CMI REPORT

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Haydom Lutheran Hospital

Midterm review of the Block Grant Support
End review of the MDG 4 and 5 project support

Siri Lange

CMI CHR. MICHELSEN INSTITUTE

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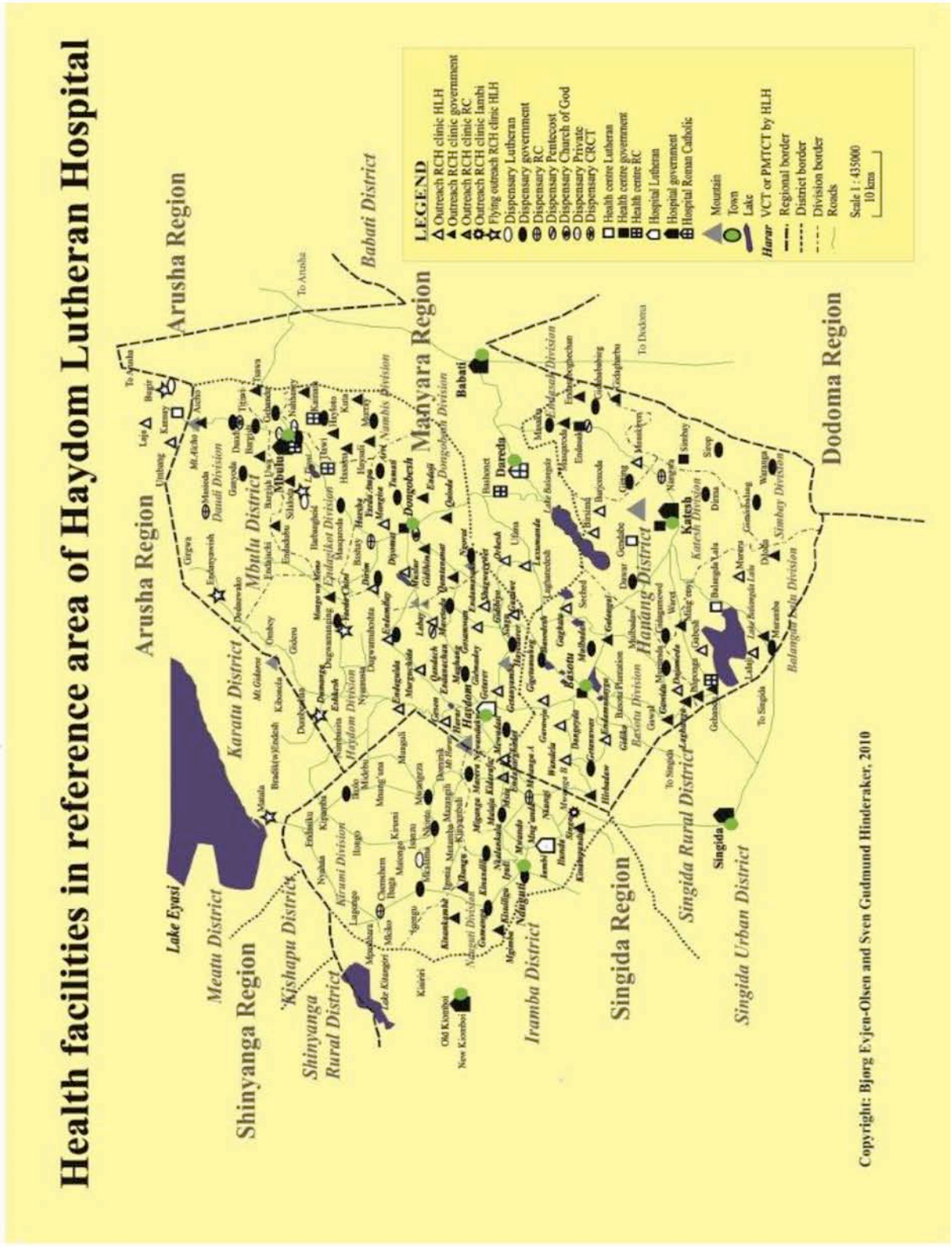
List of acronyms and abbreviations

AMO	Assistant Medical Officer
ANC	Ante-Natal Care
CAT	Core Administration Team
CMT	Core Management Team
CO	Clinical Officer
CSSC	Christian Social Services Commission
DMO	District Medical Officer
DMT	Division Management Team
ELCT	Evangelical Lutheran Church of Tanzania
HLH	Haydom Lutheran Hospital
IEC	Information, Education and Communication
MD	Medical Doctor
MDG	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
NGO	Non-Government Organisation
NIMR	National Institute of Medical Research
NLM	Norwegian Lutheran Mission
NSSF	National Social Security Fund
OPD	Out-Patient Department
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
PMTCT	Preventive Mother to Child Treatment
PSPF	Public Service Pension Fund
RCH	Reproductive and Child Health
RNE	Royal Norwegian Embassy
SOU	Standard Unit of Output
VAT	Value Added Tax
VETA	Vocational Education Training Authority
VCT	Voluntary Counselling and Testing



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Executive summary

Haydom Lutheran Hospital (HLH) was established by the Norwegian Lutheran Mission in 1955 and is now owned by the Evangelical Lutheran Church of Tanzania (ELCT). In 2011, the RNE funded 61% of the hospital's budget. This report is an end review of the special grant related to the MDG 4&5 (2008-2012) and a midterm review of the block grant support (2010-2015).

End review of support to MDG4&5

In the project period, more than 137,000 examinations of women and around 412,000 examinations of children have been conducted through the reproductive services of HLH. These services appear to be of high quality and always on schedule, but there is lack of vaccines and clinical cards since only one district provides HLH with this. HLH should cooperate more closely with district authorities, both to access supplies and to discuss the possibilities for an arrangement where HLH is in charge of the cold chain while manpower is provided by the public facilities. This is particularly important in the future since the government has agreed to fund HLH staff involved in referral services, but not staff providing primary services.

Close to 14,000 women have made use of the free ambulance services. This service appears to be a major factor behind the substantial increase in deliveries at the hospital. The number of caesarian sections has been relatively stable in the same period, indicating that the increase in deliveries to a large degree is uncomplicated deliveries. The popularity of the ambulance service has led to overspending compared to the budget, and HLH is considering ways to limit usage and/or cost sharing. In 2011 the cost of each trip was Tshs. 70,000 on average.

In the project period, 257 mothers and 179 children have joined the PMTCT program. The annual report for 2011 shows that transport costs connected to PMTC services amount to around Tshs. 850,000 (USD 567) for each pregnancy/child, much more than budgeted for. According to the HLH management the report was based on data in the WEB Erp that were incorrect.[1] It should be noted however, that in the same year there were 217 deaths in the pediatric ward and 16 deaths in the maternity ward. In a cost-effectiveness perspective, there is the possibility that more lives could have been saved if some of the PMTCT resources were spent on health education and interventions in the fields of family planning, malnourishment, and pneumonia instead. Results would be harder to measure, however.

HLH has established a separate account for MDG 4&5 funds, but in actual practice spending on MDG 4&5 has not been singled out. The services to be covered by the MDG 4&5 fund and the services to be covered by the core grant are to some degree overlapping, and separate funds add to the administrative burden. We therefore recommend that support to activities that were under MDG 4&5 are added to the core grant for the remaining period (up to 2015). Since the planned government support will not cover primary services, there is the possibility that support to outreach services will have to be funded separately in the future. In terms of deviations from the budgets, there has been up to 70% overspending on transport, and there are indications of overuse/theft of diesel. HLH should look into this before introducing cost sharing for ambulance services.

Midterm review of the block grant support

In the project period, the total number of outpatients has been 198,980 and the total number of inpatients has been 49,408. The number of major and minor and operations went down from 2010 to 2011. The main reason appears to be a "go-slow" action after a three shift system was introduced in

[1] New figures are being calculated and will be presented in the 2012 annual report.

February 2011. Estimates for 2012 show that the surgery is now back on track. Testimonies from patients reveal that the quality of treatment is perceived to be far better at HLH compared to other hospitals in the area (at district and regional level).

It is a major goal for HLH to become a teaching hospital. The plan was to open an AMO School in 2012, but the process has been delayed. The main reason is that it has proved very difficult to attract specialists, despite incentive packages giving specialists a taxable allowance of Tshs. 3 million per month. One should therefore look into the possibilities for increasing the sum, or alternatively, other forms of incentives. Subsidized quality education for doctors' children appears to be an attractive alternative.

It has been a major long term strategy for HLH to secure increased government funding. The estimates for 2012 shows that government funding now constitutes 19% of the budget compared to only 8% in 2011. The government has decided that HLH will be upgraded to Referral Hospital at Regional Level, and this will entail that the government will take responsibility for a much larger share of the budget. While this is a very positive development, it is uncertain what increased government funding will mean for the autonomy of the hospital.

Staff moral appears to have improved in the project period, but some staff members come late and/or are idle during working hours. Staffs who have been found sleeping during night shifts have been fired.

Financial management

HLH is a large institution with close to 700 employees all together. Human resource management and financial management have been identified as weak areas in previous reviews and audits. New systems for medical records and invoicing have been introduced and the staffs have been trained, but the systems are not working properly. This is partly due to technical problems, partly due to resistance from the doctors who were meant to fill in the records. The Innovex' Management Letter of August 2012 lists 32 recommendations for financial and control issues. In January 2013 close to two thirds of these recommendations had been implemented.

In 2011 misuse of PEPFAR funds was discovered, and the involved staffs in the finance department were fired. The Final Project Review of June 2009 identified large variation across cars in fuel consumption per kilometer. This was interpreted as a possible indication of misuse of resources, and the review recommended improved 'control over the hospital cars and other vehicles in terms of expenditure.' This issue does not appear to have been resolved.

Financial sustainability

HLH is a very important service provider in an area of the country where the population is poor and government health services are inadequate. Since HLH will not be able to keep its current activity level without support from RNE, we recommend support beyond 2015 under the condition that financial management is monitored closely.

1. Introduction

Haydom Lutheran Hospital (HLH) was established by the Norwegian Lutheran Mission in 1955 and is now owned by the Evangelical Lutheran Church of Tanzania (ELCT). The hospital is located in Haydom district, Manyara region, 300 kilometres from the nearest urban centre (Arusha). HLH serves an immediate catchment area of 320,000 people in the districts of Mbulu, Hanang and Iramba. The greater catchment area of the hospital covers 2.1 million people and includes Mangola, Meatu and Singida Districts. The hospital is fully integrated into the national health plan of Ministry of Health and Social Welfare (MoHSW).

