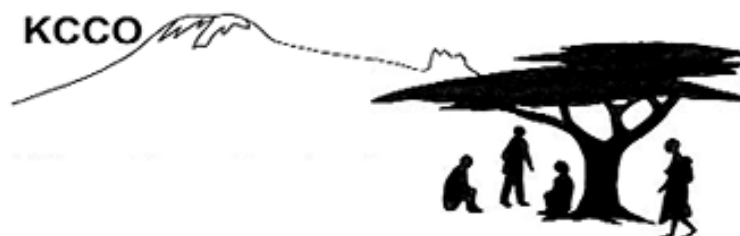


Strengthening Support for VISION 2020 from Tanzania's Public Sector



Kilimanjaro Centre for Community Ophthalmology:

Megan Kell

University of California at Berkeley, School of Public Health and Haas School of Business

Edson Eliah

Kilimanjaro Centre for Community Ophthalmology

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The Kilimanjaro Centre for Community Ophthalmology is seeking to strengthen its relationship with local districts to improve eye care services within this region of Tanzania. KCCO's goal is for the districts to supplement the significant funding that the organization contributes for eye care outreach and patient services. Therefore, it is essential for KCCO to understand how local districts allocate funding through their Council Health Management Teams, the data that they use to determine health priorities, and the relationship that the District Eye Coordinator has with this Team (CHMT).

This paper summarizes findings from interviews with CHMT members in six districts in Northern Tanzania about how they make annual funding decisions. During July 2006, these members were interviewed individually by a KCCO staff member and a consultant. This information was supplemented by interviews with National, District, and Regional Eye Coordinators as well as a literature review. See Appendix 1 for a comprehensive list of interviewees.

The first section of this paper provides context for understanding the transitions that the Tanzanian healthcare system is undergoing. The following section outlines trends in eye care financing and the key players in the funding process. The next section describes recommendations and potential strategies for KCCO to further develop its relationship with local CHMTs. This paper concludes with an outlook to the future.

BACKGROUND AND CONTEXT: Tanzania's Transitioning Healthcare System

Tanzania's healthcare system has undergone two significant and overlapping structural changes in the past two decades: decentralization and the Sector-Wide Approach (SWAp). The country is slowly decentralizing its ministries' functions over several decades so that district governments gain decision-making power in resource allocation. SWAp, introduced in 1998, brings significant amounts of donor resources into a single Basket Fund to promote efficiency and comprehensiveness in healthcare funding strategies. The goal of SWAp is to move Tanzania away from its dependency on disease-specific vertical programs, which can inhibit full decentralization. Although Tanzania's SWAp program is thought to be more advanced than in other countries, vertical programs continue to play a minor role in the country's healthcare system.¹

According to an evaluation of how these policy changes impact each other, "the overall goals of decentralization and the sector-wide approach are not incompatible: they both aim at improving technical efficiency; they encourage wider participation; and they emphasize transparency and accountability."²

¹ Remaining vertical programs include groups working on AIDS, malaria and TB issues. For example, the National AIDS Control Program gives districts testing kits and posters. TB is managed centrally so districts buy medicines from a central entity.

² Hutton G. *Decentralization and the Sector-Wide Approach in the Health Sector*. Swiss Tropical Institute: 2002, p 3.

SITUATIONAL ASSESSMENT:

CHMT History of Funding Eye Care in the Kilimanjaro Region

Because eye care services in Tanzania were historically delivered by NGOs, the government put a small insufficient budget for this healthcare activity. With the reduction of vertical programs, NGOs have reduced their support, leaving CHMTs to cover the bulk of eye care costs.³ The introduction of KCCO Direct Referral Sites⁴ and development of a regional VISION 2020 plan raised Kilimanjaro CHMT awareness, according to the Regional Eye Coordinator. However, gaining their support for eye care continues to be a substantial challenge. In the current year, only two of the six interviewed districts funded eye care in their annual budgets, with the maximum level of support at TSh 2,000,000 (about US\$1,750). Several others gave indirect support through Other Charges. The following chart shows each district's support.

