# Title: Engaging citizens in planning, budgeting, and financial management to improve health service delivery

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HEALTH SYSTEMS STRENGTHENING ACCELERATOR

## Context

- This case presents the experience of the USAID Public Sector Systems Strengthening Activity (2015-2020) and the ongoing follow-on, the Public Sector System Strengthening Plus (PS3+) Project (2020-2025).
- Tanzania has a decentralization by devolution (D&D) policy whereby delivery of services is anticipated to be informed and managed through a high level of community engagement.
- Despite the good intentions of the decentralization by devolution policy, community health needs, especially the needs for women, youth, and low-income people are not visible or effectively integrated into Government health sector plans and budgets. Community members are engaged in development of plans and budgets through village assembly meetings but there is no systematic way of incorporating their needs into plans and budget priorities. There is limited capacity of community members and health facility governing committee members to actively engage and negotiate in sessions to develop plans and budgets.
- Funds are not allocated and managed by frontline service providers and lower-level government (LLG)—community, village/mtaa, and ward levels— because of a lack of sound financial management systems. Planning, budgeting, and expenditure management systems currently stop at the council level. This hinders the ability of frontline service providers and lower-level governments to plan and manage their resources to respond to the varying needs of the community groups.

## Activity Description

- Our Theory of Change is that IF people, money, and processes are strengthened, extended, and institutionalized, THEN delivery of services will be improved. People include both government actors in health service delivery and citizens whose voices were missing in health decision making. We prioritized processes such as planning and budgeting at the local level because these were the key entry points for ensuring citizens voices are prioritized and incorporated into decisions made about health service delivery.
- We worked with different levels of government responsible for health service delivery (national, regional secretariat, local government authority, ward, village/mtaa—including health and education committees). From the community side we worked with District Level Civil Society Organizations (CSOs), private community radio stations, community-based budget monitors and women, youth, people living with disabilities (PWDs) and private sector institutions (District Business Councils [DBC], including businesses and business facilitation entities). Our main entry point was the Presidents' Office Regional Administration and Local government (PORALG) because of its role in overseeing implementation of both health and citizen engagement policies in Tanzania. We used PORALG to jointly clarify needs, design, implement, learn, and improve on priority PS3+ interventions.
- Our PS3/PS3+ intervention improved the platform for lower-level government and service providers to accommodate community priorities, by working with PORALG, regions and Local Government Authorities (LGAs) to extend automated, web-based planning, budgeting, and financial management systems. The planning, budgeting, and reporting system (PlanRep) that is used by LGAs to develop plans and budgets was customized to include all primary health facilities (and schools) and all villages/mtaa and wards, to create space for each service provider to develop their plans and budgets in the system. This helps health facilities to document communities' priorities, to clearly see the health priorities that they have set and how well those priorities are aligned to community priorities. Facilities used their priorities to set outputs in PlanRep and were able to better align their resource allocation to priority health outputs. Initially, the planning process was only focusing on planning for inputs (e.g., per diems, medicine, utilities, etc.) without a clear link to priority health problems. The additional information that PS3+ helped to add in PlanRep helps facilities to link people (community needs) with money (resource allocation) using the government's existing planning and budgeting system.
- Similarly, PS3/PS3+ collaborated with the government to introduce the Automated Facility Financial Accounting and Reporting System (FFARS) in primary health facilities, schools, and at village/mtaa levels. The introduction of FFARS helps the government to introduce Direct Facility Financing (DFF) by allocating funds directly to frontline line service providers. PS3+ also supported the government to develop the DFF allocation formula for primary health facilities by introducing a capitation formula that adjusts for variations in needs, equity, and performance across health facilities. DFF provided facilities with the autonomy to prioritize service delivery based on community priorities. The introduction of FFARS created confidence to the government that funds sent to frontline service providers will be properly utilized since PORALG and the Ministry of Finance can track through FFARS how these funds are being utilized.
- Furthermore, the PS3+ supported the initiative to engage CSOs and community owned radios to build the capacity of communities to engage and actively participate in community planning and budgeting processes. The Project also invested on mentorship and supportive supervision to make sure that Regional Secretariats (RSs) and LGAs play an active role in promoting community engagement and building the capacity to engage them and provide input into government budgeting and planning processes.
- To ensure that the use of planning, budgeting, and financial management systems at frontline service provider and LLG levels is sustainable, PS3+ also supported the government to introduce the open distance learning (ODeL) platform that can be used by facility staff and committee members to learn about new staff orientation, councilors roles, and cadres' orientation on improved systems, their responsibilities, and citizen engagement from any geographical location and at their convenience. This will help to ensure the capacity of government staff to use extended planning, budgeting, and financial management systems at a lower cost than face-to-face training.



