

CSOs submission for consideration into GFFII Investment case



*A Human Centered Approach to planning applied to
RMNCAH clients and health care providers.*

Report by

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1.0. INTRODUCTION

The Global Financing Facility (GFF) prioritizes Civil Society Organizations (CSOs) engagement in all processes ranging from planning, implementation, and results tracking. This is well-guided by the investment case and GFF-CSOs engagement strategy. The GFF-CSO engagement strategy (2018) as approved by the GFF Investors Group outlines three sub objectives related to CSO engagement and coordination as:

1. **Country Platforms** are supported to meaningfully engage civil society, in support of common goals, through implementation of the *Guidance Note: Inclusive Multi-stakeholder country platforms in support of Every Woman Every Child*.
2. **CSO Coalitions** at national and global levels are strengthened to enhance civil society alignment and capacity, and to streamline communication and technical assistance.
3. **GFF accountability** is strengthened through capacity strengthening and support for civil society's role in accountability, and increased transparency and space for accountability in GFF processes.

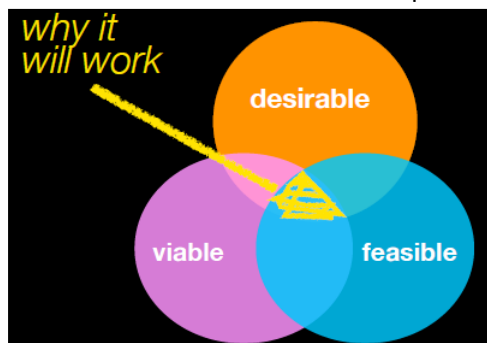
In Tanzania, Civil Society participation in GFF has been limited due to the nature of GFF implementation where existing RMNCAH Technical Working Group was named to be the platform, but never restructured to fit the purpose. CSOs therefore had to coordinate themselves and seek to engage as they were not previously engaged. Efforts have been done through the secretariat of CSO-GFF (Health Promotion Tanzania – HDT) to bring CSOs from eight regions implementing GFF¹ to review progress and undertake national and subnational level accountability activities. GFF was initially planned to end in June 2020 but was later extended to June 2021. It is expected that Tanzania will express interest to be considered for GFF phase II. With support from CSOs GFF Resource and Engagement Hub- of Population Action International, HDT applied a human-centered approach to collect data, analyze other secondary data and performance to define priorities to be considered for GFF phase II. Primary data collection involved women of reproductive age and their partners in eight regions of GFF implementation and health service providers.

We therefore submit these priorities for consideration in developing GFF II investment case and Program Appraisal Document for Tanzania for 2021-2026. We believe that these priorities will strengthen primary healthcare systems that caters for most of the health service users.

¹ These are RMNCAH low performing regions namely Tabora, Shinyanga, Mwanza, Mara, Simiyu, Geita, Kagera, Kigoma

2.0. METHODOLOGY

Health Promotion Tanzania implemented a human centered approach to collect needs and priorities



from clients and service providers. This exercise was done in 8 regions of GFF implementation² where about 10-15 beneficiaries (women and men) and 5 health service providers participated in each region. Human Centered Approach puts the beneficiary at the center of service provision then works on empathy to understand what would make a difference in their views and environment. It explores desirable

interventions, then assesses them into viability and finally their feasibility hence solution-based methodology. Clients discussed and responded to three questions on whether they received quality health services, what they perceive to be best RMNCAH services and what they wish to see improved and/or strengthened. The exercise further gave room to discuss challenges they faced and how might those challenges be addressed. On another hand, health service providers shared their perspective on efficiency of Result Based Financing (RBF) and were asked to express challenges they face in provision of quality RMNCAH service and how might we address those challenges. A total of 89 clients and service providers from 38 health facilities were randomly sampled and interviewed. See Annex I on sample units.

3.0. FINDINGS

We summarize the most overarching responses from clients and service providers, backed up with analysis from other studies and GFF performance.