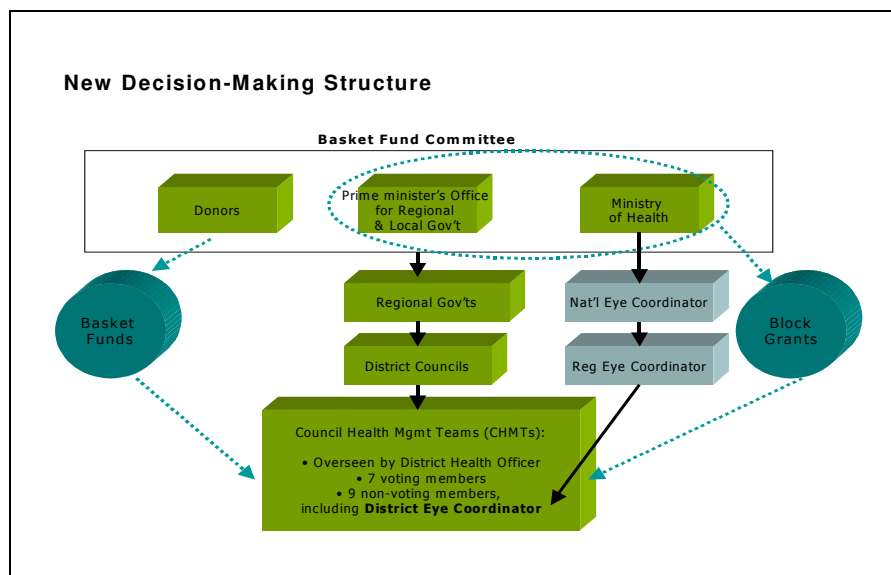
District	Funding for Eye Care in 2006-7 Comprehensive Plan Budgets	Supported Activities
1	TSh 2,000,000	10 days of cataract follow-up and 3 days of clinical officer training
2	TSh 1,350,000	Cataract patient follow-up allowance; training costs possibly covered later in year through Other Charges
3	TSh 870,000 (in 2005-6 budget)	Training 18 clinical officers on eye care for 3 days through Basket Fund; DEC transport costs covered but not included in CCHP
4	--	Funding for transport and allowance given to DEC under Other Charges (therefore not included in CCHP) in 2005-6; DEC has not confirmed DMO support for 2006-7
5	--	(Indirect support may be provided)
6	--	--

³ The International Trachoma Initiative has been one of the largest eye care NGOs but now wants CHMTs to take responsibility for these services with its basket funding, according to the Regional Eye Coordinator.

⁴ DRS are outreach clinics conducted in all Kilimanjaro districts (and the Arumeru district in the Arusha region) by KCCO/KCMC medical and non medical staff. Patients are treated at these sites for a wide range of eye conditions and are brought to KCMC for cataract surgery when necessary.

Key Players in Funding Eye Care Services

The combination of decentralization and SWAp has resulted in Tanzania's central government working closely with international donors to establish a system for healthcare resources to be allocated at a district level through CHMTs. The following organizational chart highlights key players in this system.



Basket Fund Committee, Tanzania's Ministry of Health and the Prime Minister's Office of Regional Administration and Local Government. The Basket Fund Committee, established in the late 1990s under SWAp, consists of international donors who direct a portion of their aid to the Basket Fund.⁵ There are no eye-focused donors in this Fund. In addition to these donors, the Committee includes representatives from the Ministry of Health (MoH), the Prime Minister's Office of Regional Administration and Local Government (PORALG), and the Ministry of Finance. The Committee pools its resources into this single fund annually and finances districts' health activities.

Although the Tanzanian government is represented in the Basket Fund Committee, it distributes its own funds for district healthcare separately through Block Grants. These are the two primary sources of district healthcare funding. Basket funds and Block grants share common regulations regarding how districts can utilize the funds. Although MoH maintains the motto of "Eyes on – hands off" when interacting with the districts, the CHMT guidelines are strict and result in limited financial flexibility at the district level.⁶ However, the guidelines were eased in 2004. It is likely that the guidelines will become increasingly flexible in future years as "the basket partners acknowledge the budget rigidities arising from basket guidelines and procedures at the Council levels that place restrictions on the use of Basket Funds. Basket partners are in agreement that this should be reviewed, using a phased-in approach to reduce the restrictions and in line with basket partners' own regulations on the use of the funds."⁷ Appendix 2 further describes these rules as well as other supplemental funding sources.

