health centres and dispensaries.

The audit noted that in the fourteen (14) visited CHMTs only the Ilala City Council conducted clinical audits at least once to private and voluntary healthcare facilities from 2016/17-2021/22. The audit noted that the Dar es Salaam City Council in collaboration with APHTA conducted clinical audits to 27 Private and Voluntary healthcare facilities from 19th October 2021 to 08th November 2021 equivalent to 978 of the available Private and voluntary healthcare facilities in Ilala.

Reasons for the Inadequate conduct of Clinical Audits to Private and Voluntary Healthcare facilities by CHMTs include the following:

a) Lack of Awareness of Clinical Audits at LGAs Levels

According to the Guidelines for Clinical Audits, the Ministry of Health was supposed to ensure dissemination of the developed Clinical Audit Guidelines. The audit noted that only two (2) out of the fourteen (14) Districts' Medical Officers were aware of the clinical audits, these LGAs were Ilala MC and Temeke MC. The audit reviews of the Curative Department Annual Reports indicated that the Curative Department had not conduct awareness to council with regards to clinical audits despite the fact that the Guidelines for Clinical Audit were developed in 2018.

b) Non Formation of Clinical Audit Teams at LGAs Levels

According to the Guidelines for Clinical Audit of 2020, Health Management Team of the Council/District Hospital shall form a Clinical Auditing Team that will be known as Internal Auditors within its jurisdiction. Therefore, the LGAs were supposed to ensure that these auditors conduct Clinical Audits within the LGAs. The Audit noted that none of the visited LGAs had identified and formed the clinical audit teams in their areas of jurisdiction. The reason for not forming clinical audit teams was the fact that clinical audits were not included in the Council Health Plans.

c) Non-Training of Clinical Auditors at LGAs Level

According to the National Guidelines for Clinical Audits, the RHMTs are supposed to ensure that they conduct clinical audits training to clinical auditors' facilities. The audit noted through the reviews of CHMTs Plans and Reports from 2016/17-2020/21 that CHMTs had not trained clinical auditors to conduct clinical audits at the LGAs levels which resulted in non-conduct of clinical audits.

d) Clinical Audits were Not Included in the Council Health Plans

The audit noted, through the reviews of Council Health Plans, that only Ilala City Council planned to conduct clinical audits from 2016/17-2021/22. Furthermore, the audit noted, through the review of the CHMTs Budget and Plans that the CHMTs did not budget for the conduct of clinical audits to all healthcare facilities including the private and voluntary healthcare facilities.

e) Clinical Audits were Not Mandatory

The audit noted, through the review of the Private Hospitals Act of 1991 and Guidelines for Operation of Private Hospitals of 2008, that the clinical audits were not mandatory to Private Healthcare Facilities. The audit further noted, through the review of Guidelines for Clinical Audits, that the conduct of clinical audits was not mandatory and thus private and voluntary healthcare facilities were not obliged to comply.

The consequences of not conducting Clinical Audits could be as follows: -

a) Failure to Eliminate Preventable Medical Errors at Health Facilities

According to the National Clinical Audit Guidelines of 2018, one of the objectives of clinical audits is to reduce and eliminate medical errors. According to WHO, the preventable medical error was an inaccurate or incomplete diagnosis or treatment of a disease, injury, syndrome, behaviour, infection, or other ailment. Medical errors are a serious public health problem and a leading cause of death in the world. Non-Conduct of Clinical Audits as a tool for quality improvement could impair the opportunity to learn for the purpose of improving and preventing medical errors.

b) Failure to Improve Quality of Healthcare Provided

According to the Guidelines for Clinical Audits of 2018, the aim of clinical audits is to improve the quality of clinical services provided by healthcare facilities and thus non- conduct of the clinical audits would results into gaps in addressing the quality of clinical care provided by the private and voluntary healthcare facilities.

From the Guidelines, the rationale for establishing the Clinical Audit System was to improve the quality of healthcare as suggested after the evaluation of the Star rating system done by Ifakara Health Institute in collaboration with Primary Health Care Performance Initiative (PHCPI) which suggested that the assessment and improvement of processes of care was a gap that was not well addressed in the star rating initiative. Thus, highlighting the need to have a Clinical Audit System in Place.

c) *Failure to Build the Culture of Adherence to Standards*

According to the Guidelines for Clinical Audits of 2018, clinical audits are supposed to be conducted as a way to find out if healthcare is being provided in line with standards. The clinical audits are also supposed to be conducted to enable care providers and patients to know where their service is doing well, and where there could be improvements. Non- conduct of clinical audits would not improve adherence to standards by Medical practitioners.