Over the years, HLH has received substantial financial support from the Norwegian government through the Ministry of Foreign Affairs and NORAD. The support is presently channelled through the Royal Norwegian Embassy (RNE) in Dar es Salaam. In 2011, the RNE funded 61% of the hospital's budget. The support from RNE is administered through a Block Grant and a special grant related to the achievement of Millennium Development Goals 4&5 (maternal and child health). The first part of this report provides an end review of the MDG 4&5 support (2008-2012). The second part is a midterm review of the block grant support (2010-2015).

The purpose of the end review of the MDG 4 and 5 support is to evaluate the activities connected to MDG 4 and 5 at HLH and to assess the long term sustainability of the activities. The review findings will be used as an information base for future dialogue regarding collaboration and support between HLH and RNE (see appendix 5.4 for the full Terms of Reference).

The purpose of the midterm review of the block grant is to assess HLH as a running hospital as well as a participant in the general development of Mbulu district. The review will also assess the present financing sources, as well as potentials for and capacity to access alternative or additional resources that will contribute to sustain activities in the long run. Financial management is a cross-cutting issue and is therefore presented in a separate chapter.

The consultants[2] wish to thank the staff at HLH, the Embassy, the Ministry of Health and Social Welfare, local government representatives, representatives from ELCT and the local community for their hospitality and good cooperation.

[2] BakerTilly has had the main responsibility for the assessment of the Financial Management (chapter three and relevant annexes), while CMI has had main responsibility for the other chapters and for overall editing.

2. End review of the MDG 4 and 5 project support

The main aim of the special funding for MDG4&5 was to contribute to a reduction of maternal and child mortality by improving quality and quantity of lifesaving interventions before, during and after delivery, with a specific focus on PMTCT. This goal was to be reached through the focus on seven strategies: i) Core hospital services; ii) Emergency obstetric and postpartum services; iii) Ambulance services; iv) Reproductive and child health services (RCHS); v) Prevention of mother-to-child transmission; vi) Paediatric Department; vi) Capacity building and research. The project was a 5-year project ending in June 2012. The initial project funding was NOK 2.8 million per year, NOK 14.8 million in total. In 2009 the program was granted an additional 1 million NOK to cover loss in connection with depreciation of the NOK. In 2010 HLH was granted extra funding due to rising fuel prices and power rationing, and in 2012 the project was granted an additional NOK 2 million to extend the project period from June 2012 to December 2012.

2.1 Outputs and effectiveness

The proposal and contract for the project lists a number of indicators to be monitored during the project: Number of women and children examined through reproductive and child health services; Number of women and children helped through ambulance services; Number of deliveries and delivery related statistics at the Maternity Ward; Number of mothers and children on PMTCT; and Number of children treated through pediatric ward. The project documents do no state any specific targets for planned outputs. We will therefore assess the outputs in relation to the level of outputs before the project period started and to some degree the amount of funds spent on the various activities. Statistics for the various indicators are presented in a table 1.

Reproductive and child health services

HLH has a long history of providing out-reach services, starting in 1972. There are now 42 staff members in the out-reach division. In total, there are 42 clinics, of which 5 are static and 37 are ambulatory. The great majority of the ambulatory clinics are reached by Land-cruisers, while 7 are reached by air. Out-reach appears to always take place according to schedule.

In the project period, more than 137 000 women have been examined through the reproductive services of HLH. The number has been fluctuating between 19, 606 (2009) and 31,810 (2012). In 2006, before the project under review was started, the number was in fact higher, 33,095. HLH staff use the WHO framework "focused antenatal care". The examination includes weight, blood pressure, palpating, and listening to the foetus. Pregnant women are given free malaria prophylaxis and treatment for anaemia. The out-reach sessions include health education on HIV/AIDS, new vaccines etc. Since some women have a limited command of Swahili, the HLH staff often provides health education in both Swahili and local languages. The sessions also include a short worship, often led by a local evangelist. According to anthropologists who have many years of experience in this area, this does not exclude Muslims or people who adhere to traditional religions from using the services, since there is a long tradition of using the health services of other ethnic/religious groups.[3]

A total of 411,559 examinations of children have been conducted in the project period. The number has been relatively stable throughout the period, at around 83-84,000 per year. This is considerably higher than in 2006 when the number was only a little above 10,000.

[3] Personal communication with Astrid Blystad and Ole Bjørn Rekdal. See also: Rekdal, O. B. (1999). "Cross-cultural healing in East African ethnography." Medical Anthropology Quarterly 13(4): 458-482.

Table 1. Main indicators MDG 4&5

	2006 Baseline	2007 Baseline	2008	2009	2010	2011	2012	Total Project period
Women examined through RCHS	33,095	24,933	26,509	19,606	29,232	30,108	31,810	137,265
Examinations of children through RCHS	10,1121	81,664	84,779	76,444	80,716	83,610	86,010	411,559
Admissions Maternity Ward	Na	3,859	6,444	5,225	5,990	7,222	6,874	31,755
Deliveries at the Maternity Ward	3,201	2,843	4,558	4,622	5,086	5,461	5,164	24,891
Caesarian sections	534	Na	591	582	573	549	722	2977
Number of deaths at maternity ward.	19	Na	62	18	6	16	8	110
Ambulance services (women)	na	177	2,053	2,822[a]	3,147	3,206	2,664	13,892
Ambulance services (children)	na	Na	9	19	24	17	12	81
Children admitted (discharged) from pediatric ward[b]	na	2,936	3,314	3,557[d]	3,454	3,152	2,772	16,249
No of deaths pediatric ward	na	Na	184	200	217	205	185	991
Number of deaths neonatal	na	65	73	62	77	92	108	412
Mothers on PMTCT (new cases)	26	Na	51	48	51	65	42	257
Children on PMTCT (new cases)	na	Na	31[b]	53	51	17[e]	27	179
Number of deaths (mothers and children)	na	Na	246	249	235	312	292	1334

a) From annual report 2009. Another source says 2259.

b) The figure given in the annual report for 2008 was 543, but this is probably a mistake (sum of all cases for all the months). We have here stated the number given for 2008 in the Annual report of 2009.

c) Some annual reports give figures for admitted children, some for discharged.

d) One source says 2649.

e) The Annual Progress Report 2011 says 26.

Ambulance services

Lack of access to timely and affordable transport to hospitals with obstetric care is one of the major factors behind maternal deaths in Tanzania. In early 2008 HLH decided that ambulance costs for mother and children should be free of charge and in in September 2009 the four new RNE-funded ambulances arrived, two of them earmarked for MDG 4&5. Free ambulance services appear to have had a clear impact on usage and is probably a major factor why the number of deliveries at the hospital has increased substantially since the project period started (see below). Around half of the women who deliver at the hospital have arrived by ambulance, and throughout the project period more than 11,000 women have benefited from this service. The number has varied between 2,053 and 3,206 per year, which is more than ten times higher than before the free services were initiated (177 in 2007). Ambulances travel up to 200 kilometers (one way) to fetch patients and the cars are normally called through solar-cell run VHF radios that are placed in the homes of families that have been trained in how to use them and also at HLH's health centers. There are all together 39 radio stations in the catchment area. The ambulance service has been used to a much lesser degree for children. In the whole project period, only 81 children have been registered as using this service. It should be noted that there have been many occasions where sick children have been registered on their mother's name, so that there may be substantial underreporting for children and a corresponding over-reporting for women. One reason for the low usage of ambulance services for children may be that the local population is unaware of this opportunity.

The popularity of the ambulance service has become a challenge for HLH. Some staff members argue that women delay going to hospital for delivery until the last moment because they know the ambulance will come to fetch them, while yet others call the ambulance in cases when they should not, i.e when they want to go to Haydom for regular pregnancy check-ups. There are also cases of women who call the ambulance days or even weeks in advance in order to be sure to arrive safely before delivery.

Number of deliveries and delivery related statistics at the Maternity Ward

The number of deliveries at HLH went up from 2,843 in 2007 to 4,558 in 2008, a formidable increase, accredited mainly to the introduction of free ambulance service. As a result of the increase in deliveries, the hospital redirected funds and personnel to the maternity ward in 2009, but faced the challenge of lack of qualified staff, especially senior specialists in maternal health and surgical care. Since then, the number of deliveries has increased slightly every year, reaching more than 5000 in 2011 and 2012. This means that there are presently around 400-460 deliveries per month, or an average of 14 every day. The hospital qualifies as a Comprehensive Emergency Obsteretric Care (CEmOC) facility and the health centers operated by HLH qualify as Basic Emergency Obstetric Care (BEmOC) facilities. The number of caesarian sections has been relatively stable, standing at 534 in 2006 and 600 in 2011. This may indicate that many of the women who needed a caesarian prior to the project period accessed this form of care, while the greater part of the increase in deliveries in the project period has been for normal deliveries.

The old maternity ward was not dimensioned for the high increase of births, and he situation has improved a lot after the new ward was completed in 2012.

Women who have arrived too early at the hospital and who live far away, are offered to stay at the house for relatives. HLH aims to build a maternity waiting home to ease the situation and to avoid sending women back once they have arrived. The inauguration of the new Maternal Ward in 2012 was a very important improvement for both the staff and the patients. The new ward has seven delivery rooms and a small theater.

According to a visiting specialist from WHO, HLH has one of the lowest maternal death rates in Africa. In the whole period, the total number of maternal deaths has been 110, more than half of them,

62, taking place in 2008. Since 2010 the number of maternal deaths has varied between 6 and 16 per year.[4] The most important cause of maternal deaths is postpartum hemorrhage. Since HLH is a referral hospital, some of these deaths may have been very hard to avoid. The statistics include women who died while being transported in an ambulance owned by HLH. The number of neonatal deaths has gone up in the period, but appears to be closely related to the number of admissions at the maternity ward. Partograms were introduced in autumn 2010, but according to the hospital's reports this does not appear to have had an effect. Studies from other African countries have shown that midwives find filling in partograms to be too time consuming, and therefore do not do it.