⁵ Donors contributing to the Basket Fund include the World Bank, USAID, UNDP, and Swedish and Norwegian governments.

⁶ Hutton G, p 12.

⁷ *Health Basket and Health Block Grants Guidelines for the Disbursement of Funds, Preparation of Comprehensive Council Health Plans, Financial and Technical Reports and Rehabilitation of PHC Facilities by Council.* United Republic of Tanzania Joint Ministry of Health and President's Office of Regional Administration and Local Government, 2004.

Council Health Management Teams. Each district has a Council Health Management Team (CHMT) that is responsible for deciding how to allocate health funding in the district. The CHMT consists of seven appointees who are health providers and local government staff. The central government through the Ministry of Health determines which positions are included as CHMT voting members. In addition to these seven voting members, the CHMT has “Co-opted” members who cannot vote but represent a specific disease area. These positions are listed in Appendix 3.

CHMTs appear to have flexibility in determining the level of involvement that these Co-opted members, including the District Eye Coordinator (DEC), have with the Team. While some Co-opted members regularly attend the monthly CHMT meetings, most only meet with the voting members a few times per year during the budget season. Co-opted members are not included in the meetings when the district health budget is decided upon.

CHMTs use data collected from local health facilities to determine the districts’ priorities. All CHMTs depend on quarterly reports submitted by district health facilities through a national data system known as MTUHA. These data are consolidated to form a list of the top-ten diseases in each district and CHMTs prioritize funds accordingly. However, this list is only a partial reflection of the diseases in the districts. All eye issues are grouped into the single category of “eye disease” in this data system, which generally falls in the lower half of the top-ten list. CHMTs also rely on District Coordinators to provide disease-specific information and context. In addition, some CHMTs engage other stakeholders through a general meeting or by encouraging them to submit reports about their activities.

CHMTs struggle to use this information in addressing local health priorities while satisfying national guidelines. CHMT members do not receive any specific training about how to allocate funds. However, the central government has distributed a book of guidelines that outlines cost-center ceilings and encourages districts to satisfy the National Essential Health Package priorities.^{8,9} Eye care is tucked into these priorities under “Treatment and care for other common disease of local priority.” Interestingly, CHMT members find these priorities to be more restrictive than they appear in the guidelines. They report that they emphasize former vertical program diseases – such as malaria, HIV/AIDS, maternal and child health, and tuberculosis – in their budgets because of the Essential Health Package “rules.” Some even claim that this guide gives baselines for disease-specific spending as a percent of their total funding but no documentation shared with the researchers support this. It appears that districts have more flexibility in meeting these objectives than they acknowledge. The CHMT decision-making process is further elaborated in Appendix 4.

National and Regional Eye Coordinators. Eye Coordinators exist at the national, regional, and district levels. These appointed positions exist to raise awareness about eye care services at all levels of the government. However, there are severe restrictions faced by the Coordinators due to limitations in funding, training, and management.

The National Eye Coordinator (NEC) is based in Dar es Salaam and oversees the Regional Eye Coordinators (REC). The NEC reports that she identifies eye care funding priorities for CHMTs. However, this contribution was perceived as limited at the local level because meetings with the RECs

⁸ These priorities “cover main diseases and health conditions that are responsible for the bulk of diseases burden in Tanzania,” according to the national Health Sector Strategic Plan (2003-2008).

⁹ *Health Basket and Health Block Grants Guidelines for the Disbursement of Funds, Preparation of Comprehensive Council Health Plans, Financial and Technical Reports and Rehabilitation of PHC Facilities by Council.*

are only held once per year and few RECs have access to or use the internet for communication. The REC is expected to oversee the District Eye Coordinators (DEC) within her region. Yet, similar to the difficulties in oversight evidenced between the national and regional level and due to the lack of funding for her position in the Kilimanjaro region, she has limited involvement in district eye activities.

