



**Report of a study on the  
Regional level Health Care Management  
capacity on HIV/AIDS in  
Coast, Tanga and Arusha regions**

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## Foreword

The National AIDS Control Programme (NACP) of the MoHSW with support from PharmAccess under funding from the Embassy of the Netherlands (EKN) aims to improve the quality assurance (QA) and M&E of the HIV Care and Treatment Plan in Tanzania. A major objective is the decentralization of quality assurance in the context of this Plan to regional and district levels.

NACP/PharmAccess wishes to ensure that the proposed Quality Improvement Framework for PMTCT and ART is fully integrated within the evolving planning, budgeting and M&E systems of the health sector, and specifically within the district Council Comprehensive Health Plan (CCHP) process and cycle. This will help ensure that implementation of HIV care and treatment becomes part of routine health services, and not a parallel activity. Initially, it is planned to work with Regional Health Management Teams (RHMT) and the Regional Administrative Secretaries (RAS) to strengthen their capacity to support Council Health Management Teams (CHMT) in these technical areas, thus working through the existing health system.

In initial discussions with MoHSW and others, it is recognized that the CCHP process is a great step forward, but that it requires continuing strengthening if it is to fulfill its potential for performance based funding i.e. linking the various sources of funding (block grants, basket and specific project funds) to defined performance by districts as service providers, whilst taking account of national policy developments. Contracting (using service level agreements) was identified as a potentially useful mechanism to assist with this. In the context of this project, it is suggested that contracting has a role in influencing the performance of regions and districts, and giving them an incentive to carry out Quality Improvement (QI) activities and meet quality targets, thus generating the essential data required for M&E.

Contracting is seen as a powerful management tool to improve the quantity and quality of services delivered by the regions and the districts (councils) – and indeed by non-state health care providers receiving public funding for public patients. Decentralized supervision of contracting could be undertaken by the strengthened RHMTs. Discussions have suggested that contracting could be applied not only to the roll out of HIV Care and Treatment (HIV C&T), but to all HIV services thus improving coordination between many of the diverse support initiatives.

In order to assess the capacity and the readiness of the regional health care management system and the regional administration to respond to the demands of the foreseen gradual decentralization of HIV/AIDS Care and Treatment, a study was undertaken in three regions of Tanzania. The objective of the study is to provide concrete and doable recommendations on the modalities of a specific contractual agreement ('service level agreement' or 'performance based agreement') between NACP/PharmAccess and the RHMT/RAS.

The study was successfully carried out in the 1<sup>st</sup> quarter of 2008 and the report of the findings and recommendations is presented below. I like to extend my gratitude to the consultant, Mr. Daniel Kayanda, who conducted the study and, through his professional attitude and perseverance succeeded in collection a wealth of practical as well as background documentation, providing NACP/PharmAccess with the evidence to proceed with the implementation of the QI plan for HIV Care and Treatment services.

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Jan van den Hombergh Country Director PharmAccess

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## Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral Drug
C&T	Care and Treatment
CARF	Community AIDS Respond Fund
CDC	Center for Disease Control
CHMT	Council Health Management Team
CSO	Civil service Organization
CTC	Care and Treatment Centre
DACC	District AIDS Control Coordinator
DED	District Executive Director
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
HIV	Human immunodeficiency syndrome
ICAP	International Centre for AIDS care and Treatment of Columbia University
LGA	Local Government Authorities
MoHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Programme
NCTP	National Care and Treatment Plan
NGO	Non Governmental organization
PAI	PharmAccess International = PharmAccess Foundation
PEPFAR	US President's Emergency Plan for AIDS Relief
PLWA	Person living with HIV/AIDS
PMORALG	Prime Ministers' Office Regional Administration and Local Government
PMTCT	Prevention of mother to child transmission
PWC	Price Waterhouse Coopers
QI	Quality improvement
RACC	Regional AIDS Control Coordinator
RAS	Regional Administrative Secretary
RFA	Regional Facilitating Agent
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RTL	Regional TB and Leprosy coordinator
SLAs	Service Level Agreements
SMART	Specific, Measurable, Achievable, Realistic and Time bound
SWOT	Strength, Weaknesses, Opportunities and Threats
TACAIDS	Tanzania Commission for AIDS
TB/L	Tuberculosis and Leprosy
TMAP	Tanzania Multi – Sectoral AIDS Programme
TQIF	Tanzania Quality Improvement Framework
URC	University Research Company
URT	United Republic of Tanzania

## **Executive Summary**

### *Introduction*

PharmAccess Tanzania supports the National AIDS Control Programme (NACP) in the roll-out of the National HIV/AIDS Care and Treatment Plan (NCTP). PharmAccess' support has so far been provided from national level. With the expansion of the NCTP, a decentralization of responsibilities is necessary, from national level to regional and district level, through Regional Medical Officer (RMO) and Regional Health Management Teams (RHMTs) and District Medical Officer (DMO) and Council Health Management Teams (CHMTs), in line with the Health Sector Reforms.

