How are our facilities managed?

Findings from the performance audit of health facilities

1. Introduction

Primary health care (PHC) is a crucial part of the national health care delivery system. Often primary health care facilities (village health posts, dispensaries and health centres) are the first place of contact for citizens to access treatment or prevention services.

Following concerns over shortcomings in the way primary health care facilities are managed, the Controller and Auditor General of Tanzania (CAG) undertook a performance audit of a sample of health centres (HCs)[1]. The audit aimed at assessing whether:

1. health centres are managed efficiently;
2. performance is considered when resources are allocated; and
3. measures are taken to improve publicly managed health centres.

This brief highlights the findings of this performance audit and the recommendations made by the CAG. The findings are based on a sample of thirty two health centres selected out of seven Regions and twenty Councils.

The audit reveals significant gaps in all three areas considered. Health centres are not efficiently managed; funding of Health centres is done without proper consideration of performance; and the system for performance monitoring, evaluation and reporting is neither properly updated nor effectively utilised.

The CAG finds that improving the functioning of the management chain of command (that is the functioning of the line of authority, communication, and responsibility between the different arms of government responsible for primary health care) is crucial to improving the performance of Primary Health Care facilities.

[1] The full audit report can be found at www.nao.go.tz

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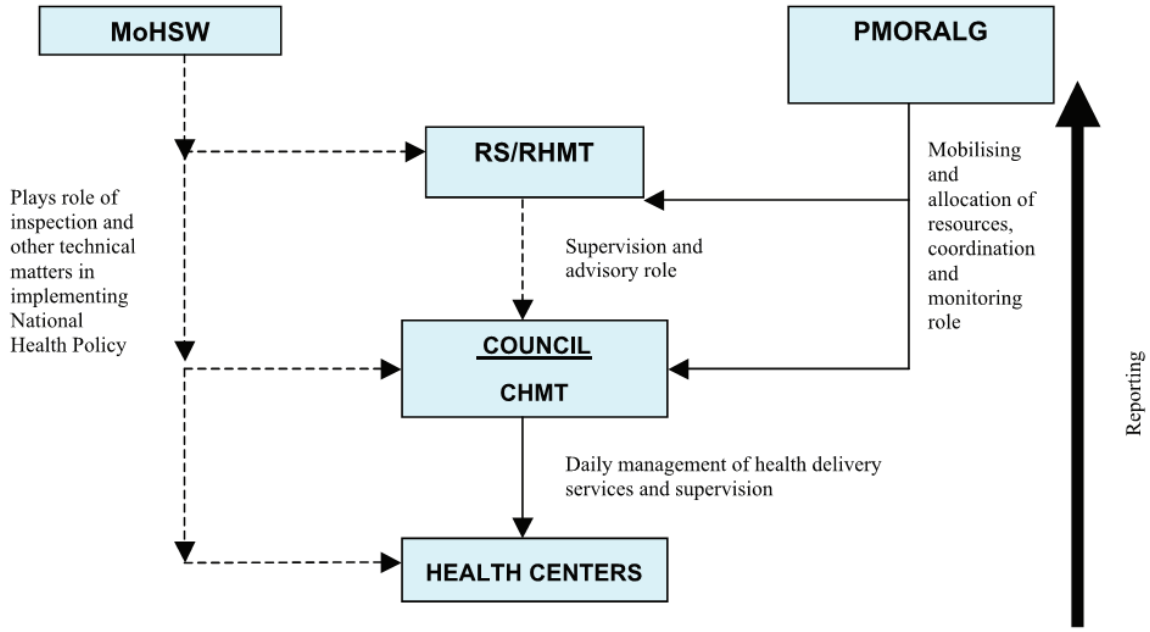
2. How are roles and responsibilities for PHC apportioned?

Primary health care facilities are supported by actors at the Central as well as Local Government level (Figure 1). At the central level there is the Ministry of Health and Social Welfare (MOHSW) and the Prime Minister's Office Regional Administration and Local Governments (PMO-RALG). MOHSW is responsible for policy making, setting standards and for overall sector monitoring. The PMORALG, on the other hand, is responsible for overall coordination, implementation of health sector policies, monitoring and controlling, and reporting in the Regions and Local Government Authorities.