Children treated through pediatric ward

The pediatric ward has 70 beds. A total of 16,249 children have been admitted at the pediatric ward in the project period (some of them readmissions). The utilization has been relatively stable in the period, with around 3,300 admissions per year, but with a slight decrease in 2012. Not all annual reports provide detailed statistics, but in 2008 the top four diseases for children under 5 were malaria (1246)[5], pneumonia (859), gastroenteritis (488) and prematurity (81). The pediatric ward has a special unit for malnourished children. In 2009 a special nutrition formula was developed which has proved effective. It is produced using milk from the hospital farm.

The total number of deaths in the project period is 991 (including neonatal deaths). This number has been relatively stable in the period, fluctuating between 184 (2006) and 217 (2010). According to the hospital's own reports, the infant mortality in the hospital is one of the lowest in Sub-Saharan Africa. As with maternal deaths, one should take into consideration that many of the children are referred to HLH from other facilities and may be very sick when treatment is started. The statistics from 2009, when a total of 200 children died, show that very many died from pneumonia (76), followed by malaria (29), and septicaemia (17). All these illnesses are hard to treat successfully if proper treatment is started late. For around one in eight of the children (24), prematurity was the main reason for death. In the same year, a number of deaths due to hypoglycemia were identified – occurring because mothers/parents fail to feed their hospitalized child at night, despite being given information on the importance of doing so.

Comparing the reasons for death with the list of top four diseases, it becomes clear that HLH successfully manages to treat the great majority of malaria cases, while a far higher percentage of children with pneumonia lose their lives. An important reason is that many arrive at the hospital too late. In 2009 the death of children between 0-28 days was much higher in February and September. It has been a central goal of HLH to increase the number of qualified staff in the pediatric ward in the project period, but it has proved very hard to recruit Tanzanian specialists. Expats have filled the gap to some degree. As for internal capacity building, two nurses have been in Norway through the Peace Corps for capacity building in infant care, while the ambulance personnel have received training through the Helping Babies Breath Programme (a neonatal resuscitation curriculum for resource-limited circumstances).

Mothers and children on PMTCT

A central component of the MDG4&5 support was to integrate PMTC in the RCHC unit and in the maternity ward. This was accomplished in 2009. As in government facilities, all pregnant women are tested (after counseling). In the project period, 257 mothers and 179 children have joined the PMTCT program. However, since the project also gives treatment to women and children who were part of

[4] In comparison, the Team Leader witnessed three maternal deaths in one maternal ward in the course of five days at a Regional Hospital in another part of the country.

[5] According to the hospital management there is reason to believe that there is an overrepresentation of malaria cases in the statistics.

PMTCT prior to 2008, the number of people who receives services is higher. As of 2011, 366 children had been included in the program since it was started. Of these, 269 were not infected, while 12 were infected, believed to be mostly due to mixed feed. The program encourages exclusive breast feeding up to 6 months, and HLH then provides free milk up to the age of 18 months. HIV positive women are offered highly active antiretroviral therapy (HAART) and treatment for opportunistic infections. In 2011 and 2012 the number of women on PMTCT was substantially higher than children on PMTCT.

In 2011, the transport costs for PMTCT follow up and support was close to Tshs. 103 million (102,960,000). The budget was Thsh. 66 million. This comes in addition to transport costs for RCHS (a little over 99 millions). Transport costs for PMTCT in 2011, divided upon the 121 children enrolled in the program in 2009 – 2011 (covering the period from mother's pregnancy to the child reaching 18 months), give a price tag of around Tshs 850,000 (USD 567) per child in transport costs only. Taking the costs of the ambulance service as a starting point (Tshs 70,000 per trip), this means 12 trips per child/pregnancy were made each year. To get a picture whether this was actually done, one needs to interview the women themselves, but that was not within the scope of this review. There is the chance that the transport costs have been inflated, especially taken the fact that many of the women are probably visited on the same day.[6]

One of the recommendations of the 2009 review was to promote research projects. There have been some delays in the progress since the original plans were rejected by the board in 2011, but HLH presently hosts 14 research projects, two of which are large scale (one on the effects of malnutrition and enteric diseases, the other on the effects of the Helping babies breathe program). The National Medical Research Institute (NMRI) has an office at the hospital, and HHL's webpage (http://www.haydom.com/) gives good information to people interested in doing research in collaboration with the hospital.

2.2 Strengths and weaknesses

The main strength of the out-reach services have been their reliability – the schedules appear to have been followed diligently and large groups of women and children attend the services. Judging from the out-reach that was attended, the statistics that are compiled are reliable, and the log books used are the same as the ones used by government facilities, which facilitates reporting to the district administrations. Despite this, we have in some cases found different figures for the same indicator and same period in various reports.[7]

Another strength of the out-reach program is its flexibility. In 2009 HLH closed one out-reach clinic due to the establishment of a government clinic in the same area. In the same year two new clinics were opened, one of them in a very remote location. While HLH did close one clinic due the proximity of a government facility, and the Annual Report of 2009 states that RCHC is "provided in close collaboration with the different district health authorities" it is unclear to what degree HLH out-reach services are offered as a parallel to public services. Women interviewed at the outreach said that they used the services of both the local dispensary and HLH's outreach. While local health authorities and facilities may be very content to let HLH provide services, there is a danger that the public system becomes dormant. Many of the dispensaries in the area do not have electricity, which is a challenge

[6] Comment from HLH: The MDG4&5 report was probably based on data in the WEBerp that were not correct at the time.

[7] The annual progress report of 2008 provides diverging figures. The narrative reports states that the number of deliveries at HLH was 3,343 in 2007. The Indicator list in the same report states that the number of deliveries in 2007 was 2,843. In this report we use the figures stated in the indicator list.

for vaccinations that depend upon a cold chain. One option could be to let HLH supply the vaccines by car, but let the local dispensaries do the actual work. According to RNE, there are indications that some of the districts where outreach services are taking place budget for the kind of primary services that HLH provides, but HLH does not receive any of these funds.

HLH depends upon the district administration of Mbulu for supply of vaccinations, HIV test kits, vouchers for malaria nets, as well as clinical cards for children. Since HLH provides out-reach for people in other districts than Mbulu, but do not get supplies from these districts, HLH is unable to vaccinate all the children who are brought for the out-reach clinics. HLH should try to access vaccines and clinical cards from the districts it works in.. In the absence of clinical cards, the out-reach staff is forced to use a simpler type of card that contains less information and no weight for height scale. This means that cases of underweight/malnutrition may be missed. We witnessed one such case during the out-reach we attended. When this child's information was transferred to a proper clinical card, it became clear that the child was in the category where intervention is needed. The HLH staff do their best to transfer all the information from the temporary cards when the proper clinical cards are back in stock, but this is so time consuming that only a small number of cards are transferred each month. Clinical cards constitute a very low cost investment that may potentially save lives. It would both save time and improve quality if HLH, in collaboration with the districts they work in, could secure a better system to obtain enough cards.

The ambulance services offered by HLH are most probably very important for maternal health, but have proved costly. In 2011, the actual costs for the ambulance service connected to MDG4&5 was Tshs 185 million while the budget was 139 million. This means that the actual cost for each trip was close to Tshs. 70,000. As we will come back to, the costs may be inflated due to theft of diesel and/or drivers' private use of the cars. HLH is in the process of implementing a control and monitoring system for all the vehicles. In order to reduce costs, and realizing that the hospital is unable to cover the whole catchment area with ambulance services, HLH has planned to make guidelines on "the geographical distinction of the availability of ambulance services" (Workplan 2010). HLH has also considered introducing a fee, but have decided to try to get external funding to continue this service (Workplan 2012). One option would be to introduce cost-sharing through post-payment of Tshs. 5-10,000.

One of the strategies HLH has used to improve mother and child health, is to make pediatric clinical guidelines (2011), special clinical guidelines for Clinical Officers and Medical Doctors (2008), and standardized charts and procedures in the examination and follow-up of patients. Studies in Tanzania and other countries have shown that many health workers do not adhere to clinical guidelines. Adherence should therefore be monitored, and in the case of non-adherence contributing factors should be identified.

2.3 Sustainability and focus in the future

It is a long term goal for HLH to uphold its present services, but with less dependence on funding from RNE. As will be elaborated later in this report, the process of securing government funding has recently taken a very positive turn. However, the MoHSW is very clear that the planned government support to Haydom is meant for referral services (including prime deliveries and deliveries for child number five and onwards) and that the funds cannot be used for providing primary services, like out-reach. If funds for such services are provided by external sources, however, the Ministry will not interfere.

Ideally, support for MDG 4&5 should be integrated with the general support to the hospital. First, the services are an integrated part of the running of the hospital, second, it has proved difficult to separate and document spending on this project, and third, separate projects adds to the administrative burden

of the hospital. We therefore recommend that support to activities that were under MDG 4&5 are added to the core grant for the remaining period (up to 2015). This means there will be one work plan and one annual report. Before extra funding is granted, however, HLH should demonstrate that it has been able to get in place a number of the improvements that have been suggested in previous reviews and audits. This will be elaborated in the chapter on financial management and in the midterm review of the block grant.

We also suggest that the focus of the MDG 4&5 efforts should be reconsidered. During the project period 2008-2012, PMTCT has been a major component, in addition to outreach services, ambulance services, and improved quality in the maternal and pediatric wards.

As mentioned earlier, the transport costs for each child in the PMTCT program have been high. The team is of the opinion that more lives could perhaps have been saved if some of these resources were spent on information on family planning/contraceptives and prevention of malnourishment during outreach – in addition to the services offered at the hospital.[8] Interviews with women at outreach and in the maternity ward revealed that families have up to ten children, and that even families with malnourished children still want to have more children (this is often the husband's preference). Health education on family planning and healthy diets for children should preferably be directed towards both men and women.

Sterilization is free at HLH (and also at government hospitals for women who have five or more children), but many women probably do not know about this option. Experience from other places in Tanzania show that women who have many children are very eager to go through sterilization, but they often meet barriers in terms of costs (i.e transport) even if the surgery itself is free. Women also need to have their husband's consent before undergoing sterilization, which is yet another reason why men should be involved in health education.

One of the research projects conducted at HLH (MalED) focuses on malnutrition and intestinal infections. An intervention focusing on family planning and improved diet for young children could possibly be linked to that project. Malnutrition leads to serious lifelong physical and mental problems and makes children less likely to survive illnesses such as malaria, pneumonia and diarrhea. A cost-effectiveness analysis of the number of children reached by PMTCT in the project period (179) with the number of deaths in the pediatric ward (991) should be considered when priorities are made in the future.