3.8 Inadequate Coordination of Regulatory Functions

Effective coordination between central level regulatory agencies, on the one hand, namely, PHAB, Medical Council of Tanganyika, Private Laboratories Board, Pharmacy Council and Tanzania Nursing and Midwifery Council, and on the other hand, the lower-level regulatory structures is essential for the efficient functioning of the decentralized regulatory system for private and voluntary healthcare facilities.

The audit noted that the coordination of regulatory framework was inadequate due to the following two factors:

a) No Established Forum to Bring Together all Key Players

The audit noted that there is no coordinated forum that bring together PHAB, PHLB, TNMC, MCT, and Pharmacy Council while regulating private healthcare facilities than each part fulfils its regulatory function separately.

Apart from that, according to interviews with Stakeholders form BAKWATA, APHFTA, SIKIKA and Tanzania Christian Social Services Commissions (CSSC), at National Level, there was no established forum that brings together the central level regulatory agencies i.e., PHAB, Medical Council of Tanganyika, Private Health Laboratories Board, Tanzania Nursing and Midwifery Council and Pharmacy Council to discuss regulatory matters and receive feedback on the implementation of delegated functions.

During verification, it was noted through interviews with personnel in the facilities that the regulatory authorities visited private health facility separately within a short period of time and issued different directives on the same issues. Lack of communication between key actors has been caused by non-priority on services provided by private health facilities specifically at dispensary and health centre level.

(b) No Established System for Organizing Routine Regulation Meetings

According to interviews with officials in the visited regions, the regulatory structures mainly depended on the memos and activity reports as a way of relaying information and obtaining feedback. However, during the audit verification in regions, LGAs and facility level, the audit noted that no report was left to councils or regional level covered what were observed during inspection

either by PHAB OR PHLB. By doing so constrains effective coordination and regulation of the private and voluntary healthcare facilities.

The notable risk on the lack of coordinated regulatory functions is contributing into the following;

Inadequate Information Exchange Between Public and Private Sectors

The audit team noted that the underpinning limited collaborative planning and service delivery coordination is a demonstrable lack of communication between public and private actors in all levels of the Health System.

Although forums and TWGs have been established to encourage collaborative dialogue, fundamental differences of approach and opinion limit the efficacy of multi-sectorial communication. Public sector informants perceive private actors (particularly those in the for-profit sector) as uncooperative and solely focused on profit motives, and several private actors expressed a desire for public actors to acknowledge their contributions to the public good.

3.8.1 Inadequate Involvement of Private Healthcare Facilities in the Preparation of the Comprehensive Council Health Plan (CCHP)

Health Sector PPP Policy Guidelines of 2013 and CCHP Guidelines of 2011 require councils to involve private healthcare facilities during the planning and budgeting on the implementation of Comprehensive Council Health Plans. During the auditing verification which involved review of documents on selected LGA's and private health facilities level, it was noted that private health facilities were invited every financial year but not attending. The audit team asked for the evidence on the involvement of Private health facilities, few LGAs were able to avail the evidence as indicated in the **Table 3.23**.

Reviewed minutes prepared during CCHP revealed that there was inadequate involvement of the private sector in the preparation of Comprehensive Council Health Plans (CCHP) as it was not done consistently.

Table 3.23 revealed the rate of LGAs involving the private healthcare facilities during preparation of the Comprehensive Council Health Plans ranged between 17% in Moshi DC to 50% in Temeke MC. The audit noted that there were no

correspondences from private healthcare facilities on the involvement during preparation of CCHP as no evidence was availed.

Table 3.23: Involvement of the Private Sector in Preparation of CCHP (2016/17-2021/22)

Name of the LGA	Number of Prepared Plans	Frequency PHF involvement	Percentage OF Involvement
Temeke MC	6	3	50
Ilala CC	6	2	33
Igunga DC	6	2	33
Moshi MC	6	1	17
Moshi DC	6	1	17
Kongwa DC	6	1	17
Tabora MC	6	1	17
Misungwi DC	6	0	0
Mwanza	6	0	0
Nyasa DC	6	0	0
Songea MC	6	0	0
Dodoma CC	6	0	0
Mbeya CC	6	0	0
Kyela DC	6	0	0

***Source**: Auditors' Analysis from CCHP Preparation Minutes (2022)*

According to interviews with officials in the visited LGAs, the reason mentioned was lack of any help they received from government. In addition to that, it was said that they were cancelled due to minimal number of participation and sometime not appeared at all private healthcare facilities in preparation CCHP, thus, they decided not to send the invitation to private healthcare facilities.

Inadequate involvement of private healthcare facilities in the Preparation of the Comprehensive Council Health Plan could affect the availability of medical services like provision of vaccination and Reproductive and Child Health (RCH), where the government tends to provide for private healthcare facilities and asked for that help, there is high interaction between the government and private healthcare facilities.