Below these two is the Regional Secretariat (working through the Regional Medical Officer-RMO), which is responsible for advising and supervising activities of the Councils. The RMO is supported by a Regional Health Management Team. At the Council level, the District Medical Officer (DMO) works with the Council Health Management Teams (CHMTs) and Council Health Service Boards (CHSBs) to support, supervise, monitor, and control the performance of Health facilities. At the facility level, each one has a facility governing committee whose responsibility is to safeguard effective use of resources and ensure smooth operation of the facility. The reporting responsibility starts from the health facilities to the MOHSW through the PMORALG.

Figure 1: Roles and Responsibilities in the Management of Primary Health Care



Source: CAG Performance Audit of Primary Health Care facilities the case of Health Centres, 2008.

3. Nine facts about the way Health centres are managed

While the chain of command in management of health facilities appears fairly straightforward, the CAG finds that health centres are still not effectively managed. Ineffective management is visible in several areas. Key factors that contribute to it are weak supervision (monitoring and controlling), poor communication and feedback mechanisms, and ineffective information management and reporting.

a. There is poor communication between Councils and Health Centres

Councils are mandated to execute primary health care services with the DMOs and Council Health Management Teams as the main actors. This implies that Councils have the responsibility of informing health facilities about guidelines, standards, approved budgets and any other requirements that are set at higher levels concerning primary health care service delivery.

The audit, however, finds that communication between the DMOs and the in-charge of Health centres is lacking in many areas. This in turn contributes to poor performance of HCs. The audit notes that important information (new guidelines, for example) is not disseminated. For example, although the Councils were supposed to communicate the new guidelines concerning the National Essential Health Package to Health Centres, they did not, with the result that staff at many health centres were therefore not aware of them. Moreover, due to weak communication, most HCs are not involved in the preparation of Council's health plans.

b. Councils do not inform Health Centres what budgets have been approved

According to planning and budgeting procedures for Councils, Health centres notify Councils of their priorities for the following year. Councils pull this information together to form the Council's annual plan, which then goes through the normal budgetary approval process. In an ideal scenario, after budgets have been approved, Councils inform Health centres about their respective approved budgets.

The audit finds that Councils do not send feedback to the HCs about the amounts of funds available for their activities, even though this kind of documentation exists at the Council level. As a result, HC management typically lacks appropriate information concerning how much Councils spend on their behalf, what it is spent on, and how much of these resources remain at the Council for other activities.

c. Health Facility Governing Committees are not effective

Each Health Centre has a governing committee which is responsible for safeguarding effective use of resources and ensuring the smooth operation of health facilities. The committees, composed of members from the community and the in-charge of the health centre as a secretary, are supposed to sit four times per year (once every quarter) to discuss the operation of the facility.

The audit finds that the committees do not carry out this task effectively. Few meetings are conducted, and they rarely discuss performance and operational matters. Furthermore, the audit finds that in most of the committees, members did not posses adequate capacity to discharge the responsibilities placed upon them. As a result, the system in place for monitoring and controlling of Health centres' own spending is also weak.

d. Resource allocation from Councils to Health centres lacks transparency and is not based on objective criteria

To achieve equity in service delivery, the Councils have to ensure that resources are allocated in a transparent way and on the basis of objectively verifiable criteria such as staff work load, demand for services, and performance at health facilities. The audit finds that this is not the case. The way resources are allocated from Councils to HCs lacks transparency, and objective criteria are not being used in the allocation process. The result is that HCs with high demand for services (expressed in terms of workload per individual full time serving personnel at the facility) in many cases receive fewer resources relative to their actual needs and compared to what is allocated to HCs with lower workloads(See annex). Figure 2 below shows workload and allocation of drugs for top five and

bottom five facilities in the list of audited facilities. Chalinze health centre, which has the highest workload among the audited facilities, only receives about 96 shillings equivalent per patient in funds for drugs each quarter. On the other hand Kilimarondo, where the workload is only 3 patients per full time serving personnel per day, receives nearly 13 times as much as Chalinze for drugs per patient. In both cases however, the amounts are too small to meaningfully guarantee availability of drugs for visiting patients.