3.1: Health system and performance analysis

Tanzania primary health systems remains weak, with low qualified cadres, weak infrastructure, and weak supply chain. Yet many patients are seen at this level of service provision. Between July 2020 and February 2021, primary health facilities amounting to 5,838 provided health services to 23.2 million Tanzanians, 60% of them being women³. As per Government Notice of 2019, there were 12,318 villages meaning that there are supposed to be equivalent number of dispensaries. President Office Regional Administration and Local Government reported that by March 2021, there were only

² Ibid

³ TAMISEMI 2021:Speech of Ummy Mwalimu, the minister of Minister of state, President Office Regional Administration and Local Government

5,325 dispensaries (43%) of what is required; this is an increase from 33.5% in 2015⁴, however these 5,325 dispensaries were not all completed to fully function. By 2015, Tanzania had 535 health centers in 3,956 wards equivalent to 13.5%, with only 21% of them being able to conduct surgery.

About 487 health centers have been constructed in the last five years making a total of health centers to be 1,022 reaching 26% of what is required. This means that increasing health service coverage and strengthening referral will have to increase the number of dispensaries from 43% to at least 75%, and correspondingly increasing the number of health centers from 26% to at least 50% of wards. If this is pursued, it will have multiple benefits in that (a) it will address clients concerns of long-distance travel and dilapidated rooms and furniture as reported in section 3.2, (b) It will increase capacity and preparedness of primary health system for RMNCAH and any health challenges, (c) It will increase access to health services closer to people (d) It will increase value and meaning of UHC agenda that Tanzania committed to.

Between 2016 to 2019, there was a downsizing of public servants including health sector for several reasons including fake certificates; this went hand in hand with presidential hiring freeze. During this time, access to RMNCAH services increased especially in GFF/RBF regions; example facility delivery increased from 50% to 80%. Evidently this alludes to likely compromised quality as we increased workload to fewer staff. PORALG (2021) estimates a need of about 11,700 health care workers to service the primary health infrastructure already constructed (107 hospitals, 487 health centers). It will therefore be imperative to consider health care workers both in quality and quantity.

3.2: Client experience of care

RMNCAH clients who participated in the consultation were asked on the services they considered to have been good under GFF phase I period:

- Availability of vaccines for children at the health centers.
- Men escorting their pregnant partners on their 1st ANC, encourages both couples to get valuable information regarding their unborn child.
- Friendly and welcoming language by healthcare providers; this was reported by about 43% of those who responded.
- CHWs household visits and referrals contribute to increased rate of ANC visits, institutional deliveries, and post-natal care.

⁴ TAMISEMI 2021

Considering that Tanzania will be focusing on quality of services, clients gave opinion on what elements of services they consider to constitute good quality and would like to see them in the GFF II investment case.

- Health providers treat clients respectfully such as not shouting and not being rude 70.6%
- Facility provides medicines such as SP, ferrous, folic acid, mebendazole, TT vaccine, ARVs, and antibiotics 70.6%
- Health providers delivers a complete physical examination such as height and weight measurement, fetal heart rate, blood pressure, abdominal examination 64.7%
- Facility provides laboratory tests such as hemoglobin, malaria, urine protein, blood group, HIV, and syphilis 50.0%
- Health care workers provide women with health education on topics such as family planning, pregnancy, nutrition, and birth preparedness 35.3%
- Facility has adequately trained staff for example: RCH, ANC, laboratory, ultrasound technician 23.5%
- Health facility has supplies such as gloves, mackintosh, cotton, and cord ties 26.5%
- Health providers listen to the client such as being attentive to their complaints 20.6%

Human-centered approach sought to understand the challenges that clients faced in accessing quality services. Below is a summary of what the challenges were:

- Shortage or no furniture's and utilities such as (hospital beds, medical equipment, dilapidated buildings and waiting rooms). In some instances – one bed is used for more than one woman and clients being requested to purchase supplies such as gloves, exercise books.
- Few healthcare providers as opposed to demand, leading to long waiting time at facilities and sometimes delay in receiving urgent services.
- Some men refuse to attend clinics with their partners thus contributing to delays in starting ANC1 or often nonattendance.

