



The Implementation of Direct Health Facility Financing (DHFF): Prospects and Challenges

By Hilda Mwakatumbula

Key messages

- The reliable and timely disbursement of funds to the facility, enhancement of local fiscal autonomy, heightened transparency, accountability, and community participation have resulted from the DHFF intervention.
- The inadequate project management capacity, weak supervision capability, limited computer access, and internet connectivity hampers the progress of DHFF.
- Periodic training at the facility level, improving access to needed resources, and boosting internet connectivity are essential to guarantee the triumph of DHFF intervention.

Introduction

The provision of high-quality service is one of the benchmarks against which a government's performance is assessed. Tanzania embarked on local government reforms through the principle of decentralization by devolution (D-by-D) to improve the effectiveness and efficiency of local decision-making, service delivery, and the twin objective of enhancing citizen participation and accountability. D by D has seen a reallocation and separation of functions between central ministries and local government authorities (LGAs).

In health, the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC) has assumed the mandate for policy (including the setting of sector priorities). D by D has also mandated the Department of Health, Social service, and Nutrition service at the President's Office Regional Administration and Local Government (PO-RALG) with coordinating policy implementation at both the regional and local government authority levels.

Tanzania launched the Direct Health Facility Financing

(DHFF) reforms programme in 2018 to improve the health system's performance (Kapologwe et al., 2019). Including better matching payment to priority service, enhancement of autonomy, transparency, and accountability at the facility. Also, promoting the proper management of funds, hence empowering high-quality service delivery and increase health services utilization¹. Prior to the DHFF, primary healthcare facilities had no direct access to financial resources unless through the council level. Councils controlled and collected all funds from primary healthcare facilities, then planned activities and budgeted for these facilities per annum (Kapologwe et al., 2019). The previous system fell short when councils failed to honor the timely disbursement of allocated budgets (Mamdani et al., 2018). Consequently, this led to the delay of project implementation in primary health facilities, which hampered and undermined the effectiveness and efficiency of healthcare services, as well as the autonomy of Health Facilities Governing Committees (HFGC)¹ and primary healthcare facilities.

¹http://www.tzdp.org.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/health/JAHSR_2018/9._JFV_Presentation.pdf Accessed on 10 March 2020

In principle, DHFF focuses on improving the revenue autonomy of HFGCs and facilities through fiscal decentralization to promote primary healthcare services. The Regional Health Management Teams (RHMT) and Council Health Management Teams (CHMT) are envisaged to provide guidance and mentorship to facility owners (Clinical Officers in charge) and HFGCs on issues related to accountability and governance at the facility level. That includes the use of financial and reporting online tools like the Facility Financial Accounting and Reporting System (FFARS).

This policy brief summarizes findings from a field study that analyzed the prospects and challenges of implementing DHFF intervention. This qualitative study was conducted in four regions, namely Dodoma, Singida, Mwanza, and Tabora, covering one LGA in each region and one primary healthcare facility per LGA. The primary data was collected through interviewing central and local government officials, service providers at the primary health facilities, and local service users. Then, secondary data from desk reviews were deployed to complement data collected from the field.

Findings

Overall, the DHFF was found to have positively influenced primary health services in three key operational areas:

Reliable and timely disbursement of funds

Fieldwork indicated that the timeliness and reliability of health funds disbursement had improved considerably, and the receipt of funds is guaranteed. Previously, funds were delayed or even reallocated at the LGA (Frumence, Nyamhanga, Mwangi & Hurtig, 2014). Facility owners were relieved by the current intervention because funds are disbursed mostly on time and directly to the facility accounts.

"Since the introduction of DHFF, the receipt of funds is most timely and guaranteed at our facility, which was not the case previously." - (Service Provider - Mwanza)

Local fiscal autonomy

The intervention has enhanced fiscal autonomy at the facility level - to HFGC and service providers. Communities are not uniform across the country, and so are the health-related needs. The DHFF intervention conferred power to HFGCs to plan and budget according to their communities and facilities demands. Therefore, it promotes the responsiveness of the healthcare system

to the community. For instance, service providers in Dodoma and Tabora respectively elaborated their different plans for the subsequent year. They were glad that facilities could freely plan and budget according to their needs.