## Activity Impact

- The extension of planning and budgeting systems to frontline service providers has helped to improve visibility/transparency of facility level plans and budgets. Currently, facilities are able to receive ceilings through PlanRep and they know the amount of financial resources that are available to facilitate delivery of priority health services to the community in each financial year. The web-based PlanRep has proved to be a cost-effective way of developing and managing implementation of facility plans compared to using manual planning and budgeting process. It has further increased autonomy of health facilities and opportunities for LLG and primary health care (PHC) facilities to set and have more influence in priorities/budgets.
- Furthermore, the introduction of FFARS has helped to improve financial management and implementation of direct facility financing (DFF). FFARS has improved accountability in the use of funds across facilities since the system is used to manage budget execution and produce financial reports that are shared with health facility governing committee members and the community for feedback.
- PS3/PS3+ support to introduce the DFF capitation formula that adjusts for variations in needs, equity, and performance has helped to improve equity in the allocation of financial resources at primary health facilities. Facilities that are in remote areas and areas that serve larger segments of the community get more resources that meet the high demand. In addition, facilities that are performing well in delivering quality services are provided with more resources for their performance, motivating them to improve quality of service delivery. Evidence shows that drug stock-out has decreased following the introduction of DFF and FFARS.
- The introduction of Government of Tanzania Health Operation Management Information System (GOTHOMIS) has help to improve the quality of services especially by reducing time spent by patients at the facility and managing facility stockouts. The system also helps to track and manage user fees paid by patients as the system has a financial model that identify the financial modality used by each patient when accessing health services.
- Furthermore, community awareness and their engagement/participation in planning and budgets has also increased following the CSOs and community radios community sensitization initiatives. In the areas where PS3+ has had its community engagement interventions, such as in Missenyi, Songwe, and Chunya councils, community members are now increasingly participating in village meetings to develop plans and budgets and they are also more actively demanding for feedbacks from health facilities. Health facilities and village governments are also increasingly sharing financial reports with communities following the increasing demand for these reports.
- Health facility governing committees have become more active because funds are flowing directly to facilities which empowers them to manage those resources, with the help of PlanRep and FFARS.

## Evidence

- In villages like Kyazi (Kitobo ward, Misenyi DC), youth and women attendance to meetings has increased to 80% of eligible members, up from 10-20% before the PS3+ interventions.
- The community radio programs have led to an increase in the number of households covered by the Integrated Community Health Fund from 2,892 to 7,231. This provides more households with financial protection when they seek health services.
- A USAID evaluation conducted in 2018 through Data for Development (D4D) shows that automated PlanRep has helped to improve efficiency in development of plans and budgets by reducing planning and budgeting costs by 51% and the costs involved in plans and budget scrutinization by 59%. (https://www.usaid.gov/sites/default/files/2022-05/PS3_Case_Brief_-_PlanRep.pdf). This achievement was realized because the plans and budget and scrutinization process is taking place online, so there is no longer a need for staff to travel to ministry headquarters, and no need to print plans and budget for scrutinization.
- Evidence shows that the extension of PlanRep and FFARS to frontline service providers and the introduction of DFF has improved the ability of facilities to plan and budget better according to community needs. The problem of drug stockouts has also been addressed in most facilities and facilities now have necessary inputs required to deliver services.

> *"A patient with at least five prescriptions can get four out of five dosage/medicines,…. that was never the situation before."* - Bernadetha Bupamba, Health Secretary at Kigamboni Health Centre (https://pdf.usaid.gov/pdf_docs/PA00Z82D.pdf)

> *"Our ability to provide services has improved significantly, we are now able to purchase goods based on needs of the facility and thus provide good and quality services. Previously, we used to receive drugs that we were not in need of or not relevant. Supply of drugs has improved by more than 65%."* - Dispensary In-Charge (https://www.usaid.gov/sites/default/files/2022-05/PS3_Case_Brief_-_Direct_Health_Facility_Financing.pdf)