The list mentioned challenges faced in accessing quality RMNCAH services were:

- Long travel distance from residents to health facilities.
- Poor infrastructures such as roads and transport contribute largely to home based child delivery.
- Delay of vaccines to infants due to stock outs.

Clients also had opportunity to discuss how might the address the challenges be addressed. The overarching responses are summarized below:

- We need enough and skilled health care workers to cover the current needs in our health facilities.
- Timely access to medicine and vaccine can be addressed by meaningful collaboration between health committees and health facilities in charge.
- Ensure there is an effective plan that recognizes and supports Community Health Workers (CHWs). E.g. allowances and stipends.
- Undertake renovations and expansion of facilities to add more rooms such as waiting rooms and labor wards to address issues around congestion in labor wards.
- Listen to us periodically, especially after we have had one birth so that our previous experiences can inform the challenges that need to addressed.
- Invest in community health insurance and subsidize households that are unable to pay for their insurance.

3.3: Health care providers responses

Health care providers provided narrative of how useful the RBF has been in their own views These are summarized below.

- RBF has supported the upgrading of health facilities which in turn has facilitated increasing access providing quality health services. Improvement such as refurbishment of health facilities, construction of new building to cater to the needs of clients, procurement of facility chairs, desks, tables, solar and generators.
- RBF has supported mobilization of funds at health facility level, and this has increased capacity and responsibility in managing day to day activities.
- RBF generated funds that were partly used to provide allowances to health care workers and this in turn increased work efficiency. As a result programmatic results such as antenatal clinic attendance and institutional deliveries were increased.
- Quarterly data verification at health facility level has largely contributed to increase of accountability and work efficiency.

Health Care providers expressed concern on weakness of Result Based Financing that will have to be improved in future:

- Weak transparency both on disbursement from ministry of finance level and spending at health facility level. Frequent stock out of commodities and supplies as an obstacle in provision of RMNCAH services.
- The increased quality of some level lead to increased clients with same number of health care providers, which could have led to being overworked and often burn out. Health care providers also expressed on job training as a need, and yet its less provided. An attempt to reach more clients during outreach services is limited by lack of transport.
- Result Based Financing was characterized by delayed disbursement and reasons for the same not known, impacting program performance.

Health service providers were asked what elements of RMCAH services constituted good quality of services and their list in highest frequency is below:

- Facility has adequately trained staff for example: RCH, ANC, laboratory, ultrasound technician 84.7%
- Facility has adequate equipment such as blood pressure machine, weighing scale, thermometer, fetal scope, examination bed, tape measure, and ultra sound machine 71.3%
- Facility provides medicines such as SP, ferrous, folic acid, mebendazole, TT vaccine, ARVs, and antibiotics 68.7%
- Facility has adequate infrastructure such as enough service and waiting rooms 66.7%
- Facility provides laboratory tests such as hemoglobin, malaria, urine protein, blood group, HIV, and Syphilis 54.3%
- Health care workers provide women with health education on topics such as family planning, pregnancy, nutrition, and birth preparedness 45.7%
- Service providers receive in-service training to keep skills current 42.0%
- There is good communication between service provider and client 42.0%
- Facilities have transport for referral such as an ambulance 24.7%

3.4. Discussion of findings

Both clients and providers provided opinion on what aspect of services they considered good and what they perceived to be of good quality. In general for quality-of-care elements comprised of items related to experience of care, provision of care, and cross-cutting essential physical and human

resources. Our analysis as is from other studies⁵, showed that experience of care was just as important to clients and providers as the availability of physical and human resources. Client's perception of the quality of RMNCAH is influenced by having a respectful, knowledgeable provider, availability of medicines, availability of medical equipment, and timely provision of services⁶. According to both clients and providers, a positive care experience by provider should include good communication, listening to the client, treating clients respectfully, keeping patient confidentiality, attending to clients in a timely manner, and allocating sufficient time to each client. These are important parameters of quality as shared by both clients and providers. Hidden under these will then have to be motivated, skilled, and adequate health care providers.