Figure 2a: Top five and lowest five facilities by workload per full time health personnel

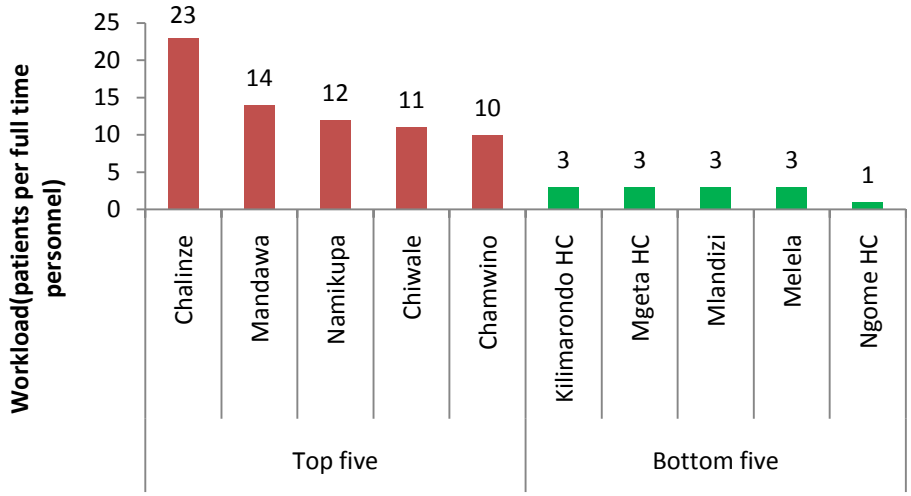
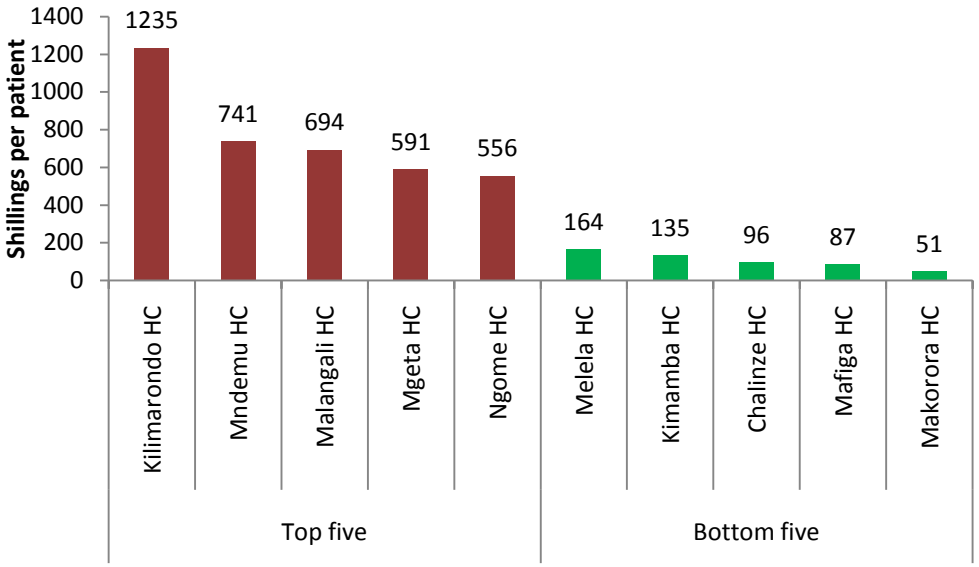


Figure 2b: Allocation of funds for drugs per quarter in Health Centres (top five and lowest five recipients)



Source of data: CAG report on Performance Audit of Primary Health Care facilities (2008)

The audit also reveals that although Councils have the power to correct mismatches between allocated financial and human resources and performance or demand for services in health centres, such powers are rarely used. For example, it is noted that the national standard for number of medical staff per facility does not consider differences in needs and performance of facilities. This

could be the reason why health staff at Ngome serves only one patient per day whereas staff at Chalinze Health Centre has to serve 23 patients every day. As such, the DMOs have a mandate, based on their knowledge of performance and demand for services in health facilities, to reallocate staff between the different HCs in their respective Councils. However, very few Councils exercise their mandate in this way to achieve an equitable allocation of staff among HCs.

e. MOHSW places insufficient emphasis on supportive supervision

The MOHSW has formulated guidelines on how to conduct supportive supervision to ensure efficient provision of health services to citizens. In practise an effective system for reporting from lower administrative levels does not seem to exist or to be enforced. The audit reveals that although an inspectorate unit responsible for supervision exists in the MOHSW, it didn't receive any supervision reports from the regional and Council levels.