According to the minutes of the general meeting in January 2009, HLH had established a separate account for MFG 4&5 funds. In actual practice, however, spending on MDG 4&5 has not been singled out. In terms of deviations from the budgets, there has been up to 70% overspending on transport. The financial management of HLH as whole will be dealt with in the following chapter.

[8] Comments from HLH: HLH already provides counseling on family planning and are giving contraceptives to people who visit the clinic, so if unmarried girls visit the clinic to get condoms or other kinds of contraceptive they will receive it. HLH have also promoted use of condoms linked to its HIV prevention programs. The church however will probably not change its view of sex before marriage, and will continue to promote abstinence.

3. Financial management

Financial management has been a great concern to HLH for many years. A number of reviews have identified weaknesses in the financial management system and provided recommendations as to what should be done, but these recommendations have not yet been fully implemented.

3.1 Risk of fraud and corruption

Being a hospital under religious ownership and structure, there has historically been a high level of trust at HLH and the management has had a tendency to take for granted that employees are honest. This has resulted in limited focus on internal control systems and there have been (and to a certain degree still are), a number of loop holes in the system

In February 2011 the Financial Advisor of HLH discovered that PEPFAR funds had been misused for at least two years, perhaps more. Cash was withdrawn from the PEPFAR account and transferred manually to the hospital account. Receipts were prepared from different series of receipt book, which was not accounted for in the hospital records. The total amount lost is around Tshs. 63 million (approximately USD 42,000). HLH immediately informed PEPFAR and RNE about the unfortunate events. Most of the Finance Department was involved, between four and nine people. Four staff members, including the Head of Finance, admitted in writing to have taken part in the fraud (Tshs. 39 million) and were fired. The staff in question agreed to pay back the embezzled funds, but very little has been collected so far. None of them have been reported to the police since a court process most probably will take many years to complete, and the law says that the hospital will be obliged to pay salaries during this period under the principle that a suspect is innocent until proven guilty. It is important to note that Norwegian funds and PEPFAR funds were kept in separate accounts. HLH has therefore guaranteed that no funds from RNE have been misused.

In another incidence two to three years ago, a senior staff member was dismissed after he had stolen building materials meant for the construction of the police station and a school.

3.2 Efforts to improve financial management

In 2011, the software Web ERP for financial management was installed and it is now being used for stock control and ordering in the pharmacy, garage and food store. The team observed that inventory records are not being maintained properly, so that the actual inventory differs from the inventory records in the accounting system. Accounting records produced by the software are not reliable on account of incorrect data entry and inadequate user training of the staff members. As a result of this, there is minimal control over the medical and non-medical inventory at the hospital, making it a vulnerable area for fraud and misuse of hospital assets. This was also observed by the statutory auditors and has been reported in the management letter.

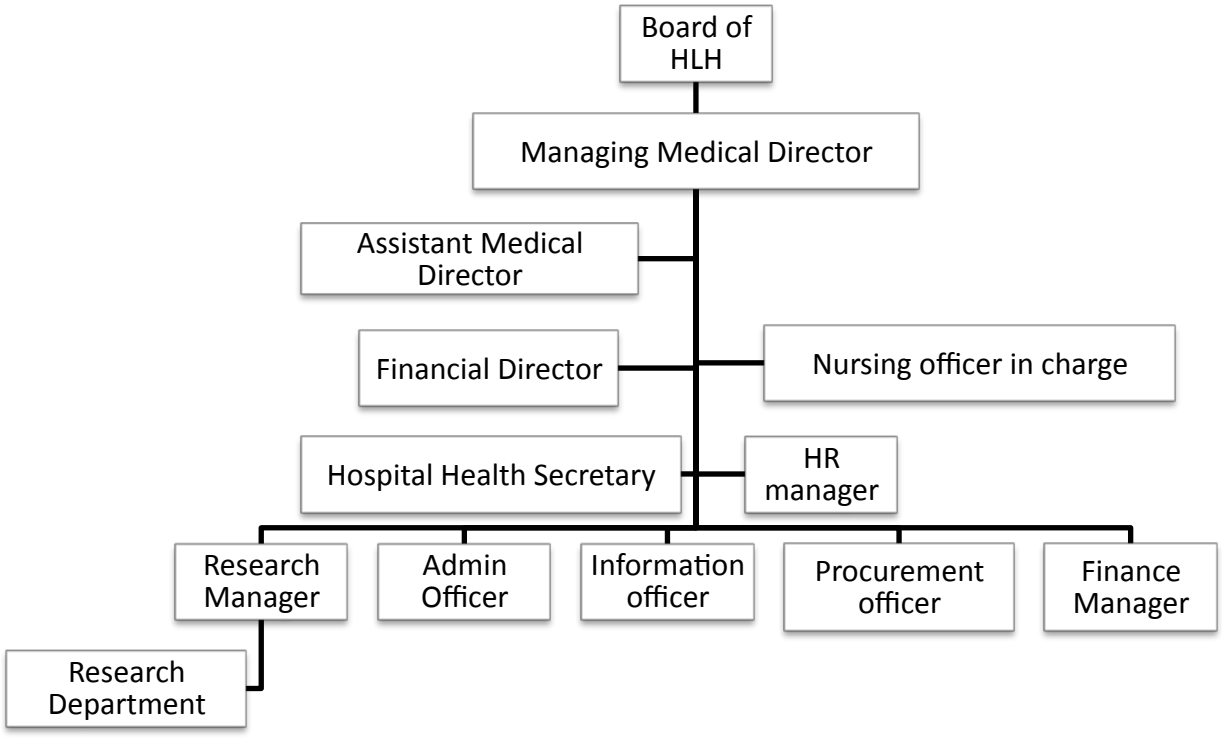
Human resources are the biggest cost for the hospital. It has been observed that there is limited control over the HR function in HLH. Control over staffing, their overtime, allowances etc., was among the challenges identified in the 2009 review that have not yet been adequately resolved. In 2012 HR software from CSSC was tested, but it was later replaced by a government system. There have been some problems with the adaptation of the government HR system. Pay rolls are prepared by the Accounts Department, and it was observed that the attendance records are not maintained properly and inadequate information is passed on for processing of payroll. We also observed that attendance records were not updated by the HR department for the month of November & December 2012 with the roster, whereas the salaries have been processed and paid. We also noted that rosters are partly filled in by pencil, which means that it can be manipulated very easily. Overtime at HLH has not been

documented properly. Recently, a new system has been introduced where the staff receives days off instead of paid overtime when working extra hours. All extra hours needs to be approved by the supervisor.

HR is a potential risk area for fraud or misuse of hospital funds by way of creation of fictitious employees whose pay is then obtained by the fraudster or by someone in collusion; or obtaining pay which is not consistent with an employee's grade. HLH is now working on implementing a system where HR collects the weekly attendance from the head of departments and makes a monthly attendance list. This will then be sent to the accountant for processing of the payroll. HLH also plans to employ an assistant to the nurse officer to get a closer follow up on attendance, overtime, off days and use of human resources.

HLH has a documented procedure for procurement, but the procedures have not been followed for procurements of goods and services. In 2012 HLH decided to establish a procurement committee to improve the procurement procedures and decrease the risk of fraud or corruption, but the committee has not yet been formed. In the second half of 2012 new routines were introduced in the administrative organization and internal control. The inventory lists are to be checked on a regular basis and the bookings are to be tracked. Such improvements will lead to a better internal control over the inventories from the end of 2012 with effect from 2013.

Figure 1. The organizational structure of HLH



3.3 Assessment of the financial management structure and capacity at HLH

HLH faces constraints regarding the capacity of the manpower in the financial management department. HLH therefore relies on expats for the Financial Director position. The current Financial Director is a Certified Public Accountant with extensive experience from working with large companies in the Netherlands. He will remain in this position until September 2013, and the hospital is in the process of recruiting someone to replace him. Finding a Finance Director with the right qualifications who is willing to work for a relatively low pay is a challenge, however.

It has been observed that there is a serious need of training various individuals in the Accounts Department, stores and other departments where Web ERP is being installed and used. Due to lack of adequate knowledge among the users of Web ERP, the data put in to software has been incomplete and thus the reports generated from the software are also incomplete and incorrect. As a result of this, implementation of Web ERP has not effectively helped to improve the internal control systems and rather have increased the concerns due to non-existence of controls at certain places, in particular the medical stores and the non-medical stores. The account staff was trained in Web ERP in November 2012 and this is expected to improve results.

3.4 Assessment of the general financial situation of HLH

For the year 2012, it was budgeted that the RNE block grant would contribute 45.5% of the total revenue. Accounts for the first half year of 2012 show that the RNE block grant contributed 54.1% (see annex 5.3.3). The main reason for this is that the two planned contributors, MOHSW (Staff Grant) & 'new donor' have not contributed as budgeted. According to the MoU with the region, the increased government funding will be available from July 2013. According to the HLH management, expenses have been lower than budgeted without reducing activities. Similarly on the expenditure side it has been observed that there has been overspending on some of the budgeted activities while expenditures on salary, wages and allowances have been scaled down (this is closely connected to the new shift schedules and the policy of not paying for over time).

In addition to the current half yearly report, we also analyzed the financials for the year ending on 31 December 2011 (see annex 5.3.4). We found that the control over budget lines and budgeted activities has been inadequate. For example, the budgeted amount for medicine was Tshs. 150 million, while the actual amount spent was more than double, around 282 million, and while there was no budget post for a water tank for the guest house, 66 million was spent on this. Some of the expenses have in actual terms increased disproportionately when compared with 2010, like the amount spent on allowances and medicines (see annex 5.3.5). Expenditures on medicine increased from around Tshs. 141 million in 2010 to around Tshs. 382 million in 2011.

Further analysis of accounts shows that the balance of other receivables stands at Tshs. 249,373,000/- after writing off Tshs. 128,351,000/- as bad debts. This means that total increase in other receivables during the year amounts to Tshs. 238,740,000/-. It is unclear why such credits are being extended to the customers. The Annual report for 2011 provides details of Special fund balances (page 26). Some of the balances are negative. This shows that the amount spend on these activities have exceeded the funds received for it and that general funds have been used for those specific activities (see annex 5.3.6).