According to both clients and providers, continuation of use of facility-based delivery services is influenced by good communication, politeness, and confidentiality during initial service provision⁷. This means that the quality of ANC service provided will have a bearing on whether a woman will deliver at home or at facility. When examining RMNCAH score card, for fourth quarter of 2020, we see that ANC4 coverage was 92.4%, but corresponding facility delivery was 70.8%. Health system should understand that clients are connected to each other and once one is mistreated or had bad maternal or baby outcome, the same experience is likely to inhibit another client to use services. For example clients narrated how women of low socioeconomic status face discrimination and even denial of services if they cannot purchase required supplies at the time of delivery. This means that efforts to increase both coverage and quality will have to ensure that women do not have to purchase required materials for delivery. These can be covered through pooled funding that the government and GFF may put together.

Health work force shortages are a limitation for providers striving to deliver high-quality services. Providers highlighted that the shortage resulting in long wait times and shorter duration of visits with clients. In Tanzania, there are only 157 nurses, and midwives per 10,000 population⁸. This information is consistent with PORALG estimation of health care work force of 52% gap. Manzi et al

⁵ Ashley Sheffel et al: Understanding client and provider perspectives of antenatal care service quality: a qualitative multi-method study from Tanzania. June 2019

⁶ Tancred T, Schellenberg J, Marchant T. Using mixed methods to evaluate perceived quality of care in southern Tanzania. *Int J Qual Health Care*. 2016;28:233-9. [Medline:26823050](#) [doi:10.1093/intqhc/mzw002](#)

⁷ Stal KB, Pallangyo P, van Elteren M, van den Akker T, van Roosmalen J, Nyamtema A. Women's perceptions of the quality of emergency obstetric care in a referral hospital in rural Tanzania. *Trop Med Int Health*. 2015;20:934-40. [Medline:25726853](#) [doi:10.1111/tmi.12496](#)

⁸ The 2018 update, Global Health Workforce Statistics, World Health Organization, Geneva (<http://www.who.int/hrh/statistics/hwfstats/>).

(2012) reported that 44% of the expected clinical staff were not present to deliver services, highlighting the severe shortage of human resources contributing to the health crisis in Tanzania⁹. Improving health care work force will be an essential step in reducing barriers to delivery of high-quality maternal health services.

A key focus of One Plan III and GFF investment case therefore should be to maintain and scale up coverage and improve the quality of services which is seen as a major challenge to reducing maternal and newborn mortality. Among others this may entail reviewing existing RMNCAH guidelines to improve service quality at health facilities and to develop metrics for assessing experience of care as part of national monitoring and evaluation of the quality of health services.

4.0. Recommendations

Considering the consultation and analysis presented in this paper, GFF phase 2 investment case should include the following:

- 4.1. Prioritize infrastructure development at primary health care level (dispensaries, health centers and district-based hospitals) to include construction, renovation, necessary furniture's and medical equipment's . Aim to reach 75% coverage at dispensary and health center level),
- 4.2. Prioritize health care workers quantity and quality to allow optimal functioning of primary health facilities, with special emphasis on innovative motivation schemes for health care workers,
- 4.3. Review existing RMNCAH guidelines to include aspects of service quality notably respective maternal care as appropriate and leverage technology to coordinate learning sessions to ensure shared vision on quality among health care workers.
- 4.4. Prioritize and recognize community outreach through community health workers as a link between households and health facilities among others to facilitate accountability and responsibility.
- 4.5. Where distance to facility is a barrier, prioritize outreach services including but not limited to health service market (Gulio la afya).