3.8.2 Inadequate Reporting of Private Healthcare Facilities to LGAs

According to the Health Sector Strategic Plan (HSSP IV) of July 2015 – June 2020, the private healthcare facilities are supposed to provide quarterly reports to LGAs.

Private healthcare facilities were required to submit reports on the status of the daily health operation to the LGAs. The review of annual reports from the visited LGAs level noted that healthcare facilities did not submit their reports to the PHAB coordinators at the District level to the District Laboratory Technologists and Pharmacists in their respective LGAs.

According to Interviews with officials of Private Healthcare facilities in the visited LGAs, the reasons for inadequate reporting was that they were unaware of the requirement of reporting.

CHAPTER FOUR

AUDIT CONCLUSION

4.1 Introduction

This chapter presents conclusions of the audit categorized in two main parts namely, overall conclusion and specific audit conclusions. The conclusions are based on both the overall and specific objectives of the audit presented in Chapter One of this Performance Audit Report.

4.2 General Conclusion

The audit concludes that, the Ministry of Health has not adequately regulated the Private and Voluntary Healthcare facilities. The Ministry has not ensured that the Provision of Healthcare services provided by Private and Voluntary healthcare facilities is of good and acceptable quality.

The regulatory functions such as procedures for registration, supportive supervisions, inspections, regulations of prices are not well functioning as intended. Moreover, the Ministry of Health's coordination and reporting mechanisms for its regulatory functions are not functioning as they are supposed to function which has, to large extent, affected the quality of healthcare services provided by Private and Voluntary Healthcare Facilities.

The weaknesses on the regulations of the Private and Voluntary Healthcare Services have been noted to be more than 80% as the Private and Voluntary healthcare facilities have failed to attain 3 stars in the provision of healthcare services, which is an indication that the quality of healthcare services provided by these facilities are not at the level envisioned by the Ministry of Health.

The pharmaceutical services in the attached private and voluntary healthcare facilities are not at the required standards in which between 70% and 100% of the facilities across LGAs have weaknesses such as unregistered pharmacies/ drug shops, lack of registered professionals to administer drugs and inadequate storage facilities and infrastructures. On the other hand, the weaknesses of the regulatory function have resulted into Private and Voluntary Healthcare Facilities to operate with insufficient number of Health workers which ranged between 43% and 73% across each cadre.

Furthermore, the processes and procedures for the registration of healthcare facilities are not functioning as pre inspections are not timely conducted, lack of standard timeliness for registration of healthcare facilities and delays in issuing notification letters.

Supportive supervision to Private and Voluntary Healthcare facilities have been noted not to function so well. This was also coupled by the fact that inspections of private and voluntary healthcare facilities were not adequately done contrary to the requirements.

Moreover, the Ministry of Health has not put sufficient efforts into regulating the prices of medical services charged by the Private and Voluntary Healthcare facilities and it only focuses on the ensuring that the prices are displayed on boards.

4.3 Specific Conclusions

4.3.1 The Ministry of Health's Process and Procedures for Registration are not Functioning Adequately

The Ministry of Health's process and procedures for registrations are not functioning adequately. There has been delays in registration of private and voluntary healthcare facilities due to delays of issuing notification letters and registration certificate to applicants. The variation in the approval of the registered facilities from application varied considerably across the private and voluntary healthcare facilities, regions and LGAs. There is no established standard timeliness for the registration due to lack of client service charter and ineffectiveness of the established online system.

Similarly, the Pre inspections of the applications for registration of Private and Voluntary healthcare facilities are not sufficiently and adequately done, which resulted into a huge number of applications to be corrected at higher level.

The Ministry of Health has not managed to ensure that Private healthcare facilities renew their license on a timely manner and after consideration of their applications which resulted into facilities operating without valid licenses.

4.3.2 Supportive Supervisions to Private and Voluntary Healthcare Facilities are Not Adequately Done

The supportive supervision to Private and Voluntary Healthcare facilities are not adequately done. The CHMTs and RHMTs have not managed to conduct supportive supervision to Private and Voluntary Healthcare facilities at least once each quarter. The CHMTs have not managed to visit each healthcare facility periodically and as a result the Ministry of Health does not have information on the quality of healthcare services provided by the Private and Voluntary Healthcare facilities.

Also, there is inadequate reporting by CHMT to RHMT and Ministry of Health on the visited healthcare facilities such that the observations basing on the supportive supervision are reaching the responsible authority for Private and Voluntary Healthcare facilities which is the Ministry of Health.

Furthermore, there is no adequate measure taken to the repeated weaknesses observed during the frequent visits conducted by CHMT as the RHMTs report directly to PORALG, thus making it difficult for the Ministry of Health in understanding the challenges in the provision of Healthcare services by Private and Voluntary Healthcare Facilities.