3.5 Procedures that have been implemented in order to avoid misuse of hospital funds

Extensive recommendations as to how the financial management of HLH can be improved have been provided in the Final Project Review of June 2009 and in the Innovex' Management Letter of August 2012. At the time of this review, many, but not all of the recommendations have been implemented (see annex 5.5). Some of the major issues which are still not addressed are the following:

- HLH has not developed a policy regarding the provision of services to assist in priority setting.
- Efforts put into investigating the reasons for the increasing trend in expenditures and the declining trend in revenues of the hospital cars has not been effective. More dedicated efforts needs to be put in to controlling the increasing expenditure and bring in efficiency.
- The exercise to evaluate the impact of the increase in user fees on the accessibility and utilization of hospital services has not been done.
- We could not see specific efforts being made to develop a system for periodically assessment of the income and expenditure profiles of the income generating assets of the hospital.
- Recommendation for eliminating the weakness in the collection of cash at the cash counters has not been implemented fully. Risk of misappropriation still exists.
- There are still weaknesses in the recording and issuing of invoices for the workshop.
- There is inadequate control over the Human Resource Management, employee database and payroll processing.
- There are still weaknesses in Web ERP and therefore the accounting and stock data available from the system is not reliable.
- Disaster recovery plan and backup of IT database off-site is still not in place.
- Stock records maintained in Web ERP are not reliable and not much has been done to resolve this issue.

More efforts need to be put in to strengthening the internal control systems.

4. Mid-term review of the Block Grant Support

4.1 Main activities concerning Result area 1

The main goals of Result area 1 is continuation of hospital and outreach services at present levels; and to sustain current levels of core hospital services (outpatient, outreach, surgical, mother and child) both access and quality wise during the 5-year period. Outreach services and mother and child health have been covered in the end review of MDG 4&5.

Table 2. Selected indicators result area 1

	2008	2009	2010	2011	2012 Estimate	Cumulative since 2010
No. of outpatients	60,508	57,896	56,496	72,484 [b]	70,000	198,980
No. of inpatients	na	15,077	15,664	16,744	17,000	49,408
Average stay days	na	6.2	7.5	6.9	6.9	-
No. of major operations	1,755	1,995	2,191	1,858	2,219	6,268
No. of minor operations	2,118	1,719	1,779	1,641	1,812	5232
No. of deaths (following surgery)	282	365	319	347	254	920

a) Per 1000 live birds.

b) Increase due to including sick OPD children seen by a doctor in RCHS clinic and TB cases (not included earlier)

The number of outpatients went up substantially from around 56,500 in 2010 to around 72,500 in 2011, due to including sick OPD children seen by a doctor in RCHS clinic and TB cases. In 2012 HLH introduced a user fee, but since the statistics of 2012 are not processed yet, it is unclear whether this has had an effect. The number of inpatients has been more stable, with a small increase (1000) from year to year, and standing at 16,744 in 2011.The average number of stay days has shown a small upward trend over the last four years, and there is a large variation. A number of patients stay for many months, either because they go through long term treatment (like burns and cancer), or because they can't afford to pay for referral to another hospital. According to the staff, some patients stay at the hospital after treatment because they are unable to pay and they are therefore kept until their relatives or others bring enough money. According to the management, such situations should not occur, since these patients should receive funding from the poor patients fund.

The number of major and minor and operations went down from 2010 to 2011. The main reason appears to be a "go-slow" action after a three shift system was introduced in February 2011. Before, staff would be called for emergency operations at night and would be paid a special allowance for over time. With the new system operations at night is part of the rooster and are not compensated. HLH saves around Tshs. 40 million per month in reduced overtime. The new system caused discontent and some staff members threatened to strike, in addition to the "go-slow" action. The estimate for 2012 is back at 2010 levels, however.

HLH provides services to the population in seven districts and four regions (see map on page iv). Many of the in-patients who were interviewed had been given transfer from district hospitals to HLH,

either because the district hospitals did not have functioning equipment (like x-ray), or qualified surgeons. Patients with burns and complicated fractures appear to be transferred in most cases. Other patients come directly to HLH on their own decision because they believe that the quality of treatment is better at HLH. Another anecdotal evidence of the quality of HLH services is that staff at the regional administration in Babati (2.5 hours away) whom we talked to said that they prefer HLH for medical treatment rather than using the Regional Hospital located next door. There is a conception that HLH offers better services in terms of hard working staff, better equipment, and high quality medicine given at correct dosage.

In addition to having better equipment, the focus on research and continuing learning through teaching sessions by visiting researchers probably contributes to the quality of HLH services compared to governmental hospitals. And while HLH struggles hard to hire specialists at a permanent basis, visiting expat doctors and specialists contribute to quality treatment and capacity building.

In 2010 HLH had 45 students in various training institutions throughout Tanzania, many of them building capacity on malnutrition, burns and intensive care.

Medical records

HLH has used EPI-Info for medical records, but the intention has been to replace it by Care 2X in order to improve the records. Care 2X was introduced in 2011 and training of doctors and nurses was started that year. The plan was that Care 2X should be used by doctors from the moment they start taking history. There has, however, been considerable resistance against using the system, since it adds to present work tasks and is time consuming, particularly for staff with limited computer literacy. Doctors therefore write by hand, and then secretaries enter the information, but many of them don't know the medical terms. At the moment, the system is not working properly. A major problem is that the staff member who was maintaining the system has left HLH, and external programmers charge very high fees for their services. In 2010, there was an attempt to link Care 2X and WebErp but this link has now been disabled. From 2011 the invoices have therefore be done manually.

4.2 Efforts to make HLH a teaching hospital

It is a major goal for HLH to become a teaching hospital. The guidelines say that a hospital with 3 different training programs is eligible for the status of teaching hospital. Currently, HLH has a Nursing school and training for Medical Interns. The plan was to open an AMO School in 2012, but the process has been delayed. The main reason is that it has proved very difficult to attract specialists. The government has appointed several specialists to work at HLH, but none of them have accepted the placement. The MoHSW therefore encourages HLH to hire specialists directly, rather than through the Ministry.

In an effort to attract specialists, HLH has from 2011 offered an incentive package which includes free, fully equipped housing, as well as a Tshs 3 million top up of their monthly salary (2 million after tax). Specialists who reside in cities may easily make the same amount of money in a week or two. One should therefore look into the possibilities for increasing the sum, or alternatively, other forms of incentives. Subsidized quality education for doctors' children appears to be an attractive alternative. HLH has discussed the possibility of facilitating the establishment of a high quality school at Haydom, but will not spend hospital resources on this. Specialists may find the prospect of having

their school children living with them rather than sending them to a boarding school at a young age very attractive.[9]

Five medical doctors employed at HLH have been sent for specialization at other institutions in Tanzania (surgery, pediatrics, internal medicine, and gynecology). Two of them will be back at HLH in February 2013. It is a challenge, however, for HLH to retain staff who have been sent for specialization. Contracts are made with each individual, stating the number of years they will have to serve at HLH after completed training, and the amount the staff member has to pay back if he/she refuses to do so. A lawyer is present when the contract is signed. The first contracts had some loop holes, but this has now been corrected. HLH has issued a court case against one doctor who has been sponsored by the hospital for specialist education and who hasn't come back. There is the potential danger that individuals will refrain from coming back, and simply regard the money to be paid back as a 'soft loan' since it is interest free. HLH's policy is to offer specialist education to doctors from the local area, who are more inclined to come back.

In addition to the AMO school, HLH is planning to open a laboratory technician school in 2013 and nurse anesthetist training in 2014. As soon as one of the three is established, HLH may apply for the status of teaching hospital. It is unclear how long the process of accreditation may take.

Nursing school

In 2011 the Haydom School of Nursing achieved accreditation. The school has had separate accounts from June 2011, and an independent board from 2012. Members include representatives from the district administration, the local area (secondary school), HLH, and the KCMC nursing school. The Government pays for two staff members and the final examinations are organized under the MoSWH. In 2011 the school had more than 200 students. The school fee is Tshs. 1.2 million per year, but there is special fund for orphans. The strategic plan of the school is to offer training from diploma level to BA by 2015, but the school will then need to hire teaching staff with a MA. The school has an exchange program with Norway. HLH hirers many of the students after graduation (50 in 2011), but many leave after a few years. According to the head of the school, students prefer work in governmental institutions because of the pension system and because faith based hospital are perceived as being more 'strict' when it comes to work performance.

4.3 Efforts to secure diversified funding

RNE has for many years been the main funder of RNE, covering 60 and 61 percent of the budget in 2010 and 2011 respectively. Obtaining new sources of external funding was one of the three main challenges identified in the revised work plan (February 2012). The major strategy of HLH is to secure substantially increased government funding in the coming years, and it will most probably succeed in doing so.

[9] A good local school costs around Tshs. 2-3 million per year, while international schools in Tanzania cost around Tshs 19 to 25 million per year (USD 12,500-16,800) for grades 1-8.

Table 3. Sources of income (in percentage) [a]

Source of income	2010	2011	2012 (budgeted)
Norwegian Embassy	60.0	61.0	56.6
Tanzanian government	7.5	8.0	19.0
Patient fees	11.2	10.0	12.0
Others/new donor	1.0	7.0	5.0
Non-medical service income	9.3	9.0	4.0
Research/external income	11.0	5.0	3.0

a) Based on table in Annual Report 2011 and revised work plan for 2010-2014 (February 2012).

Increase financial support from the Tanzanian government

In October 2010, the Minister for Health and Social Welfare announced that ten faith based hospitals, including HLH, would be upgraded to be Referral Hospitals at Regional Level to provide specialist care.[10] This entails that the government, when the process has been completed, will cover the following expenses: salaries of the majority of the staff (excluding unqualified staff like medical attendants and purely religious functions), medical expenses, equipment, operational costs, and a bed allowance (which will be for the actual number of beds, 429, while the bed allowance up to now has been for 250 beds only). Expenses for buildings will not be covered, neither should the funds from MoHSW be spent on providing primary services. It is a requirement that the hospital has access to specialists (see above for challenges HLH faces in this regard). The Ministry will provide HLH with a block grant for salaries, but the responsibility as an employer will be with the hospital, including hiring and firing. HLH will be free to top up government salaries from own/external sources. The Government will monitor the usage of the block grant to ensure value for money.