District Eye Coordinators. DECs are often one of the best trained – and in some cases, the only – eyes care providers in their districts. They are appointed to their position, generally trained as eye nurses, and have previous health provider experience. DECs have only basic eye medicines and can provide primary eye care services to eye patients at the district hospital and conduct outreach clinics in other district health facilities. Some have been trained how to perform surgery for trichiasis. They are encouraged to train other health providers about eye disease so that they may also treat patients or grant referrals. However, limited funding often restricts their ability to travel and train others within their districts. They collaborate with KCCO on DRS activities by promoting the clinics, providing services to patients and following up with post-surgical individuals. Their administrative responsibilities to CHMT include drafting the annual eye care budget which generally requests funding for patient follow-up and outreach clinics (fuel and allowance), clinical officers training, and equipment. They also submit quarterly reports to CHMT members about the status of eye care in their districts.

The biggest challenge that DECs appear to face is a lack of financial support from the CHMTs. However, a major part of this issue relates to their interaction with the CHMT members. DECs lack assertiveness, which results in CHMTs ignoring their funding requests. The absence of assertiveness seems to be related to the generally low level of training and advancement compared to the more prominent programmes (e.g., HIV/AIDS, malaria) and their lack of skills in planning and management. Many DECs are nearing retirement and have only served in the role of service delivery. Only one DEC in the Kilimanjaro region reports that she regularly attends CHMT meetings and has the opportunity to speak about eye progress in the district. Other DECs generally attend one or two meetings a year in the budgeting season or if a specific eye issue arises; several report that they are not invited to attend the other monthly meetings. Most DECs do not attend Supervision Visits to their district's health facilities even though it is common for other Co-opted members to do so.¹⁰ The DECs' lack of involvement results in their having significantly less contact with CHMT members than they otherwise would.

The DECs' limited assertiveness carries over into the budgeting process. Several DECs report that they either failed to submit a budget to the CHMT this year or did not follow up to find out if their activities had been funded. While CHMTs do not hold appeal sessions for unfunded budget requests, several other Co-opted members mention that they follow up with the DMO in an individual meeting. However, no DEC reports doing so.

The lack of management coordination presents another challenge to the DECs. They essentially have two bosses – the REC and the districts' DMO – but appear to lack guidance from either. DECs are expected to report to the REC and most state that they have a good relationship with the REC. However, their interaction is often limited by lack of resources. In fact, many DECs in the Kilimanjaro region meet with the REC less than once per year. The DECs are also accountable to their DMOs,

¹⁰ Supervision visits are when CHMT members visit district health facilities as a team to evaluate facility performance and needs. These are usually held 1-4 times per month.

who effectively control the districts' purse-strings. However, many DEC's seem to have minimal interaction with this officer.

PROPOSED STRATEGIES:

Gaining CHMT support for eye care funding has been an uphill battle for KCCO and the Kilimanjaro DEC's in recent years. However, it appears that KCCO's recent activities to engage both parties have stimulated some interest among CHMTs. There are seven key ways for KCCO to sustain this momentum and ensure CHMT support in future years.

Increase Patient Numbers

Eye care will remain under-appreciated until the general population is more aware of the need for it, according to many DEC's and CHMTs. Much of the population does not view eye care as a high priority or faces barriers in receiving appropriate care. This results in an under-diagnosis of eye disease and undermines the need for eye care funding when CHMTs review the MTUHA data and top-ten disease lists. Expanding outreach efforts to a broad population would result in more people presenting themselves for eye care services. Increasing the number of patients seeking care will raise the position of "eye disease" in the top-ten disease ranking and potentially result in greater CHMT funding.

Action Items. The following recommendations are meant to increase the number of patients seeking eye care, forcing this issue to gain recognition by CHMT members:

- Work with the DEC's to sensitize the public to the eye care issue through pamphlet and poster distribution, as suggested by several CHMT members.
- Continue to offer provider training so that appropriate diagnoses are made.
- Develop an educational video about the spectrum of eye diseases that can be shown to DRS patients as they wait to see the providers.
- Teach children about the eye in science classes.