> "There is no adequate monitoring from the central level on supportive supervision to bring impact on performance URT 2009, page 41

Furthermore, the audit finds that the Ministry has failed since 1999 to enforce effective use of the supervision guidelines in a manner that would have the desired impact on the performance of Primary Health Care, both at the regional and at the Council level. Apart from failing to effectively enforce supervision, the audit also finds that most of the recommendations provided by the supervisors to health centres are either irrelevant for the purpose of improving performance or go beyond the mandates of the HCs and hence cannot be implemented.

f. Supportive supervision of HCs by Councils has several shortcomings

Councils are expected to use supportive supervision as a tool for identifying and addressing gaps, and for supporting health providers to effectively carry out their tasks. According to the guidelines set by the MOHSW, each Health Centre has to be visited four times (once every quarter) in a year. Furthermore, for the supervisory visits to be of value, each Council is required to plan and priorities its visits; communicate them to HCs and undertake them according to the plan; provide oral as well as written feedback; and document the findings and feedback given to health centres after the visits.

Figure 2: The Supervision Stages

Source: CAG report on Performance Audit of Primary Health Care facilities (2008)

The audit finds no indication of supervisory visits either being planned or prioritised. None of the 20 visited Councils had a plan for supervision visits that clearly stated the objectives of the visits and priorities. The consequence is that in 80 percent of the Councils, supervision did not meet the prescribed criteria of good practice (that is there were too few, too many or no supervision visits to the HCs).

"As a matter of fact the audit team has not been able to find any report that deals with analysis or advice on how to improve efficiency"
URT (2008) Page 32

Even where visits were conducted, the audit found that documentation about feedback to the HC following supervisory visits was inadequate. Save for information that oral feedback was given, the Council Health Management Teams did not compile any comprehensive Council Supervision Report showing what was found. It is therefore unlikely that experiences from the visits are well utilised by HCs to correct gaps in their performance. This is confirmed by the finding from the audit that *performance of HCs is not in any way correlated with the supervision that is carried out by Councils*.

g. Regional Secretariats do not adequately monitor performance of Councils

The Regional Medical Officer through the Regional Health Management Team is required to undertake supportive supervision (on a quarterly basis) of the way Councils manage the performance of health centres. The RHMTs are also responsible for examining the financial and technical reports that Councils prepare. The audit finds however that these actors at the regional level are, like actors at the Council level, weak and unable to fully perform their mandate to support Councils to improve their services.

- **The RHMTs do not conduct supportive supervision as required.** The audit finds that only in a fifth of the 20 Councils audited were supervisions conducted four times as was required in 2007.

- **A connection is lacking between the regional and Council level management of HCs.** The audit reveals that regional supervision attaches very little importance to how Councils manage HCs.

"It is obvious that supervision cannot be a supportive tool if it is not conducted as required"
URT (2008) Page 35

h. The Health Management Information system (HMIS) is not working effectively

In 1993 the MOHSW introduced the HMIS, whose objective is to facilitate monitoring and controlling, and to support improvement of health services. This would be achieved by making available in a timely manner accurate and credible data concerning the situation in health facilities. The information generated would then be used as a basis for undertaking corrective actions, and for planning future interventions.

The audit finds several shortcomings concerning the HMIS:

- The information management system is not being updated as required; it contains unreliable information, and has been underutilised for a long time.

- Performance indicators are not used as a basis for assessing service demand and to decide resource allocation
- The system excludes data on some important health programs that ought to be monitored too
- Reports that Councils receive from HCs are rarely analysed and evaluated for credibility before they are forwarded to higher levels
- Since Councils do not act on the reports from HCs, the HCs do not get feedback to guide them on steps to take to improve their performance and statistics generation.
- Staff in many HCs lack essential skills on how to fill in and use the data in the system and as such, important data fields are left blank.
- Since information is not scrutinised, reliability of information that is eventually sent to higher levels for policy and planning purposes is undermined.