Christian Social Service Commission (CSSC) is coordinating the process and has held discussions with PMO-RALG, as well as making a template for MoU to be used by the ten faith based hospitals. A central issue is how the governing boards should be composed, and who shall be responsible for appointing board members representing the government. Two years have passed since the decision was made, but the process has not been completed for any of the ten hospitals. So far only one of the ten selected faith based hospitals (CCRBT) has signed a MoU. In the opinion of CSSC the MoHSW has not prioritized the process after the decision was announced in 2010, and has problems meeting the financial commitments. The Commission still hopes to complete the process by April 2013.

The agreements will be made between the Regional Administration and the selected faith based hospitals. The MoHSW has made it clear that as part of the country's decentralization by devolution, the Ministry will not be involved directly in this process. When the MoU has been agreed upon, it will go to the Attorney General, and then be sent to the MoHSW for comments. Following this process the final MoU will be signed. Since costs need to be included in the national budget, however, HLH will not be able to receive funds for the financial year 2013-2014. HLH should aim to have the MoU processed and signed as soon as possible, in order to be included in the budget for 2014-2015 (budget negotiations starting in January 2014).[11] When the MoU has been signed a governing committee, with

[10] Gazeti la Jamhuri ya Muungano wa Tanzania. Issue 91 (46). 12. November 2010. The decision to upgrade HLH was also mentioned during the Presidential election campaign in Manyara.

[11] This MoU will replace the MoU that was signed by the RAS and the Bishop on behalf of ELCT Diocese of Mbulu and the Mangement of Haydom Hospital in July 2012.

representatives from the government and the owners of the hospital, will be set up. The majority of the members of the governing committee are to represent the owners.

So far, the only benefit HLH gets from having been selected as a Referral Hospitals at Regional Level is an account at Medical Stores Department (MSD). HLH receives the same amount of drugs as a regional hospital, but very often the requested medicine is out of stock and has to be purchased from private suppliers.

HLH has asked to be invited to the Budget meeting of the Region and this has been approved for 2013. There is a process to allocate a separate code for HLH in the regional budget. Before this is achieved, HLH will have to get its funds through the regional hospital. In January 2013, the RAS of Manyara discussed the funding of HLH with the Minister of Finance and the Minister of Health and Social Welfare. The ministers have asked to get HLH's payrolls and the names of all staff. This gives reason for optimism.

The Region has accepted to take responsibility for all qualified staff in a long term perspective, starting with 231. Medical attendants are not included in this category. Since HLH has 234 medical attendants, it means that the hospital either has to upgrade them, fire them, or find other ways to finance their salaries. According to the HLH division leaders, some of the senior Medical Attendants do a very good job due to their long experience.

When the process has been completed, the government funding of the hospital will be managed by the RAS, while the day to running of the hospital will be the responsibility of HLH. The finances of the hospital will be linked to the regional finance system and governmental funds for salaries, diesel, etc. will be audited. The Region expects to be informed about external funds in a transparent manner, including support given in kind (equipment such as vehicles and medicine) but it will not have a role in authorizing expenditures. The Region will not interfere with the volunteer/expat system at HLH.

Challenges in connection with increased government funding

In the history of HLH the attitudes towards government and church involvement in the hospital has shifted. While earlier Managing Medical Directors may have feared that close collaboration with the government may entail limited autonomy and possibly reduced quality of services, the present Managing Medical Director see close collaboration with the government as the only solution for strengthening the long term sustainability of the hospital. MoHSW and CSSC do, however, have slightly different perceptions as to what increased government funding will mean for the autonomy of the hospital. Will, for example, MoHSW or the Region have the right to transfer HLH staff who are paid for by the government to other health facilities? This question need to be addressed in the ongoing negotiation to finalize a MoU between HLH and Manyara Region. The introduction of Government auditing will probably also necessitate a clearer distinction between the non-medical activities of the hospital (garage etc) and the medical, as well as between primary services and referral services.

Income from other sources

Since HLH's major strategy is to secure increased funding from the Tanzanian government, and this has proved to be a time consuming process, less time and resources have been spent on fund raising activities from other sources. However, in May 2011 HLH hired a Hospital Information Officer who is responsible for fund raising. He will prepare a comprehensive fundraising plan to be presented at the first board meeting of 2013.

Fundraising in Norway is done first and foremost in cooperation with Friends of Haydom, and has traditionally been in the form of equipment and voluntary work, but there are also other sources of support in Norway. For example, one of the Norwegian board members raised funds to build the new Maternity ward. HLH gets some income from hosting a one week clinical course for 25 Norwegian

doctors in Developing Country Medicine. The course is organized by the Norwegian Medical Association (Vest-Agder Branch).

HLH has also sought to increase its income by introducing and/or increasing fees for patients. In July 2011 an OPD fee of Tshs was 500 introduced. During late autumn 2012, the hospital introduced an admission fee of Tshs. 20,000 for adults, and 10,000 for children over five. If the total treatment costs are lower when the patient is ready to go home, the patient will be refunded the difference. The prices for surgery vary between around Tshs. 30,000 to around Tshs. 120 000, which is around one tenth of what a private hospital in Arusha charges for similar treatment. Patients admitted to the Amani ward (substance use disorders) pay Tshs 240,000 upon admission for a 6 week stay including treatment and food. While it is too early to assess the long term effects of cost sharing, it is our judgment that the majority of patients will be able to raise sums up to Tshs. 20,000 from their extended families for hospital treatment. In the words of one informant when we asked how he felt about the expenses hospital treatment entailed: "Expenses – well, we are more concerned about getting well!" (*Gharama – si tunaangalia uhai!*). While surgery and treatment at the Amani ward may be out of reach for the poorest of the poorest, Tshs. 500 for OPD does probably not prohibit anyone from accessing such services. It should be noted that in actual practice, HLH exempts very poor hospitalized patients from payment.

4.4 Non-medical development activities

For many years, HLH aimed to be a central development actor in Haydom district. In recent years this vision has been modified, and the present management now wishes to focus on core hospital activities. This is in line with recommendations that has been given by RNE and the 2009 review.

Haydom Vocational and Entrepreneurial Training Center (HVETC)

The HVETC was established with assistance from the hospital, but the hospital has not been involved in the operations over the last two years. The school has its own Board. Members include the Medical Director of HHL and representatives of the Mbulu diocese. The board is chaired by an employee of a local Secondary School, and the Board hires the staff. HLH does not support HVETC financially, but the Finance Department does the book-keeping for the school. HVETC gets financial support through Friends of Haydom (FoH) and the Lions in Mandal.

4-Corner Cultural Project (4CCP)

The 4CCP was initiated in late 2006 by HLH.[12] The main aim was to create a place for communication and conflict resolution for the four ethno-linguistic groups in the area. 4CCP is funded by Norwegian Church Aid (through RNE) and does not receive any funds from HLH. The staff of 4CCP is on the payroll of HLH, but the costs are reimbursed from the 4CCP.[13] In 2010, the programme was registered as an autonomous organization, but NCA has asked that the contract for the support is with HLH and that HLH keeps the accounts. The Managing Medical Director of HLH sits on the Board. 4CCP has contacted Kristen Idrettskontakt (KRIK) in Norway and foresee a process where KRIK will replace the role that HLH has played so far in keeping the accounts etc.

[12] For more details about the 4CCP, please see the programme's Annual Report 2011 (http://haydom.no/media/1265/4ccp-annual-report-2011-f-1.pdf).

[13] Some of the staff were originally HLH staff and want to remain so. With the planned Government funding of HLH staff, these staffs have to be transferred to a separate 4CCP payroll.

Rain water harvesting

The hospital's rain-water harvesting program is a program under the 4CCP, financed by the Norwegian Church AID (NCA). Some rainwater tanks have been put up in primary and secondary schools in the area. At HLH one rain water tank was constructed in 2011. It is serving the guest house. The plan is to cover other buildings gradually.

4.5 Improvement of staff moral

Poor motivation among some staff members was pointed out as a challenge to provide quality services in the 2009 review. Improving staff work-ethics was also pointed out as one of three major challenges in the revised work plan (February 2012).

One expat, who stayed at the hospital for several months in 2011 and who was back in January 2013, says that there is a noticeable difference in staff attitudes, the staff being more caring and professional. Other expats, who were working at the hospital for the first time, emphasize that staff moral and motivation is very unevenly distributed among the staff. There appears to be two main groups; one doing the very best that they can under the circumstances, and another group that are idle a lot of the time and who do not give timely attention to seriously sick patients. Late coming is also common.

In July 2011, HLH hired a new staff member whose main area of work is to strengthen motivation and ethics among the staff. The present HR officer was employed in 2010. For the many staff members who were working without contracts, contracts were set up, and the process has now been completed for 80-90 percent of the staff. As part of this effort, HLH introduced performance appraisals in December 2012. So far, all employees have filled in the forms, but the forms have not yet been appraised by senior staff. The forms will form a basis for promotions. According to government regulations promotions shall take place every third year, but at Haydom it is has not been done since 2007 (and then only for staff that had been employed for at least four years).

HLH uses the government scales for salaries. In the period 2008-9, the Government raised wages substantially, and it was difficult for HLH to do a back payment. Only in 2010, and after negotiations with the union (TUGHE), the staff was paid 67% of the back pay. In addition to following the government pay scale, HLH has introduced some allowances on top, including a housing allowance (10% of salary), a monthly top-up allowance of Tshs. 30,000 for doctors, COs and nurses, and a modest allowance for out-reach. The pension system has been a major source of discontent for staff members who are paid by HLH. As pointed out in the 2009 review, for a health worker with 30 years of service and a salary of Tshs 400,000, the difference amounts to Tshs. 12 mill upon retirement. HLH now tries to get all its employees to join the government pension scheme. In contrast to public facilities, however, where the employee pays 5% and the employer 15%, HLH pays 10%. The introduction of the government pension scheme is a very positive development, but it is attractive for younger employees only, since senior employees will not benefit from shifting from their present scheme. Older employees express bitterness about the fact that they will be "left to die" upon retirement. The introduction of the government pension scheme will most probably not have negative effects on the long term economic viability of HLH since the government has agreed to take responsibility for the majority of the clinical staff in the future.