⁹ Manzi F, Schellenberg JA, Hutton G, Wyss K, Mbuya C, Shirima K, et al. Human resources for health care delivery in Tanzania: a multifaceted problem. *Hum Resour Health*. 2012;10:3. [Medline:22357353](#) [doi:10.1186/1478-4491-10-3](#)

- 4.6. Prioritize health promotion on nutrition beyond micronutrient supplement and work with CSOs to identify, process and use locally available food to address malnutrition issues.
- 4.7. Appropriate use of comparative advantage of CSOs to allocate resources to them to create and or sustain bi-directional feedback from community to facility and vice versa.
- 4.8. Increase transparency at national, regional, district and facility level by engaging multistakeholder to determine how services are being provided and how resources are being allocated and used.
- 4.9. Prioritize multisectoral oversight at health facility level to reduce stock outs and promote resource pooling to support health insurance for the poorest and most vulnerable.
- 4.10. Strengthen mechanism to ensure timely disbursement of funds. Doing so will tackle challenges related to procurement of health commodities and financing of other activities at facility level.

5.0 Annexes

5.1. Annex 1: GFF implementation regions, RBF data collection

S/o	NAME	CSO	REGION	NUMBER OF RBF RECEPIENTS AND SERVICE PROVIDERS INTERVIEWED			
				M	F	TOTAL	SERVICE PROVIDERS
1.	Fatuma Hamady	MAPEC	Kagera	3	7	10	5
2.	Hamimu Malilo	BAKWATA	Kigoma	5	8	13	2
3.	Frank Kasamwa	Mass Media-BARIADI	Simiyu	4	6	10	5
4.	Ramadhan Rajab	Thubutu A. Initiative	Shinyanga	3	7	10	7
5.	Farida Mzimhiri	TAHEA	Mwanza	7	3	10	5
6.	Theophil Kayomb	OWSL	Mara	4	6	10	5
7.	Kevin Meza	Himiza Social Justice	Geita	5	5	10	5
8.	Harold Kilonga	TACEDE	Tabora	5	11	16	4
	TOTAL					89	38

5.2 Annex 2: Regional CSOs consulted

S/o	ORGANIZATIONAL NAME	REGION	ADRESS
1.	Misenyi AIDS and Poverty Eradication Crusade (MAPEC)	Kagera	P.O Box 52, Kyaka Off Karagwe Road, Kyaka-Missenyi,Kagera Mob: +255 784 502 771 or 0782216333 Email: mapecttz@yahoo.com or mapec1960@yahoo.com
2.	BAKWATA	Kigoma	BAKWATA HIV/AIDS Kigoma P.O.BOX 645 Email:bakwatahivaid@yahoo.com
3.	Mass Media Bariadi	Simiyu	P.O.BOX 176, Bariadi, Simiyu massmediabariadi@yahoo.com Phone: 0784 494 360
4.	Thubutu Africa Initiative (TAI)	Shinyanga	Thubutu Africa Initiative P.O. Box 1195, Shinyanga Jonathan.kifunda@thubutuafrica.org 0767 254 201
5.	Tanzania Home Economics Association (TAHEA)	Mwanza	P.O.Box 11242, Maunu st. Nyegezi area, Plot No.436, Block B, Mwanza marykabati@yahoo.co.uk 0754443226
6.	One World Sustainable Livelihood (OWSL)	Mara	P.O.BOX 1057, Musoma, Mara. theophil.kayombo@oneworldtanzania.org 0754 872512
7.	Himiza Social Justice	Geita	Rafiki House, Plot No. 10, Block 'J', Msalala Road, Kalangalala, P.O.Box 378, GEITA, TANZANIA info@himizasocialjustice.or.tz Office Tel: +255 (0) 28 2520207 Mobile: +255 (0) 785 226 322
8.	Tabora Center for Development (TACEDE)	Tabora	Harold Kilungu, Executive Director, hkilunguz@gmail.com +255 784 517796

5.2 Annex 3: Reference group

The reference group members participated in virtual/zoom meetings with Health Promotion Tanzania- program team where they will use their experience to provide guidance and networking for successful advocacy.

Name	Position/Qualification	Address
Prof. Sia Msuya	One Plan III Consultant	siaemmanuelimsuya@gmail.com
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