The consequence is that at all stages in the management command chain, both operational level (HCs) and management level (Councils, Regions and national) adequate, relevant and suitable information for decision making is lacking. Notwithstanding the shortcomings, the audit reveals that the MOHSW had neither asked for suitable and relevant information nor initiated any evaluation of the HMIS for PHC as at the time the audit was being undertaken.

i. Information in progress reports forwarded to the national level from the regional level is not suitable

The central government (MOHSW and PMORALG) needs adequate and credible information that it can use as a basis for decision making concerning national health care services. Health Planning guidelines thus require RS/RHMTs to assess technical and financial reports from Councils before sending them to higher levels.

The Audit finds that the teams at the regional level do not sufficiently analyse reports from Councils and are unable to detect that the reports are provided without physical verification and are often not reliable. **The audit found many instances where activities that were being reported as conducted at the Council level were in actual fact neither conducted nor provided with the assumed resources.**

> *"All put together these shortcomings hamper the RS/RHMT from providing the national level suitable information as a base for political decisions and funding of PHC"*
> *URT (2008) Page 37*

The audit reveals further that reports from the Health Management Information System often lack operational data concerning supervisions conducted, cost of resources received and spent, workload, records of action taken to improve performance, and missing medical supplies.

Since the actors at regional level do not analyse this information, such gaps are neither detected nor corrected. As Regional Secretariats use the information as a basis for reporting to higher levels and for requesting further funding, the implication is that the reports and information that the national level receives and uses as a basis for policy and funding decisions is defective.

4. Conclusions and recommendations

The Controller and Auditor General finds that management of health facilities is weak in part due to ineffective supervision (monitoring and controlling), breakdowns in communication and feedback mechanisms, and because of weaknesses in information management and reporting mechanisms. Correcting these shortfalls requires that actors at all levels in the management command chain of primary health care undertake efforts to ensure that the mechanisms in place are working. The audit thus recommends that:

- MOHSW and PMO-RALG to improve monitoring and controlling (supervision) and communication (feedback) and reporting mechanisms at all levels including ensuring that the HMIS is updated and gaps in performance addressed.
- Regional Secretariats put more emphasis on performance issues in their monitoring and evaluation of PHC at the Council level. This includes also examining how Councils manage and safeguard effective allocation and efficient utilisation of resources set aside for PHC services.
- Councils promote efficient spending of resources for PHC services. This includes making budgets and human resource allocations transparent and based on performance, improving communication and feedback mechanisms, and undertaking regular monitoring of HC spending and performance.

References

URT (2008), a Performance Audit on the Management of Primary Health Care: A case Stud of Health Centres, Dar es Salaam, National Audit office of Tanzania. Accessed from www.nao.go.tz on 3rd June 2010

Annex: Visitors, work load and allocation of funds for drugs in audited health facilities

Health Centre	Visitors (Patients) per day	Workload (Visitors per full time health facility staff per day)	Amount allocated for Drugs per quarter (Shillings)	Quarterly allocation for Drugs per patient (Shillings)
Kilimarondo HC	18	3	2,000,000	1235
Mndemu HC	30	4	2,000,000	741
Malangali	32	4	2,000,000	694
Mgeta HC	33	3	1,755,000	591
Ngome HC	40	1	2,000,000	556
Nkowe HC	40	4	2,000,000	556
Kisiju HC	43	4	2,000,000	517
Mkuzi HC	42	4	1,755,000	464
Kasanga	48	5	2,000,000	463
Mkamba	49	6	2,000,000	454
Kitangari	51	5	2,000,000	436
Chiwale	53	11	2,000,000	419
Mkoka	55	-	2,000,000	404
Njinjo	62	9	2,000,000	358
Mwera	55	3	1,755,000	355
Ugogoni	65	7	-	-
Chihangu	67	8	2,000,000	332
Chamwino	70	10	2,000,000	317
Nagaga	70	9	2,000,000	317
Namikupa	70	12	2,000,000	317
Masoko	75	5	2,000,000	296
Ipogoro	95	3	2,000,000	234
Lugoba	97	5	2,000,000	229
Mandawa	100	14	2,000,000	222
Mahula	125	10	2,000,000	178
Sabasaba	115	3	1,755,000	170
Mlandizi	135	3	2,000,000	165
Melela	50	3	740,000	164
Kimamba	165	8	2,000,000	135
Chalinze	231	23	2,000,000	96
Mafiga	225	7	1,755,000	87
Makorora	380	8	1,755,000	51

- Information not available

Source of Data: CAG report on Performance Audit of Primary Health Care facilities (2008)