The in-charge of each Department is responsible for absence. If someone is not present, a form should be filled and sent to the human resources department. The staff member is then supposed to work extra at a later stage to compensate. According to expats however, there appear to be few or no consequences for persons who are idle during work hours or who turn up late for work. One reason may be seniority – that younger staff members have difficulties reprimanding colleagues who are older than themselves. Another factor may be the close relations between the staff, the fact that they

all live in the same community. The management has, however, fired 15 staffs who were found to be sleeping during night shifts. This reaction was perceived as unfair by their colleagues.

It should be noted that lack of motivation is very common among Tanzanian health workers, as has been documented in a number of academic studies.[14] Although the salary level for Tanzanian health workers has been raised drastically in recent years, many feel that they are underpaid and that they should be given higher pay or other forms of incentives in order to exert maximum effort. In the words of two of the division leaders: "People need to be given something as motivation"; "We don't have anything to give to them, only praise". Pay for Performance (P4P) has been introduced in the district. HLH has an agreement with the regional administration from July 2011 that HLH will be part of it, but it has not yet been implemented. The HR officer believes that P4P will improve commitment if and when HLH takes part.

Several staff members have visited Norway, either through escorting patients, as part of training, or through the Norwegian Peace Corps (FK). They all talk very positively about the experience, and such visits appear to build loyalty and pride in working at Haydom.

[14] See, among others: Songstad, N. G., O. B. Rekdal, et al. (2011). "Perceived unfairness in working conditions: The case of public health services in Tanzania." BMC Health Services Research **11**(34): 1-15.

4.6 Recommendations for the project's 2013 – 2014 time span

Indicators – need for disaggregated data

The key indicators are valuable for providing an overview of the hospital's activities, but the annual reports should to a greater degree give disaggregated data on illnesses and deaths (only one of the annual reports contains such data). Disaggregated data will make it easier to assess potentials for improvement and where extra resources are needed. Number of stay days is in itself not an appropriate quality indicator since many patients are forced to stay longer than necessary because they have been unable to settle their bills. While the number of deaths in the maternal and pediatric wards may give an indication of the quality of services, also this measure would be more meaningful if these deaths had been divided into subgroups. As a referral hospital, HLH does receive patients who are extremely sick, and this influences the survival rate.

Continued focus on core hospital activities

For many years, Haydom aimed at being a central development actor in the local community, and until recently lack of services in the Haydom area entailed that HLH had to be self-sustained with a number of services. Friends of Haydom has been central in offering gifts to HLH. While gifts such as knitted wool 'incubators' save lives among premature babies, other donations have for various reasons turned out to be a liability. The Managing Medical Director of HLH wants to make the hospital the core activity. One option could be to sell or rent out the tractors, trucks and other assets. The money could then be spent on building a quality primary school (not to be run by HLH) in order to attract specialists. A focus on core activities would also entail that HLH would have to reduce the number of non-clinical staff.

Government funding, continued autonomy, and RNE funding in the future

HLH has come a very long way in ensuring governmental funding for the referral services of the hospital. As the situation stands now, there are four major issues that need to be taken into consideration concerning RNE support in the future. First, the achievement of government funding is a time consuming process, and one must take into account that the government's commitment to pay salaries may not materialize before the project period is over in 2015. Second, the government will not fund medical assistants, who now constitute around 200 staff members. It is unrealistic that HLH will be able to attract the same number of qualified staff to replace them, and many of them are doing an essential job. Third, in order to attract specialists, HLH needs to top up the government salaries. Fourth, since MoHSW is vocal on the fact that it will not fund HLH to provide primary services, a strategy must be found on how to address this challenge. Moreover, HLH may need legal advice as to how the increased government funding can be achieved at the same time as protecting the hospital's autonomy. Since HLH will not be able to keep its current activity level without support from RNE, and since HLHs services are very important for reducing morbidity and mortality in the area, we recommend support beyond 2015.

Improved financial management

HLH needs to put efforts and resources into solving the financial management issues that have been identified in this and previous reviews. Since many of the senior staffs in the Finance Department were fired after fraud was discovered in 2011, it is understandable that this process takes time, but the seriousness of the issues means that RNE should make new funding available with a clausal that the most central tasks have been accomplished.

References

In addition to the project documents, the following publications have been consulted:

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Appendix I: Itinerary

Date	Description
Monday January 14	Arrival at Haydom at noon Introductory meeting with core management Guided tour of the hospital Informal interviews with patients Meeting Finance Department Informal interviews with expats
Tuesday January 15	Introduction at Sala Visit to out-reach clinic Endamilay Informal interviews with women using the out-reach services Informal interview with Friends of Haydom representative Compiling data, Finance Department Meeting ELCT Bishop, Assistant and General Secretary
Wednesday January 16	Informal interviews with expats Interview with HR officer Interviews with Heads of Divisions Interviews with Tanzania Union of Government Health Workers (TUGHE) representatives Visit to dental clinic Informal interview with expat about the cultural centre Compiling data, Finance Department Compiling data, HR Interview with Medical Director
Thursday January 17	Transfer to Babati Interview with Regional Administrative Secretary (RAS) Transfer to Dar es Salaam
Friday January 18	Interview with MoHSW Meeting Baker Tilly Meeting Royal Norwegian Embassy Interview with Christian Social Services Commission (CSCC)

Appendix II: Persons and groups consulted

Olav Espegren	Managing Medical Director
Andersson T. Sakweli	Assistant Managing Medical Director
Amon Ndeki	Information and Fundraising Officer
Huruma Sangali	Human Resource Officer
Martha E. Massawe	Administrative Officer
Timothy Dakay	Finance Officer
Emmanuel Mighay	Hospital Patron
Athanasio Bitippe	Assistant Nursing Officer, Secretary for TUGHE
Ezekiel Tsuhhay	Assistant Nurse, TUGHE member
Woman, ca 40 years, 9 children	Last child delivered by caesarean at HLH
Woman, ca 40 years, 10 children	Last child delivered by caesarean at HLH
Woman, 24 years, 3 children	Out-reach services, has given birth at Haydom once
Woman, 29 years, 1 child	Out-reach services, has given birth at Haydom once
Woman, 30 years, 6 children	Out-reach services, has given birth at Haydom once
Askofu Zebedayo Daudi	Bishop, ELCT, Mbulu,
Nicholaus Nsanga	Reverend, Assistant to the Bishop of ELCT Mbulu
Gilbert Eliezér	Acting General Secretary, ELCT Mbulu
Andrea Norman	Head of Surgical Division
Bertha A. Sutte	Head of Out-reach
Sesilia E. Lori	Head of Nursing School
Ruth E. Mneney	Head of Medical Division
Angella Baynit	Head of Mother and Child Division
Yeconia Zacharia Focus	Head of Medical Services
Claudio Bitegeko	Regional Administrative Secretary, Manyara Region
Dr. Rodwin Mung'ongo	Ministry of Health and Social Welfare
Kailas K. Bhattbhatt	BakerTilly
Alarakhia Mehjabeen	Royal Norwegian Embassy
Peter Maduki	Executive Director, Christian Social Service Commission
Male and female health workers	Expats – volunteers and students

The Financial Director was on holiday during the team's visit but has provided extensive comments to the first draft report.

Appendix III: Financial management

Discrepancies between the half yearly report submitted and the accounting records as per Web ERP.

Sr. No.	Account head	Amount as per		Difference	Comments
		Half yearly report	Web ERP data		
1	Non-Medical Service Income	259,836,441	675,731,273	415,894,832	Income short reported
2	Other revenue grants (corporate donors)	199,952,859	-	- 199,952,859	Income excess reported
3	MOHSW medicine grant	100,000,000	-	- 100,000,000	Income excess reported
4	Mal-Ed and HBB projects contribution	73,225,968	-	- 73,225,968	Income excess reported
5	Medicine and Medical Supplies	380,498,321	232,147,368	148,350,953	Expense overstated
6	Equipment and Maintenance	240,312,557	301,090,387	- 60,777,830	Expense understated
7	Other operating Expenses	616,704,964	1,185,588,368	- 568,883,404	Expense understated
8	Surplus / (Deficit)	(78,530,440)	(502,881,498)	(424,351,057)	Deficit understated

Expenditures (budgeted and actual)

Sr. No.	Expenditure head	Amount Budgeted	Actual Expenditure	Difference
1	Salary wages & allowances	2,882,765,000	2,209,522,820	-673,242,180
2	Medicine and Medical Supplies	311,295,000	380,498,321	+69,203,321
3	Equipment and Maintenance	196,555,000	240,312,557	+43,757,557
4	Other operating Expenses	930,785,000	616,704,964	-314,080,036
5	Capacity Building	206,080,000	169,862,786	- 36,217,214

Income (budgeted and actual)

Sr. No.	Income Head	Amount Budgeted	Actual Income	Difference
1	Medical Service Income	546,060,000	476,633,222	-69,426,778
2	Non-medical Service income	178,190,000	259,836,441	+81,646,441
3	Other income generating activity	84,400,000	145,531,111	+61,131,111
4	RNE Block Grant contribution	2,100,000,000	1,968,503,937	+131,496,063
5	RNE MDG 4&5 contribution	56,000,000	104,986,877	+48,986,877
6	Friends of Haydom	155,000,000	-	-155,000,000
7	Other gifts	48,085,000	8,666,081	-39,418,919
8	MOHSW Staff Grants	500,000,000	265,252,200	-234,747,800
9	MOHSW Bed grant	6,250,000	14,199,700	+7,949,700
10	District Basket fund	33,340,000	24,000,000	-9,340,000
11	Other revenue grants (corporate donors)	245,000,000	199,952,859	-45,047,141
12	MOHSW medicine grant	68,500,000	100,000,000	+31,500,000
13	New donor	502,905,000	-	-502,905,000

Financials for the year ended 31 December 2011

Expense Head	Budget	Actual
o Water Tank guest house	NIL	66,137,000/-
o Medicine	150,000,000/-	382,152,000/-
o Building material	90,000,000/-	101,181,000/-
o Other equip. maintenance	75,000,000/-	154,524,000/-
o Diesel for hospital vehicle	350,000,000/-	545,442,000/-
o Education scholarship exp	215,000,000/-	345,243,000/-

Source: Page 21, 22 and 23 of audited financial statements

Items with particularly high increase

Expense Head	2011	2010
o Allowance for staff	739,123,000/-	574,647,000/-
o Other salary & allowances	75,527,000/-	NIL
o Medicine	382,152,000/-	140,934,000/-
o Diesel for hospital vehicle	545,442,000/-	387,194,000/-
o Educational scholarship	345,243,000/-	283,098,000/-

Special funds balances (from Annual report 2011)

Account Head	Balance 2011
o School revolving fund	26,257,000
o Exchange program Haukland	12,053,000
o Revolving fund expenses	59,025,000

Apendix IV: Terms of Reference

Review of the Royal Norwegian Embassy's support to Haydom Lutheran Hospital, Tanzania

Project: TAN-3112 MDG 4 and 5 (end review)

TAN-2315 Haydom Lutheran Hospital – General Support (mid-term review)

Agreements: TAN-07/083 NTPI, NGO, Haydom Lutheran Hospital

TAN-09/084 Haydom Block Grant Support 2010-2014

1 Background

Haydom Lutheran Hospital (HLH) is a first level referral hospital located in Mbulu district, Manyara region. HLH was first established by the Norwegian Lutheran Mission in 1955, but was taken over by its current owner, the Evangelical Lutheran Church of Tanzania (ELCT), in 1963.