4.3.3 Inspections to Private and Voluntary Healthcare Facilities are Not Adequately Done

The Ministry of Health has not managed to adequately conduct inspection to Private Healthcare facilities. The coverage of the inspection has been minimal, and few private and voluntary healthcare facilities have been visited over the years. The Ministry has not managed to ensure that Private Hospitals Advisory Board conducted inspection to at least 70% of the private and voluntary Healthcare.

The Ministry of Health has not attained its objective of ensuring that all the Private Health laboratories are inspected annually, and this has resulted into jeopardising the quality of healthcare services provided by Private Healthcare facilities this was due to the fact that the Ministry of Health's inspection plans were not risk based, fragmented inspections by Boards and LGAs responsible for inspecting private and voluntary healthcare facilities.

4.3.4 The Ministry of Health has Not Adequately Regulated the Prices of Medical Services Charged by Private and Voluntary Healthcare Facilities

The Ministry of Health has not adequately regulated the prices of medical services charged by Private and Voluntary Healthcare facilities as it has ineffectively managed to ensure that prices are displayed in a conspicuous place to enhance the transparency of medical prices so as to protect unexpected price increase and unreasonable charges. The Healthcare facilities that have displayed prices ranged between 13% to -70% across the visited LGAs.

On the other hand, the Ministry of Health has not conducted monitoring of prices of the services rendered by the Private and Voluntary healthcare facilities. During supportive supervision and inspection, the prices are not adequately as the only variable that is crosschecked is the availability of displayed prices and not whether patients were charged the correct amount as displayed in the boards. Moreover, the Ministry of Health has not reviewed the prices' structure rendered to medical services. This depends on the NHIF price lists which are not timely reviewed and they only cover a small segment of population with NHIF cards.

4.3.5 The Ministry of Health has Not Adequately Conducted Clinical Audits to Private and Voluntary Healthcare Facilities

The Ministry of Health has not adequately conducted Clinical Audits to Private and Voluntary Healthcare Facilities. MoH has not conducted clinical audits to private and voluntary healthcare facilities despite having the plan to conduct clinical audits to all private and voluntary healthcare facilities. MoH has no long-term plan for clinical audits, uncertain of the budget to implement clinical audits, and the National Steering Committee for clinical audit is not functioning.

On the other hand, LGAs have inadequately implemented clinical audits. The LGAs have not formed the clinical audit teams in order to train them on the implementation of clinical audits. The clinical audits are not mandatory, and LGAs have not included them in the Council Health Management Plans and Budgets. This has an impact in the quality of healthcare provided as Private Healthcare facilities will not be able to eliminate preventable medical errors for improving the quality of the provided clinical services.

CHAPTER FIVE

AUDIT RECOMMENDATIONS

5.1 Introduction

The audit findings and conclusions pointed-out weaknesses on the regulation of private and voluntary healthcare facilities. The areas that need to be improved were related to strategies and plans, capacity, regulation and monitoring and evaluation for provision of better healthcare services.

Therefore, this chapter provides recommendations to the Ministry of Health and their respective councils and boards responsible for regulation of private and voluntary healthcare services.

The National Audit Office believes that based on the principles of 3Es of Economy, Efficiency and Effectiveness, these recommendations need to be fully implemented to ensure improvements of community health.

5.2 Recommendations to the Ministry of Health

5.2.1. To Improve Registration of Private and Voluntary Healthcare Facilities

The Ministry of Health is urged to:

1. Strengthen the Registration System by ensuring that each stage of registration of Private Healthcare facility is allocated with standard time for completion and ensure that all actors abide to the set timeliness.

5.2.2. To improve Inspection of Private and Voluntary Healthcare Facilities

The Ministry of Health is urged to:

1. Develop a long-term comprehensive risk-based inspection plan through institutionalized compliance risk assessment of each registered private and voluntary healthcare facility and use that as the basis for conducting inspections.

5.2.3. To Improve Supportive Supervision to Private and Voluntary Healthcare Facilities

The Ministry of Health is urged to:

1. Regularly track the payment of fees and allocate a percentage of the collected fees based on agreed terms to RHMT and CHMT (Council Health Management Teams) to aid in supportive supervision of the Private and Voluntary healthcare facilities at lower levels.

2. In collaboration with PO-RALG strengthen the mechanism to plan, conduct and receive feedback on the supportive supervision conducted to Private and Voluntary Healthcare Facilities at lower levels.

5.2.4. To Improve Clinical Audits to Private and Voluntary Healthcare Facilities

The Ministry of Health is urged to:

1. Strengthen the Clinical Audit System and ensure that the Clinical Audits are mandatory, planned and implemented to Private and Voluntary Healthcare facilities.

