REPORT OF THE DPG HEALTH RETREAT

WEDNESDAY 2ND OCTOBER 2019

DOUBLE TREE HOTEL, DAR ES SALAAM

REMARKS BY DEPUTY PS-HEALTH, PORALG

The Deputy Permanent Secretary (PS), President's Office-Regional Administration and Local Government (PORALG), Dr. Dorothy Gwajima made a few remarks to the DPG H about Accountability issues. She appreciated partners support to the Government to ensure improved health outcomes. She noted that there are so many things which have been done on the ground on the six health systems building blocks, but the performance is still poor. For example, she mentioned poor utilization of public sector facilities, and that even while the government is investing in public sector facilities, people are attending at private sector facilities. This shows that there is a problem which has not been realized. Do we have a monitoring system to track how service delivery is conducted at the health facilities? RHMTs and CHMTs do supportive supervision but they do not see these problems. We have leadership and governance problem to monitor what is happening in the health facilities. Until we do like what was done in Makole health centre, we will not be able to improve the service delivery. The Deputy PS was able to introduce 90 days of change at the Makole health centre after realizing poor service delivery at the facility.

1. MAKOLE MODEL FOR ACCOUNTABILITY (PORALG)

From the presentation, several issues were identified which contributed to poor service delivery at the Makole health centre (HC). Among others were: ineffective ward rounds, absenteeism, poor nursing care, poor division of labour, corruptive practices, long queues, etc. Most of the deaths at the Makole HC occurred when the doctors were not around. Four major blocks of interventions below were made to improve the situation:

1. Interventions to promote individual performance.
2. Interventions to promote oversight service delivery.
3. Interventions to promote respect to client.
4. Interventions to client's focused.

There was also mismanagement of funds collected at the HC and a lot of exemptions. This was improved, and the facility was able to trap all collections at the HC.

The lessons learnt from the Makole HC include:

- Supportive supervision is not enough if routine oversight system within the facility is weak.
- Over reliance of institutional performance and less emphasis on individual accountability for results, jeopardizes quality of services. The RHMTs and CHMTs do supportive supervision quarterly and they don't do individual performance monitoring.
- Poor performance of existing rules lessens accountability culture.

Way forward:

- The Makole model was presented during RMOs and DMOs Annual conference in September 2019 in Dodoma, where they agreed to facilitate rollout of the Makole HC in 507 facilities.
- Promote leadership and governance where RMOs and DMOs performance will be measured.
- Strengthen central level guidance and tools.
- Design the learning component and implement, etc.

DISCUSSIONS:

- A need to capacitate health workforce to become health managers and be able to adopt the Makole model was stressed. It was stressed that, what is being questioned as far as Makole model is concerned, is professionalism and not management issue. Professionals' behaviors are not up to standards/ job requirements for example, a doctor seeing only 2 patients per day is not acceptable. So, there should be a system to change the behavior of both the providers and managers.
- Makole model is impressive as it talks about how we should reorganize the systems for service delivery not only in Tanzania but globally. For example, if we want to reduce maternal mortality, we can have action at community level. This is a lesson that through Makole model, we can improve accountability, community engagement and multi-sectoral collaboration. It shows multiple approaches can be used to bring change and not only one approach. In this way we can reduce maternal mortality.
- There is a need to come up with a performance monitoring accountability for quality service provision and improved health outcomes. It's also important to note that the success at Makole was measured by revenues generated and number of patients served by providers. It would be important to measure health outcomes and quality of services as an indicator of success for any expanded program on governance and accountability.
- Can we re-categorize Makole HC to a hospital? It was mentioned that Makole is very well staffed (perhaps overstaffed) and other facilities may not have the same issues or require the same interventions to improve.
- Changes should be facilitated by monitoring and evaluation tool.

2. RETHINKING: SWAp TWGs REVITALIZATION (MOHCDGEC)

- It was noted that despite efforts that have been made to revitalize the TWGs, they do not meet as per the SWAp calendar.
- This is also a challenge in planning for JAHSR as they are supposed to do their annual plans.
- The HSSP IV MTR findings noted among others, the TWGs focus on day to day issues rather than policy issues, members are not committed to their respective TWGs, they use the platform to push forward their own Agenda which is not in health policy or TWG. ToR are not clear as to whom the TWG leaders and members are accountable to.
- Observations from TWGs include: delayed information on TWGs meetings; changing locations of the meetings and inadequate participation of other sectors beyond MoH.
- The key questions to improve the TWGs: how should we group the TWGs? Is it under HSS framework or HSSP IV objectives? How can the accountability of TWGs members be improved?
- The ToRs are not results oriented.

DISCUSSIONS:

- The challenge is that the TWGs are not streamlined in Government's governance system. This needs to be corrected.
- What is an accountability incentive to attend meetings? What do we want them to deliver?
- They could be inactive because they are not streamlined in the governance system.
- How do we bring the implementers at sub-national level on board?
- TWGs can be placed under HSSP IV objectives and the number of the TWGs can be reduced to 5 or 6. They can also be re-arranged as per the Health systems building blocks with clear ToRs. If necessary, they can have sub-committees.
- The TWGs are motivated by tangible Agenda as they are meant to discuss policy issues.
- The recommendations from DPs will be shared with the MoH management.
- HSSP IV MTR recommendations suggested that Policy priorities shouldn't be a top-bottom approach hence, in this year's JAHSR TRM, all Regional Medical Officers (RMOs) and 26 District Medical Officers (DMOs) will participate fully.

ACTIONS:

- The role of TWGs and why do we need them should be discussed at the Joint Annual Health Sector Technical review meeting to include other stakeholders i.e. the CSOs, NGOs and private sector as we are planning for HSSP V. Advised to add more days after the Technical Review meeting (TRM).
- The recommendations from DPs will be shared with the MoH management.