HLH has a holistic approach when it comes to catering for the needs of a human being, focusing not only on physical health, but also on the mental, spiritual and social needs.

HLH has, throughout the years, received substantial financial support from both the Norwegian government through the Norwegian Ministry of Foreign Affairs (MFA), and NORAD. In March 2010, the MFA and HLH signed a new Contract, extending the Block Grant Support for the next five years 2010-2014. The financial grant is not to exceed NOK 75 million in the agreed Project period.

The Millennium Development Goals 4 & 5 (MDG 4&5) support from the 2007 Agreement between HLH and the MFA ends in 2012. The NOK 14.8 million Agreement was additional fund to support the hospital's activities related to maternal and child health care, as well as the hospital's integration of PMTCT in its daily activities.

In addition to MFA funding, HLH is financed from patient fees, support from the Tanzanian Ministry of Health and Social Welfare, revenues from research collaboration, internally generated income, as well as contributions from Norwegian organizations and private individuals. HLH is continuously working towards obtaining new sources of external funding in order to reduce the HLH's dependency on RNE funding. The aim is to receive a more balanced income mixture by 2014 than what is currently the case.

In accordance to the Block Grant Support Contract a mid-term review should be carried out in 2012, and the MDG 4& 5 Agreement require an end point review. These Terms of Reference (ToR) are intended to provide guidance for both these reviews. In addition to the two Project Contracts, the ToR take into account the recommendations mentioned in the Final Project Review of June 2009, the Revised Budget and Work Plan 2010-2014 of December 2010, and the Auditors reports including management letters for calendar year 2010 and 2011.

2 Mid-term review of the Block Grant Support

2.1. Project goal and objectives

The Block Grant Support is contributing to the implementation of HLH overall strategy. The project goals and objectives are therefore the same as the overall goals and objectives for the hospital with the exception of Results Area 5.

The goals of the HLH are:

1. Improved health of population and in particular infants, young children and mothers in the hospital's catchment area
2. Improved health service delivery systems in Tanzania

To achieve this, HLH has divided the General Support Project into the following Result areas:

Result area 1: Continuation of hospital and outreach services at present levels

Result area 2: Becoming a Teaching hospital by end-2015

Result area 3: Financial and human-resources for continuous operation secured by end 2014

Result area 4: HLH recognized node for MDG 4&5 operational research by 2011

Result area 5: HLH as a change agent in the surrounding Community (no funding from the Norwegian Embassy goes to result area 5)

The objectives according to the different strategic result areas are as follows:

1. Result area 1: sustain current levels of core hospital services (outpatient, outreach, surgical, mother and child) both access and quality wise during the 5-year period
2. Result area 2: to establish the hospital as a teaching hospital by establishing teaching and training facilities
3. Result area 3: increase Tanzanian government financial support, as well as prepare and implement a local fund raising strategy
4. Result area 4: disseminate and use knowledge obtained through various research programs, as well as establish an ethics committee
5. Result area 5: capacity building and poverty alleviation through the strengthening and expanding education and counseling activities in the 5-year period (no funding from the Norwegian Embassy goes to achieve the objectives for result area 5)

2.2 Review objectives and intended use

The objective of the mid-term review is to assess HLH as a running hospital within the health care system and as a development agent in the Mbulu district. The aim of the review is also to consider whether HLH is able to sustain the current level of activity long term, as well as its ability to adapt to a constantly changing health environment.

HLH's financial situation compared to budget and the hospital's capacity to access alternative and additional monetary resources will also be assessed. The Government of Tanzania's wage and pension policy, as well as how the country's increasing inflation rate affects HLH outputs should also be included into the financial assessment of HLH.

The review findings will be used to adjust the implantation of the project in the last phase if needed, and as an information base for future dialogue regarding collaboration and support between HLH and RNE.

2.3. Scope of Work

The mid-term review of the Block Grant Support should focus on, without restricting itself to the following:

- Assessment of results and achievements
  - List and review the main activities concerning Result area 1
  - A short assessment of the progress made towards HLH becoming a teaching hospital (Result area 2). A more detailed evaluation on this will be made in the end point evaluation of the Project
  - Assess the progress made on securing increased funding (Result area 3)Assess the progress report on the establishment of Haydom Vocational and Entrepreneurial Training Center, the hospital's rain water harvesting, and its 4-Corner Cultural Project (Result area 5)
- Assessment of challenges, including an assessment of risk factors and how they are handled.
  - The risk for fraud and corruption should be addressed specifically, including assessing the risk of misappropriation of funds, as well as addressing steps and procedure that have been implemented in order to avoid misuse of hospital fund, if such steps have been taken
- Assessment of the financial management structures and capacity at LHL and assessment of the general financial situation.
  - A summary of the financial situation so far in accordance to the budget plan (costs and expenditures, cash flow, income, stocks, projected running budget for 2012-2014)
  - Whether the recommendations mentioned in the Final Project Review of June 2009 and Innovex' Management Letter of August 2012 have been implemented
  - Whether the internal weaknesses and inefficiencies mentioned in the August 2012 Innovex Management Letter have been improved
  - Whether the challenges mentioned in the Revised budget and work plan for 2010-2014 have been addressed (obtaining new sources of funding, improvement of staff moral)
- Recommendations for the project's 2013 – 2014 time span
  - Assess whether the key indicators are appropriate to measure progress (medical statistics such as number of stay days in hospital etc.). Give recommendations for improved reporting if found appropriate.
  - Assess the needs for adjustments in the activity plans and/or in the more overall project design (inputs and/or outputs), and give recommendations for the remaining project period.

3. End review of the MDG 4 and 5 project support

3.1. Project goal and objectives:

The Goal of the Project is to contribute to reduction of maternal and child mortality by improving quality and quantity of lifesaving interventions before, during and after delivery, with a specific focus on PMTCT

In regards to the MDG 4&5 related goals, HLH is working towards achieving them by improving the general indicators that the hospital is using relevant for MDG 4, 5 and 6.

The contract states:

"Progress will be measured at an ongoing basis in terms of process and output indicators, looking at trends. Among indicators are:

- number of women and children examined through reproductive and child health services,
- number of women and children helped through ambulance services,
- number of deliveries and delivery related statistics at the Maternity Ward,
- number of mothers and children on PMTCT,
- number of children treated through pediatric ward."

3.2 Review objectives and intended use:

The objective of the end review is to evaluate the MDG 4 and 5 activities at HLH and to assess the long term sustainability of the activities.

The review findings will be used as an information base for future dialogue regarding collaboration and support between HLH and RNE.

3.3 Scope of Work

The end point review of the MDG 4 and 5 project should focus on, without restricting itself to the following:

- A description of actual outputs compared to planned outputs
- Plan deviations and their explanation
- An assessment of the effectiveness of the Project, of achievements in relation to purpose
- Assess strengths and weaknesses in the project design and in the implementation of the project.
- Inadequacies related to financial and budget control and reporting
- Whether purchases were done according to the MDG 4&5 Agreement
- Assessment of HLH's capacity to deal with aforementioned inadequacies
- An Mbulu/Myanara impact assessment if possible
- That Project funds are properly accounted for
- Whether there are any unutilized MDG funds, including accrued interests, and whether these have been returned to MFA
- Assessment of the MDG 4&5 Project's sustainability, and advice vis-à-vis a potential Agreement renewal

4 Implementation of the review

The sources of information and methodology to be employed should include:

- Desk study of relevant documents including the Grant Contracts, revised budget and work plan for 2010-2014, annual reports, financial and budget reports, audited accounts, minutes from annual meetings, and other relevant documents such as national plans and district plans.

- Field visits to HLH
- Meeting with relevant officials (church, community, government, RNE, other development partners)

The review is to be undertaken by two consultants and the estimated number working days for each consultant are 10-13 days (two days to review background documents and prepare for the study, 5 days fieldwork and 3 days to write up the report).

Required expertise:

Team leader: Norwegian or international health expert with knowledge on hospital management in resource limited settings. Experiences from similar reviews or evaluations are required. *Team member*: Local expert on health financing with good knowledge on the Tanzanian health system. Experiences from reviews and evaluations are required.

RNE will provide the necessary documents either in advance or during scheduled meetings.

5 Reporting

The team will submit their report in English. The draft report should be received by the RNE no later than 01.02.2013. The final report should be finished no later than one week after RNE and HLH have commented on the drafted report. The report should be maximum 20 pages, including a 1-2 page summary. The report should also include a section on lessons learned and recommendations. In addition, the report should be made available in both an electronic and paper version.

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INDEXING TERMS
Tanzania
Health services

Haydom Lutheran Hospital (HLH) is an important service provider in an area of Tanzania where the population is poor and government health services are inadequate. In 2011, The Royal Norwegian Embassy funded 61% of the hospital's budget, but the long term goal is to terminate the support. The government has decided that HLH will be upgraded to Referral Hospital at Regional Level, and this will entail that the government will take responsibility for a much larger share of the budget. While this is a very positive development, it is uncertain what increased government funding will mean for the autonomy of the hospital. Challenges that HLH need to address in the future include incentive packages to attract specialists, and proper implementation of the new systems for medical records and invoicing.

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