Improve Data Collection and Reporting Capacity

In addition to increasing the number of patients seeking eye care services, it is important to improve the manner in which eye care data is shared with CHMTs. The two main sources of eye disease data that CHMTs receive are DEC reports and MTUHA measurements. However, both sources are limited in their ability to give an accurate portrayal of eye disease in the districts. DEC's generally submit quarterly reports to their DMOs who then make this information available to other CHMT members. Only one DEC submits monthly information to the CHMT. These reports are often little more than the DRS quarterly summaries produced by KCCO, which give the number of patients with certain diagnoses (cataracts, glaucoma, and refractive error) and the number of eye medicines distributed to patients. DEC's may supplement these reports with the number of patients that they have seen in their clinics during the quarter and an expanded list of patient diagnoses (such as conjunctivitis); however, few DEC's collect data from other district providers even though they may also treat eye disease. MTUHA data, the other source of eye information used by CHMTs, only measures annual "eye infection" rates in districts without breaking down the diagnoses by specific condition. CHMT members acknowledge that neither data source provides a comprehensive perspective on eye care in each district.

Because eye care falls under the "Local Priority" category in the National Essential Health Package, KCCO must convince CHMTs that it qualifies as one by demonstrating service need and utilization

within districts. Therefore, it is important to present eye care as a problem impacting a broad cross-section of the population. It may also be useful to emphasize that eye care is a quality of life issue when seeking CHMT budgetary support. Both of these strategies would require KCCO to broaden the information that it presents to CHMTs.

Action Items. Emphasize that eye disease affects a broad cross-section of the population. Because much of the CHMT decision-making is based on the number of people impacted by a particular disease, it is essential for districts to receive data on the prevalence of all eye diseases – including everything from conjunctivitis to cataracts – and patient demographics. CHMTs report that the following information would help them better understand the status of eye disease and care in their districts:

- A short description of district’s current eye care situation
- Magnitude of the problem: Total number of patients screened and treated for eye disease in district, combining patient numbers from the DEC, DRS and other health providers
- Prevalence of all common eye infections and diseases
- Demographics (age, gender, and ward) of patients, by disease type
- Estimated level of unmet need across district
- Types of equipment currently used and needed

KCCO and the DECs should establish an effective reporting mechanism. An example of how this information could be presented is shown in Appendix 5.

Empower DECs

Developing the DECs to become strong advocates for eye care is essential. Their current lack of assertiveness when interacting with the CHMTs is preventing eye care from receiving necessary funding. In addition, the DECs’ limited management and administrative expertise results in missed deadlines and lack of follow-through on funding issues.

The fundamental challenge related to DECs is that this position is offered to nurses who are expected to become managers and advocates with almost no management training or support from the Ministry of Health. However, KCCO is in a unique position to support the strengthening of the CHMT-DEC relationship as it collaborates with all DECs in the Kilimanjaro region.

Many DECs report that they find it difficult to engage CHMT members about eye care issues. The REC suggests that the educational hierarchy within CHMT may intimidate DECs: many are nurses while most CHMT members are assistant medical officers (a.k.a. clinical officers) who are generally referred to as “doctors” in their communities. She suggests that it is important for the DMO and other CHMT members to understand that the DECs have appropriate training to accurately address eye care issues.

Action Items. There are several ways for KCCO to collaborate with DECs to strengthen their position in the CHMTs. The primary goal of such activities is to increase the credibility that the DECs possess in the eyes of other CHMT members. Many of these activities are based on recommendations from other Co-opted members.

- Offer advocacy and lobbying training: DECs are not empowered to consider how they can improve eye care funding. It may be useful for KCCO to hold training sessions on lobbying for DECs. Such training could focus on developing strategies to engage CHMT members and learning how to present eye care budgets and data at public meetings. Data collection should also be addressed. This training would demonstrate to DECs that there is more to their jobs

than simply submitting written budgets. Several DEC's report that this type of support would be helpful. The NEC is also in favor of this initiative, particularly as a component of the V2020 district plan. Such empowerment may also distinguish DEC's from other Co-opted members who also seem to be timid about interacting with CHMTs.

- Engage CHMTs through supervision visits: CHMT members make Supervision Visits to the facilities throughout the year to evaluate their status and utilization of CHMT funding. DEC's should be encouraged to request that their DMOs include them on these visits. Several Co-opted members report that attending such visits gives them the opportunity to inform other CHMT members about the specific health issues that they are covering. One interviewee writes reports after each visit about her observations in relation to her field; these reports are then used by CHMT members to identify issues to include in their planning. Attending Supervision Visits will enable DEC's to build relationships with CHMT members.