Between 2007 and 2010, with the financial support of the Embassy of the Kingdom of the Netherlands (EKN) PharmAccess will support NACP with a gradual decentralization of HIV/AIDS Care and Treatment efforts to these lower levels in the health sector. This shift in responsibilities requires a re-definition of the roles of the various players related to HIV/AIDS, in particular NACP, RHMTs and CHMTs. 'Service Level Agreements' (SLAs) may be introduced as part of an output based management approach at regional level.

In order to help establishing a system of decentralization between the NACP and the regional health management teams it is important to have a sound grasp of whether or not the regions are ready to assume new responsibilities and, if so, whether the regions have the required capacity to implement the new responsibilities. The overall objective of the project is to contribute to the expansion of good quality HIV/AIDS care and treatment services to as many HIV+ people as possible in a sustainable manner.

### ***Objectives of the study***

A study was conducted between January and March 2008 in Coast, Tanga and Arusha regions; and within each region, two districts were selected for further analysis.

The objectives of this study are:

- to make a thorough assessment of the capability of the health care management at regional level to cope with the demands of the foreseen gradual decentralization of HIV/AIDS Care and Treatment
- to make concrete recommendations on the modalities of a potential specific contractual agreement ('service level agreement' or 'performance based agreement') between the NACP/ PharmAccess and the RHMTs and/or the Regional Administrative Secretaries (RAS).

### ***Means of gathering information***

Information was gathered by making use of the following sources:

- Documents such as operational plans, periodical reports, supervision reports and relevant guidelines related to the project outputs;
- Interviews conducted with executive health staff and relevant staff from the Regional Administrative Secretariat, the District Executive Director's office and partner organizations;

A Questionnaire was developed which was used in guiding discussion with respondents.

### *Limitation of the study*

One of the major challenges in collecting information is absence of ready compiled and up to date information in the RAS offices, RHMTs and CHMTs such as the inventory of equipment and list of staff. The solution to this problem was either to make physical counting of vehicles and computers or discussion with relevant staff of units; and for staff lists it was required to look in some cases at staff personal files.

## **Findings from the study**

This report presents key findings of the current capacity of the regions and districts health care systems and come up with recommendations on the further steps to be taken in the decentralization of the responsibilities from National level to the Regional Health Management Teams.

Quite prominent in the area of HIV/AIDS Care and Treatment is the presence of the partner organizations in the regions: EGPAF, ICAP and AIDS Relief. The three mentioned partners are currently supporting the area of Care and Treatment including data management by providing technical support like data personnel, nurses and doctors and the procurement of laboratory equipment, computer and others; including maintenance and repair.

Another relevant partner is the Regional Facilitating Agency (RFA) working with national or international organizations selected by the Tanzanian Government to support implementation of the Tanzanian Multi – Sectoral AIDS Programme (TMAP). RFA is acting as an arm of the Tanzania Commission for AIDS (TACAIDS). The appointed RFAs are responsible for the smooth processing of funds granted by the Community AIDS Respond Fund (CARF).

The RFA is present in all regions of Tanzania and is focusing in the following areas:

- To assess Civil Society Organizations of the respective regions, analyze their needs and capacities;
- Build capacity in the regional secretariats, local government authorities and civil society organizations;
- Monitor and evaluate sub-projects and Community AIDS Respond Fund (CARF)

The RFA in Coast region is Action Aid, in Tanga, GFA Medica is present, a German consulting company, and for Arusha region the RFA is Strategic Trainers Associates.

Furthermore, a number of NGOs and CSOs have been established through community initiatives for HIV/AIDS interventions working at the door steps of the people.

### *Approaches in making agreements for execution of project objectives*

Different modalities of agreements between the partner organizations and either the government or community CSOs and NGOs were observed. The most common agreements encountered are:

- signing a contract based on a Memorandum of Understanding or

- developing Terms of Reference with clear indicators, targets and responsibilities for each party; (e.g. NACP, RHMT and partner organizations).

### *Existence of operational plans and sources of funding*

All Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs) have developed an annual Health plan which reflects objectives and activities and budget of the calendar year. The operational plans are used for monitoring implementation of the agreed objectives, and therefore it is part of the M&E tools.

The regions and districts receive their funding for their Plans from the government through block grant, donor support through basket fund, project support by NGOs and Development Partners such as USAID, JICA, GTZ, EKN and DANIDA.

### *Management of finance for health*

Financial management is properly developed due to experience with opening and managing government accounts such as the health account maintained at the district level; the RMO/AIDS and TB/L accounts are maintained at regional level.

Financial and substantive reports have been prepared to reflect finance and activity performance and sent to MoHSW, PMORALG, and relevant partners on a quarterly and monthly basis. According to government financial regulations the RAS and DED have the administrative mandate on proper financial management through approval of work and payments with an audit check by technical auditors of the internal audit unit in the RAS and DED offices.

### *Availability of equipment and qualified staff*

Most of the RHMTs and CHMTs have access to a computer for their work and have the availability of at least one vehicle for supportive supervision. In accordance to the staffing levels guide and demand, qualified staffs for RHMTs and CHMTs are present. Temporary absenteeism for attending postgraduate studies of 4 out of 6 DMOs of the 6 districts covered in the study was noted. All 4 districts had Health officers acting in the capacity of a DMO. All RMOs were present, and 1 out of 3 Health Secretaries at regional level was absent for attending postgraduate studies.