> *"I won't have more expenses going to and from Temeke hospital until my wife recovers to get back home,… I have managed to get 17 of the 23 listed drugs and minor medical equipment here at the Health Centre and with a fair price that I can well manage."* - Fredy Gama, the husband to a pregnant woman who delivered her baby at Kigamboni health centre (https://pdf.usaid.gov/pdf_docs/PA00Z82D.pdf)

## Facilitators

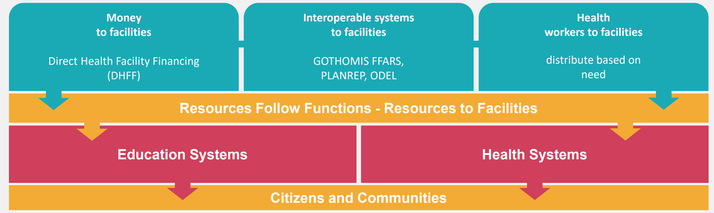
- Prior to the start of USAID PS3/PS3+ implementation, the Project signed a Memorandum of Understanding (MOU) with PORALG. This helped to ensure that there is mutual commitment, trust, and respect from both sides and clear direction on how system strengthening interventions will be jointly implemented while also complying and aligning with Government Machineries Policies/Acts/Circulars/Guideline/Plans.
- A co-creation, co-design, and joint implementation of interventions between the government and the PS3/PS3+ technical teams. Before implementation of any interventions, the government and the Project met to discuss the challenges and agreed on appropriate interventions. The teams collaborated in the implementation of these interventions.
- Willingness of the government to cost share implementation costs. The government was willing to cost share training costs (e.g., perdiems and transport costs) to orient users on the use of strengthened systems such as PlanRep and FFARS. This was coming from PORALG and LGAs' own budgets.
- Building on existing public sector systems and not introducing parallel systems. Most of the interventions that PS3/PS3+ supported were not new but were rather building on existing public initiatives. The focus was more on improving efficiency in the public sector systems to improve service delivery, especially in underserved areas.
- Using local expertise in development and improvement of public sector systems. Local information system experts were used to program planning, budgeting, and expenditure management systems without dependence on external experts. This ensures that the systems will be sustainably maintained including accommodation of new requirements as they arise from users.
- Collaboration with other implementing partners and development partners such as PATH, PharmAccess, SDC, GIZ, UNICEF, WHO, and WB in the implementation of identified interventions.
- Putting frontline service providers at the core of PS3/PS3+ implementation strategy. All interventions were designed in such a way that they are contributing to improvement in services delivery at frontline service providers.

## Challenges

- Encouraging service providers to improve governance and citizen engagement as much as clinical service delivery. Health service delivery actors do not collect or consider governance related indicators when considering how to improve health service delivery. For example, it is not unusual for supportive supervision to report on technical matters leaving aside issues of good governance (e.g., regularity of governing committees' meetings, or facility posting on notice boards income and expenditure reports).
- Limited IT infrastructure (e.g., internet, computer) for effective use of improved systems (PlanRep, FFARS) across all levels. Some facilities need to travel to council headquarter or nearby township to access the internet. Also, most villages do not have a computer. PS3+ developed mobile phone versions of PlanRep and FFARS to enable a smooth planning process for health committees that oversee health facilities.
- Delays in disbursement of budget funds and reimbursement of health insurance claims sometimes hinders the ability of facilities to deliver services, especially at the start of the financial year.
- Staff turnover affects continuity in use of systems and crating high demand for training to new and transferred staff. Provision of online distance learning (ODEL) through the application of information communication technology (ICT), which is self paced and flexible, has helped onboard and orient new recruits quickly and cost-effectively.

## Lessons Learned

- System strengthening interventions are more likely to be successful when they form part of an existing government priority and there is a high level of government staff engagement.
- System interventions that are implemented across the board are more easily accepted by the government compared to pilot-based interventions. This was the case for most of the PS3/PS3+ interventions which we implemented across the country (e.g., PlanRep and FFARS)
- It is necessary to set clear demarcations/scope of system support interventions that projects will be implementing vs. what the government will support. This helps to facilitate smooth implementation.
- Frontline service providers need to be at the core of system strengthening interventions. It is necessary to link system reforms to the objective of service delivery improvement.
- Improving systems does not lead to improved service delivery unless the systems are concurrently built with the intent of increasing the autonomy of health facilities.

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