Strategic Funding Requests

Because some CHMTs struggle with the funding ceilings for fuel and allowances, KCCO and the DEC's may have a greater chance of funding success if they request support from categories that do not have such limiting caps.

Action Items. Become more strategic in making funding requests. As DEC's gain a better understanding of how the CHMTs make decisions, they can determine how their own Council responds to various types of requests. This information can be used by KCCO and the DEC's in budget development and funding requests.

Expand KCCO's District Presence

Many CHMT members are interested in knowing more about KCCO's involvement in their districts. CHMT members are appreciative of KCCO activities and receptive to the potential for greater collaboration in future years. However, there appears to be some misconceptions about KCCO's function and its level of investment in the districts. Some interviewees suggest that KCCO seems to be too focused on cataracts rather than all eye diseases. Others appear to underestimate the support that KCCO provides to the districts. Interestingly, many CHMT members report that the larger KCCO's investment is in their districts, the more willing the CHMT will be to commit resources to eye care.

Action Items. Expand KCCO's annual district reports to include the following information:

- Current KCCO district activities
- Annual spending in district on DRS and other activities
- KCCO's plans for future activities within the district

CHMT members report that this information would be most useful in the budgeting season. An example of how this information may be provided is in Appendix 5. Many districts are receptive to KCCO attending CHMT meetings during the budget season to further discuss these issues. One district recommends that KCCO share eye care "best practices" from other parts of Tanzania and abroad with them.

As DEC's strengthen their connections to CHMTs, it is important for KCCO to maintain a visible presence in the district. Several DEC's report that meetings between the CHMT and KCCO validate their work and are important to continue. These meetings are an opportunity for CHMT members to become familiar with KCCO efforts and understand its commitment to the districts. In addition, they provide DEC's with the opportunity to see how KCCO presents eye care issues so that they may be able to continue these efforts independently in future years.

Another way to inform CHMT members about eye care issues is to invite them to observe DRS. This will not only raise their awareness about KCCO activities but also show how the DEC's engage in communities.

Partner with Other NGOs

The Regional Eye Coordinator suggests that there needs to be greater collaboration among NGOs that collect regional and district eye care data. She reports that KCCO and the Lions Club are now working together; however, connecting with Kilimanjaro CBR and Kibosho Hospital is also important. The National Eye Coordinator is expected to distribute an improved data form to regions and districts, replacing a previous form that was not comprehensive.

Action Items. Adopt the NEC data reporting form. There may be opportunity for KCCO to bring together active NGOs to adopt standard practices in eye care data collection, particularly as the REC faces resource limitations.

National Lobbying

Even under the decentralized system, the Tanzanian central government continues to influence health data collection and issue prioritization. According to the NEC, specific disease groups do not do any lobbying per MoH guidelines. Nevertheless, the NEC is developing strategies for KCCO and other NGOs to promote eye care services at national level. While she is not yet disclosing the details of such plans, this appears to be an opportunity for KCCO to work more closely with her to raise the eye care issue. The NEC also supports a national effort to revise eye care data collecting and reporting efforts. She has submitted recommendations to the MoH so that the data will capture more details about eye conditions, particularly regarding more serious diagnoses.

Action Items. KCCO may work with the NEC to raise the issues of eye care at the national level and improve the MTUHA data reporting system. By convincing MoH that eye care should be a national priority, there is potential for districts to become more willing to direct funding toward this issue.

IMPLEMENTATION: Future Outlook

It is expected that CHMTs will become increasingly empowered as they gain more budgeting experience and the central government expands their decision power. There is great potential for KCCO, the Kilimanjaro REC, and Kilimanjaro DEC's if they prepare for this transition. In order for KCCO to accomplish its goal of increasing CHMT commitment to eye care, it is important for the above-mentioned initiatives to be implemented prior to next year's budget season. Some issues, such as data reporting and strategic funding requests, can be fully launched by next season. Other issues, such as DEC empowerment and CHMT-KCCO relationships, will take longer to establish. However, by starting now and creating clear annual funding goals that both KCCO and the DEC's can strive toward, it is likely that eye care will be recognized as a key health priority in the years to come.