5.2.5. To Improve Regulation of Prices Private and Voluntary Healthcare Facilities

1. Devise a mechanism for periodical reviews of Prices rendered by Private and Voluntary Healthcare Facilities.

5.2.6. To Improve Coordination of Regulatory Function of Private and Voluntary Healthcare Facilities

The Ministry of Health is urged to:

1. Establish a mechanism for effective implementation of regulatory activities through enhancement of the collaboration among different actors involved in regulation of Private and Voluntary Healthcare facilities and reduce duplication of efforts and fragmentations.

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APPENDICES

Appendix 1: Responses from the Ministry of Health

This part covers the responses from the Ministry of Health. The responses are divided into two parts namely general comment and specific comments from the Ministry of Health These responses are prescribed below:

General Comment

Ministry of Health appreciates on comments made by the Audit Team from CAG which of their objective is to improve performance of responsibilities for development of quality healthcare services. We promise to work on the auditors' observations shortfalls for future betterment of healthcare services provision.

Specific Comments

S/N	Recommendation to the Ministry of Health	Comments from Ministry of Health	Planned Actions	Implementation Timelines
1.	Strengthen the Registration System by ensuring that each stage of registration of Private health facility is allocated with standard time for completion and ensure that all actors abide to the set timeliness.	MOH agrees with auditors' observation on the delay of registration of health facilities. HFRs system for health facility management was developed in 2021 to improve the registrations. Time for registration and the availability of data for use in the ministry of health has been improved though we still have some challenges to work on; a. Most of the health	The Office of Registrars Private Hospitals is preparing Standard Operating Procedure with time allocation.	30th March, 2023.

S/N	Recommendation to the Ministry of Health	Comments from Ministry of Health	Planned Actions	Implementation Timelines
		facilities applications are sent to the Registrar with a lot of gaps which were not identified by the lower levels. (RMO and DMO) b. The applications must be approved by Board meetings which are conducted quarterly. Due to un avoidable reasons sometimes the date of meeting is postponed.		
2.	Develop a long-term comprehensive risk-based inspection plan through institutionalized compliance risk assessment of each registered private and voluntary healthcare facility and use that as the basis for conducting inspections.	MOH agrees with auditors' recommendation to develop a long-term comprehensive risk-based inspection plan.	Develop a long term comprehensive risk based inspection plan.	30th June, 2023.

S/N	Recommendation to the Ministry of Health	Comments from Ministry of Health	Planned Actions	Implementation Timelines
3.	Regularly track the payment of fees and allocate a percentage of the collected fees based on agreed terms to RHMT and CHMT (Council Health Management Teams) to aid in supportive supervision of the Private and Voluntary healthcare facilities at lower levels.	MOH agrees with auditors' observation on delay of return of 10% annual fees to the health facilities. However, the ministry reports that, before the closure of the financial year the payment for this fund is issued and a total of 20,714,000/= and 19,772,000/= TZS returned to the facilities by 2020/21 and 2021/22 respectively. RETURN 10% PRIVATE FACILITIES.xlsx. We are aware of the previous recommendations that this amount is not adequate and efforts are underway to review the amount.	The amount was reviewed and increased from 10%- 30%.	Implemented
4	In collaboration with PO-RALG strengthen the mechanism to plan, conduct and receive	MOH agrees with auditors' recommendation to develop a	Develop a long-term comprehensive risk based	30th June, 2023.

S/N	Recommendation to the Ministry of Health	Comments from Ministry of Health	Planned Actions	Implementation Timelines
	feedback on the supportive supervision conducted to Private and Voluntary Healthcare facilities at lower levels.	long-term comprehensive risk-based inspection plan.	inspection plan.	
5	Strengthen the Clinical Audit system and Ensure that the Clinical audits are mandatory and conducted to all Private and Voluntary Health care facilities.	MOH agrees with the auditors on the inadequate clinical audit for the private health facilities. We also agree that CA is important for improving the performance of these facilities. CA has been performed to National, Zonal, Special, Regional and few selected District Hospitals.	We have a plan to scale up this process to other facilities including private.	2023/2024
6.	Devise a mechanism for periodical reviews of prices rendered by private and voluntary healthcare facilities to enhance price transparency and accountability	MOH agrees with auditors' recommendation to Devise a mechanism for periodically and reviews of prices rendered by private and voluntary healthcare facilities to enhance price transparency and accountability	PHAB have set an agenda in the upcoming board meeting to discuss the current fees provided in Private health facilities and advice the MOH for improvement.	2023/24

S/N	Recommendation to the Ministry of Health	Comments from Ministry of Health	Planned Actions	Implementation Timelines
7.	Establish a mechanism for effective implementation of regulatory activities through enhancement of the collaboration among different actors involved in regulation of Private and Voluntary Healthcare facilities and reduce duplication of efforts and fragmentations.	MOH agrees with auditors' recommendation to establish a mechanism that for effective implementation of regulatory activities through enhancement of the collaboration of different actors involved in regulation of Private and Voluntary Health care facilities and reduce duplication of efforts and fragmentations	Set meeting with Health Partners and set standards to enable reduce duplication of efforts and fragmentations.	30th June. 2023.