"The main challenge facing our healthcare facility is unreliable access to water. We are planning to dig a well and install a tank to ensure access to clean water and sanitation at our facility." - (Service provider in Dodoma)

"We are planning to build a wall around our facility as well as extend and equip our maternity ward. Now, the demand for the maternity ward is higher compared to its ability." - (Service Provider in Tabora)

Transparency, accountability, and community participation

DHFF has enabled HFGCs to play a more central role in primary healthcare planning and budgeting. Given their close ties to local communities, HFGCs have enhanced local actors and communities' participation in overseeing essential primary healthcare functions. Consequently, this has influenced performance in the critical areas of service delivery in the health sector, such as enhanced infrastructure at the facility and ensured the availability of drugs and medical equipment at the facility:

"The availability of medicine is mostly guaranteed at primary healthcare facilities in our council, except for hard-to-reach areas during rainy seasons. The community is willing to contribute to infrastructure projects taking place at their facilities." - (member of CHMT at Manyoni - Singida)

Despite the gains in primary healthcare following the introduction of DHFF, respondents also reported challenges associated with the reforms. These include:

The inadequate project-management capacity

Most service providers at the facility level have limited background/ experience in finance, accounting, and procurement. The facility in-charge/ clinical officer is required to conduct financial planning, acknowledge the receipt of funds, keep financial books, and report using online information systems like FFARS. Besides, the facility owner must follow the cumbersome procurement procedures when purchasing equipment

¹ Health facility governing committees (HFGCs) were introduced in 1999 to provide room for communities to participate in health service delivery management. HFGCs are responsible for developing plans and budgets for the facility and ensuring the quality of service. The HFGC consists of five community members and three appointed members from the ward, village, and facility in-charge officer.

for the facility. Facility owners received only one-time training on financial management, which is not enough for a layman in the financial and procurement professional. Consequently, during reporting seasons, service providers complained about spending a considerable amount of time on bookkeeping and reporting instead of attending patients:

"I have limited knowledge of finance, accounting, and procurement. There is a need for further training on how to use reporting tools like FFARS. The process of financial reporting consumes time, which could be used to attend patients—considering limited healthcare workers at our facility." - (Service Provider in Dodoma)

Weak supervision capabilities

HFGCs and service providers rely on their LGAs for technical assistance. LGAs are required to advise facilities on governance and management, including resource mobilization and management, as well as the audit of funds. Supportive supervision and mentorship at the facility level are essential for the health sector to reap the potential of DHFF. However, limited LGA resources - including service vehicles, undermine the ability of the staff at the council level to perform their roles. This challenge is more profound in councils where health facilities are in hard-to-reach areas and far from the LGA offices, thus require extra resources for supervision.

"We have limited resources (such as vehicles) to visit all facilities, including those under construction for supervision because some are miles away from the council." - (member of CHMT at Manyoni - Singida)

Computer access and internet connectivity

The DHFF relies on internet connectivity to access the financial reporting software (FFARS - Facility Financial Accounting and Reporting System). However, facilities without computers and internet connectivity can use the manual version of FFARS and then switch to an automated one as soon as the infrastructure allows. Several health facilities—particularly those in rural areas, have limited computer access and suffer from the limited and often unreliable internet connection, hence impede the effectiveness of DHFF as it leads to duplication of work. The accountant has to either visit unconnected facilities to upload manual reports to FFARS. Otherwise, the facility in-charge officer has to divert portions of their work time to travel long distances to access the internet - mostly at internet cafés or the LGA's office.

Conclusions and Policy Recommendations

In conclusion, the brief has presented the prospects and challenges following the implementation of the DHFF intervention. Findings suggest that healthcare professionals have positively welcomed DHFF reforms. The intervention has led to reliable and timely disbursement of funds at the facility, increase local fiscal autonomy, and enhanced transparency, accountability, and community participation. Apart from the benefits, DHFF encounters some bottlenecks, including inadequate project management capacity, weak supervision capability, limited computer access, and internet connectivity.

The following recommendations are being outlined to improve the implementation of DHFF:

The first is to increase training at the facility level. Regular training is vital for service providers and HFGC to become familiar and comfortable with DHFF interventions and FFARS software. Training at the facility level can be customized for HFGCs and service providers. The training for HFGCs should insist on governance and accountability. Coupled with this, training on computer literacy and financial resource management is essential to service providers, including input procurement and use of financial management systems like FFARS - for financial reporting and PlanREP for budget and planning.

Second, enhance the availability of key human resources and financial resources. Assistant accountants should be recruited for those wards deprived of a health center, as there around 3821 geographical wards without any health center¹. Since there shortage of human resources in the health sector, appointing assistant accountants can reduce the burden to clinical officers and help them focus on the provision of core healthcare services. As well, ensure access to financial resources at the council level for supervision.

Third, invest in ICT technology and connectivity. The MoHCDGEC and PORALG may liaise with the Universal Communication Service Access Fund (UCSAF) and development partners to boost internet connectivity to primary healthcare facilities. Investments should also be made for enabling infrastructure to support electronic reporting by supplying computers or tablets to the primary health facilities.

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This study was funded by the Swiss Agency for Development and Cooperation



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REPOA

Headquarter

157 Mgombani/REPOA Streets, Regent Estate, P.O. Box 33223, Dar es Salaam, Tanzania
Tel: +255 22 2700083 Cell: +255 75 409 1677 Fax +255 22 2705738
Website: www.repoa.or.tz Email: repoa@repoa.or.tz

Branch Office

2nd Floor, Makole East, Kisasa
Dodoma, Tanzania

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