3. HEALTH SECURITY AGENDA AND DISEASE OUTBREAK PREPAREDNESS (WHO)

- Only 20% of 194 countries worldwide met the International Health Regulation (IHR) requirements as per 2012 assessment i.e. preparedness to prevent, detect and respond.
- The Joint External Evaluation (JEE) conducted in February 2016, documented progress in Global Health Security Agenda (GHSA) in Tanzania. The findings showed among others, functional Emergency Operating Centre (EOC), high immunization coverage, etc.
- It's now three years since the last JEE, the country needs to rethink on conducting another JEE to measure progress in GHSA.

DISCUSSIONS:

- There is a funding gap to mobilize resources on health security plan. How has this been addressed? WHO has supported the MoH to come up with resource mobilization tool to track resources and populate the tool. The tool will be integrated into a portal for partners' access.
- There are currently so many plans on health security. The MoH could provide partners with updates on those plans. The challenge is that the plans are reported at different forums where majority come from vertical programmes.
- How do we strengthen health systems to be able to respond at community level? The implementation of the health security plan should be linked with progress in health systems. Community engagement is taken care of under community surveillance.

4. OVERVIEW OF RECOMMENDATIONS FROM HSSP IV MTR (MOHCDGEC)

- The MTR noted a lot of progress in the health sector in the past four years.
- However, there is no much improvement in equity. Reaching the poor is still a challenge.
- In remote areas health facilities are not enough and staffing levels are low.
- Community participation is increasing however, there is a need to improve outreach service delivery.
- Tanzania has a good immunization coverage due to outreach services, can't we use these outreach services for other programs as well so as to reach the remote areas as much as possible?
- Financial resources: NHIF is slowly increasing with 8% coverage.
- Governance: intersectoral collaboration needs a balance on what we can do centrally and what can be done at sub-national level.

Way forward:

- Focus on people rather than diseases as focus on diseases has brought inequitable access to services, fragmentation of resources, etc.
- Increase focus on quality.
- Increase productivity of health staff.
- Increase efficiency (management systems, governance at LGA level).

DISCUSSIONS:

- How can we keep pace of the population growth in the next HSSP V?
- Going forward, we should discuss how we collaborate with other sectors.
- On NCDs, it is important to promote prevention. What is lacking is comprehensive analysis on disease burden, etc (policy briefs), which could help the MoH to advocate for more budget allocation.
- Health in All Policies (HiAP) agenda will assist in increasing resources for the health sector, not only for NCDs but for community engagement as well.
- Neonatal, maternal mortality and NCDs are increasing, can we say HSSP V will focus 60% - 80% of our energy to these three areas as we are claiming to develop so may policy priorities?
- Health is not only about disease burden, there are other issues like gender: early marriages which have impact on the health.
- We should have UHC investment case, we can take case studies from Uganda, Ethiopia and Rwanda where they have focused on 4 – 5 things. Probably the neonatal, MMR and NCDs could be the focus, which they mean: quality, coordination and decentralization.

5. UPDATE ON HRH HIGH LEVEL MEETING (MOHCDGEC)

- The planned meeting will take place on 15th November 2019.
- Two presentations are expected: (1) Situation analysis (2) Policy options and costing.
- Involvement of other sectors is crucial though it has been minimal. The MoH will continue to communicate with the relevant sectors.
- UNICEF has produced an HRH video on absorption, they will also produce one on production.

6. GROUP WORK ON DPs ADVOCACY MESSAGES (DPs)

- Areas for advocacy messages during JAHSR TRM and throughout the next year were selected and DPs were grouped to work on them accordingly.
- Four advocacy areas selected include: adolescents, community health systems, health financing and urbanization.

ACTIONS:

- All the working groups to send their work on advocacy messages to DPG H Troika and Secretariat.

7. GLOBAL FINANCING FACILITY (WORLD BANK)

- The GFF Director, Dr. Muhammad Patel briefed DPs on the GFF and responded to their concerns accordingly.
- The GFF was built on every woman, every child's concept. It is like a sub-sector of SWAp to improve RMNCAH.
- It is also a multi-donor trust fund which is governed by a Secretariat at the World Bank.

DISCUSSIONS:

- The understanding of GFF coordination was not clear. It is now much clearer that the GFF grant links up with an IDA credit. In Tanzania, the GFF grant is included in the IDA credit for Primary Health Care for Results (PHC4R), where parts of the grant/credit go through health basket fund (HBF). The Results Based Financing (RBF) funds does not use HBF channel. One can therefore say that GFF is channeled through the formal existing systems, but GFF is blended with the WB credit.
- It is very difficult to quietly say a certain percentage of GFF funds has gone to a specific activity as it goes through the HBF and RBF which support various activities.
- What is requested is transparency on any credit which GFF supports.
- The path of GFF will depend with country's ownership.
- For Tanzania, it was clear from the beginning that the government will use existing structures for GFF coordination. However, DPG Health has already a well-structured coordination with government both on policy level and with various TWGs. GFF should pay more attention and align better to already established structures and programs.
- GFF is also used to leverage/ mobilize resources e.g. USAID for the first time has used government financing mechanism to support GFF. Power of Nutrition is also a partner to GFF and is co-funding the WB credit in Tanzania.
- GFF has also been supporting the Single National Health Insurance e.g. actuarial studies, advocacy to Members of Parliament, study tour to Ghana, etc.
- We need to work with the government to ensure that if there are gaps, they are addressed.

8. AOB:

DPs COMMENTS ABOUT THE RETREAT

- Presentations and discussions were very useful.
- The HSSP IV MTR agenda has come on the right time.
- Presence of both MOHCDGEC and PORALG was appreciated for improved sector dialogue.