Appendix 2: Audit Questions and Sub-Questions

This part provides details for the questions which were involved during the Audit.

Audit Main and Sub-Questions

Audit Question 1	**To what extent do Private and Voluntary Healthcare facilities Provide Quality Healthcare Services to Citizens?**
Sub-question 1.1	Are private and voluntary healthcare facilities meet the required Standards to ensure quality healthcare services?
Sub-question 1.2	Does MoH ensure that private and voluntary healthcare facilities have adequate and qualified medical personnel to enhance quality?
Sub question 1.3	Do the private and voluntary healthcare facilities have adequate and appropriate infrastructures for provision of quality healthcare services?
Audit Question 2	**Do MoH ensure that Private Healthcare facilities are adequately registered?**
Sub question 2.1	Are private and voluntary healthcare facilities timely registered?
Sub question 2.2	Are the verification processes effective to ensure that only private and voluntary healthcare facilities that meet Standards are registered?
Sub question 2.3	Are private and voluntary healthcare facilities timely renewing their registration and operating licences?
Sub question 2.4	Are the registration and licences fees for private and voluntary hospitals adequately collected?
Audit Question 3	**Are supportive supervision to Private and Voluntary Healthcare facilities effective to ensure Provision of Quality Healthcare Services?**
Sub-question 3.1	Do MoH implementation of supportive supervision to private and Voluntary healthcare facilities to enhance quality of healthcare services?
Sub-question 3.2	Is there a well-functioning feedback mechanism with regards to supportive supervision undertaken to private and voluntary healthcare facilities?
Sub-question 3.3	Is there an effective process to monitor and evaluate the conduct of supportive supervision to private and voluntary healthcare facilities at lower levels?
Sub-question 3.4	Is there an effective coordination mechanism MoH with other stakeholders during implementation of supportive supervisions?

Audit Question 4	**Are the MoH Inspections to Private and Voluntary Healthcare facilities effective to ensure Provision of Quality Healthcare Services?**
Sub-question 4.1	Are the inspection plans and priorities informed by adequate risk assessments?
Sub-question 4.2	Do MoH adequately implement the planned inspections to enhance quality of private and voluntary healthcare services?
Sub-question 4.3	Do the MoH take appropriate enforcement actions to address non-Compliance with statutory requirement?
Sub-question 4.4	Are the inspections conducted by MoH effective in enhancing quality of healthcare of private and voluntary healthcare facilities?
Audit Question 5	**Do the MoH adequate regulates the Prices of medical services charged by Private and Voluntary Healthcare facilities to enhance Quality?**
Sub question 5.1	Do private healthcare facilities charge maximum determined prices to ensure affordability of healthcare services in private and voluntary healthcare facilities?
Sub-question 5.2	Has the MoH regularly monitor the prices of Medical Services charged by private and voluntary healthcare facilities?
Sub Question 5.3	Are private and voluntary healthcare facilities applying for charging the maximum prices than the already determined prices?
Sub-question 5.4	Has the price structure of medical treatment rendered by private and voluntary healthcare facilities regularly reviewed?
Sub-question 6	**Does MoH ensure effective coordination of Regulatory function?**
Sub-question 6.1	Does MoH established and implemented effective mechanism for coordinating key stakeholders on development of CCHP?
Sub-question 6.2	Is the private healthcare facilities timely reporting to CHMT?

Appendix 3: Reviewed Documents

This part provides details on the documents that were reviewed and the reasons for review.

Category	Name of Document	Reasons
Strategic Plans	MoH, PHAB, MCT, Pharmacy Council, MCT Regional and Districts Strategic Plans 2016/17-2021/22	To examine strategies on interventions on provision of Healthcare services by Private and Voluntary Providers
Annual Plans	MoH, PHAB, MCT, Pharmacy Council, Medical Council, RHMT and CHMT Regional Regional and districts Annual Plans (206/17-2021/22	To examine strategies and interventions on regulation of Heath care Service by Private and Voluntary facilities on a yearly basis.
Annual Implementation Reports (2015/16-2021/22)	MoH, PHAB, MCT, Pharmacy Council, Medical Council, RHMT and CHMT Regional and Districts Annual Implementation Reports 20116/17-2021/22	To evaluate progress of implementation of the planned activities relating to regulation of Healthcare Services by Private and Voluntary facilities
Annual budgets and budget implementation reports	MoH, PHAB, MCT, Pharmacy Council, Medical Council, RHMT and CHMT Annual Implementation Reports 2016/17-2021/22	To examine the implementation of activities related to regulation of Private and Voluntary Care Services by Private and Voluntary facilities
Research reports and Publications	Review and assessments reports on regulation of private Healthcare facilities Healthcare Services by private and Voluntary Healthcare Services by research institutions	To be acquainted with the results of research conducted on regulation of Healthcare Services by Private and Voluntary Healthcare facilities
Monitoring and Evaluation Reports	MoH, PHAB, MCT, Pharmacy Council, Medical Council, Regional and Districts monitoring and Evaluation reports 2016/17-2021/22	To evaluate the progress made on the implementation of the planned activities regarding provision of Healthcare services by private and voluntary Healthcare Service providers in the country.

Category	Name of Document	Reasons
Supportive supervision reports	MoH, RHMT and CHMT supportive supervision reports 2016/17-2021/22	To evaluate on the implementation of the planned supportive supervision regarding provision of Healthcare services by private and voluntary healthcare service providers in the country.
Registration reports and files	Private healthcare facilities registration reports 2016/17-2021/22	To evaluate registration of Private healthcare facilities such as timeliness, annual renewal of licences
Inspection Reports	MoH, RHMT and CHMT Pharmacy council inspection reports 2016/17-2021/22	To evaluate on the implementation of the planned inspection regarding provision of healthcare services by private and voluntary healthcare service providers in the country.

Source: *Auditors' Analysis on Documents Reviewed (2022)*

Appendix 4: Persons Interviewed and reasons for the Interviews

This part provides details on the interview persons and why they were interviewed.

Institution	Official Interviewed	Reason(s) for Interviewing them
Ministry of Health	Director of Human Resource Development (DHR)	To assess the effectiveness and efficiency of the development of Health Sector Development such as
	Director of Health Quality Assurance (DHQA)	To examine the effectiveness and efficiency of Quality Assurance mechanism to Private and Voluntary Healthcare facilities
	Chief Pharmacist (CP)	To assess the efficiency and effectiveness of the regulation of pharmacies within the Private healthcare facilities.
	Director of Policy and Planning (DPP)	To assess the value for money of the activities related to regulation of private and voluntary healthcare facilities
	Private Hospitals Board Private Healthcare facilities Registrar	To assess the efficiency and effectiveness of the regulation of the private healthcare facilities
	Private Health Laboratories Registrar	To assess the efficiency and effectiveness of the regulation of the private health laboratories within the healthcare facilities
	Registrar of Pharmacy Council	To examine the Registration and licensing of pharmaceutical personnel and premise

Institution	Official Interviewed	Reason(s) for Interviewing them
		within the private and voluntary healthcare facilities
	Registrar of Pharmacy Council	To examine the Registration and licensing of medical personnel within the private and voluntary healthcare facilities
	Director of Curative Services (DCS)	To examine the effectiveness and efficiency of the regulation of private and Voluntary healthcare facilities at District level
Private and Voluntary Healthcare facilities Managements	Private Healthcare facilities Directors and Managers	To examine the effectiveness of the regulation of private and voluntary healthcare facilities by MoH.
President's Office Regional Authorities and Local Governments	Regional Health Management Team which comprises of Regional Nurse, Regional Medical Officer, Regional Pharmacist and Regional Laboratories	To examine the effectiveness and efficiency of the Regulation of private and voluntary healthcare facilities at regional level
	Districts Health Management Team District Nurse, District Medical Officer, District Pharmacist and District Laboratory Technologist	To examine the effectiveness and efficiency of the regulation of private and Voluntary healthcare facilities at District level

Source: *Auditors' Analysis on Interviewed Officials (2022)*

Appendix 5: Chronology of Decisions Aimed to Improve the System for Regulating Private Healthcare Facilities in the Country

This part presents the chronological decisions Aimed to improve the system for regulating private healthcare facilities in Tanzania per specific year.

Year	Decision	Objective of Document/Decision
2018	Guidelines to Establish and Operate a Private Hospital, 2018 were issued	To assist stakeholders who wish to establish and operate private hospitals or those who wish to understand how private hospitals can be established and operated in mainland Tanzania
2017	Standard Treatment Guidelines and National Essential Medicines List Tanzania Mainland-Review were issued	To provide changes in the management of various diseases following recommendations from WHO and experts from local and international medical associations and agencies
2017	Basic Standards for Healthcare facilities-Volume I Household and Community Level were issued	To Guide establishment of Community/ Household Level
2017	Basic Standards for Healthcare facilities-Volume 2 Dispensaries, Health Centres, Stand Alone Dental Clinics and Rehabilitation Medicine facilities were issued	To Guide establishment of Dispensary; Health Centre; Standalone Dental Clinic (run by Dental Therapist, ADO); and Standalone Rehabilitation Medicine facilities (Physiotherapy, Prosthetics and Orthotics, Occupational Therapy, and Speech and Language Therapy) Level
2017	Basic Standards for Healthcare facilities -Volume 3 Hospitals at Level I & II and Stand-Alone facilities at Level I & II were issued	To guide establishment of Level II Hospitals and I; Level 1 Clinics (Medical Clinic, GP-Clinic, Polyclinics, comprehensive Dental Clinic run by MO, DO, etc.); and Level 2 Clinics (Specialised Clinics Run by Medical Specialists).
2017	Basic Standards for Healthcare facilities -Volume 4 Hospital at Level III & IV and Specialised Clinics at Level III were issued	To Guide establishment of Level III and IV Hospitals; and Level 3 Clinics (run by Super Specialists)
2013	Standard Treatment Guidelines (STG) and National Essential	To provide health practitioners with standardized guidance in

Year	Decision	Objective of Document/Decision
	Medicines List Tanzania (NEMLIT) were issued	making decisions about appropriate healthcare for specific conditions found in Tanzania
2009	Health Sector Strategic Plan July 2009–June 2015 (HSSP III) was developed and approved	Provides an overview of the priority strategic directions across the sector which are guided by the National Health Policy, Vision 2025, the National Programme for Economic Growth and Poverty Reduction (MKUKUTA in Kiswahili) and the Millennium Development Goals.
2008	Human Resources Strategic Plan was prepared	To guide the health sector in proper planning, development, management and effective utilization of human resource
2007	Health Laboratory Practitioners No. 22 was issued	To Provide for Registration and Regulation of Health Laboratory Practitioners
2007	Health Policy was developed	To facilitate the provision of basic healthcare services that are of good quality, equitable, accessible, affordable, and sustainable and gender sensitivity
2006	Joint Assistance Strategy for Tanzania was prepared	National medium-term framework for managing Development co-operation between the Government of the United Republic of Tanzania (Government) and Development Partners so as to achieve national development and poverty reduction goals.
2002	National Health Insurance Fund (NHIF) was established	Ensuring accessibility of healthcare services to people
1999	Poverty Reduction Strategy (PRS) identifies health as a priority	To provide Medium-term strategy of poverty reduction, developed through broad consultation with national and international stakeholders, in the context of the enhanced Highly Indebted Poor Countries (HIPC) Initiative
1999	Health Sector Reform Program of Work (1999 – 2002) was developed and approved	Designed to improve functioning and performance of the health sector and ultimately the health status of the population.
1999	Health Basket Fund was Introduced	It pools donors and Government funds to pay for long-term improvement in the

Year	Decision	Objective of Document/Decision
		health sector and supports the implementation of the Health Sector Strategic Plan-IV (2015-2020)
1998	Agreement to enter a SWAP programme in Health was enacted	Approach addresses all areas in the health sector including those already identified in the Health Reform Programme and ensured that both government and donor funds are used to agreed priorities and health financing is delivered in an more effective and efficient manner using common implementation arrangements
1997	Enactment of Private Health Laboratory Registration No.10 Act, 1997	To regulate the registration and management of private health laboratories managed by approved persons and in respect of health laboratory services to be rendered by private laboratories
1994	Proposal for Health Sector Reform Agreement to Enter a SWAP programme in Health was developed and approved	To develop a number of median term programmes of work (POW) and annual plans of action (POA)
1993	Government/Development Partners Appraisal Mission on the Health Sector was conducted	Sector Wide Approach to collaborative development work in the health sector has resulted in greater sector coherence and consistency
1991	The Private Hospitals (Regulations)(Amendment)No.26 Act which recognised the role of Private Sector and Voluntary Health (*The Liberalization of Private Healthcare Provision*) was enacted	To make provision for the management of private hospitals by individuals and organisations.
1990	The First National Health Policy was issued	Focus on reduction of infant and maternal morbidity and Mortality; ensuring equitable access to healthcare services; self-sufficiency in human resources for health; community, involvement for health promotion and disease prevention; multi-sectorial, collaboration. in

Year	Decision	Objective of Document/Decision
		Addressing health) issues and the responsibility of the family and individuals on one's health.
1977	Enactment of the Private Hospitals (Regulations) Act, No.6 1977	To make provision to restrict the management of private hospitals to approved organizations, to control fees and other charges payable in respect of medical treatment and other services rendered by private hospitals, to regulate scales of emo-luntents payable to medical Practitioners employed at private hospitals, and to make other provisions connected with those Matters