### *Problems and challenges*

Together with the strength and opportunities mentioned above, a number of problems were identified:

- Inadequate funds at regional level for supportive supervision and general administration is a major challenge for the RHMT.
- Supportive supervision reports are available, but not well maintained and organized for easy accessibility. There is neither a culture to compile findings from the checklist used in gathering information, nor a practice to maintain a file system for keeping reports from visits. RHMTs complained that they do not get compiled reports of supervision made by staff from the MoHSW and partner organizations; CHMTs and Health Facility staff had the same concern as the RHMTs.
- In accordance to COWI (2007) evaluation report, composition of RHMT members and their mandate at district and Health facility levels are not clearly stated in the process



of Health sector and Local Government Reforms in Tanzania. Similar findings were observed by JICA (2007). However, talking to officials of the MoHSW and PMORALG, efforts have been made to define the composition mix and mandates of RHMT.

- Inadequate skills by RHMTs and CHMTs on Planning, Monitoring and Evaluation resulting in production of objectives of operational plans which are not specific, realistic, measurable, achievable without a proper time frame (SMART).
- Assessment and general issues of quality assurance are still a challenge as described at the introduction part above.
- Capacity Development for data personnel, clinical and relevant staffs on data management is not included in the health operational plans at the regional and district levels. Capacity Development on data collection, analysis and reporting is done as an additional activity through partner organizations' support.
- All RAS pointed out that approval of payments with all signatories (A+B) from within the health sector has limited transparency to the top authorities of the regions including the RAS and Regional Accountant. This has resulted into weak internal control of finance due to the lack of appropriate mechanisms on segregation of duties. This problem is common for TB/L and HIV/AIDS accounts at regional level.
- Apart from (Sub)Treasury staff, no one (including partner organizations) is allowed to access bank balance and bank reconciliations on Deposit accounts; this also limits transparency to the partner organizations including PharmAccess.
- Payments to the Health Department at regional level can only be effected within two to four weeks as observed in Arusha and Tanga Sub Treasury. This will cause a delay to the timely execution of work.
- In all regions and districts visited, internal and external audits have not been done routinely. In Arusha RHMT for example, external Audit was done in 2004, and the next done in February 2008. Among other reasons, absence of Auditors as for the Coast region in the year 2007 is a reason for audit not to be implemented. Heavy workload due to inadequate number of Auditors (one or 2 only) supporting all departments in the RAS offices, as compared to actual need.
- The audit processes as revealed in the reports are not comprehensive enough to include all types of audit such as System Based Audit for detailed review of controls, Value for Money Audit to review management arrangements and Computer Audit.
- All management staff at the MoHSW, RHMTs and partner organizations have not made a Manager's Checklist or an equivalent tool to ensure good financial control of receipts, fixed assets, expenditures and other liabilities.
- As it was learned through the Basket Fund External Audit report executed by PricewaterhouseCoopers in 2007, the financial reports at district levels are consolidated, but not disaggregated enough to describe each expenditure item despite the fact that they are developed through Epicor software.
- Furthermore, poor working morale of staffs due to delayed promotion, low remuneration package, excessive workload and inadequate mechanisms to reward good performance has affected the production of good quality data.

## ***Recommendations***

The above mentioned findings end in the following concrete recommendations:

- A contractual agreement between NACP/PharmAccess and the Regional authorities, should be developed.
- The contractual agreement should include the RAS as part of the detailed Terms of Reference attached
- The specific contract should be signed between NACP/PharmAccess and RHMT/CHMT as advised by RHMTs and CHMTs during the study.
- The detailed Terms of Reference with indicators and targets to assess objectives and activities for the contractor, and the detailed plans and budgets will be attached.
- A special account for the project to be opened, not being a “deposit account” given the delayed payment and the restrictions to partner organizations to access bank balance, bank statements and bank reconciliation, which are important elements to describe and justify expenditure against receipts.
- Work to be approved in the health sector but cheque to be signed by RMO/DMO and RAS/DED or their delegates.
- Whenever it is necessary to use existing deposit account and Health accounts, ensure that the contract has a clause for permission for the PharmAccess auditor and management staff to have access to books of accounts and obtain copies of bank balance and bank reconciliation for every month.
- Request for approval of work to be processed at least two to four weeks before implementation of work to avoid the effect of delayed payments as experienced in Tanga and Arusha.
- Ensure that separate books of accounts are established for the project. Within the contract, an agreement should be put forward to ensure that PharmAccess’ internal and external Auditors and relevant staff have no limitations in access to all project documents including bank balances and reconciliations.
- Ensure that monthly visits to regions are carried out by the project Auditor of PharmAccess to oversee implementation of financial transactions and performance of agreed objectives. During such visits, all types of Audits such as System based Audit, Value for Money Audit, and Computer Audit are conducted.
- NACP with support of PharmAccess should develop a Manager’s Checklist for ensuring good financial control and use it to guide in developing a supportive supervision checklist (see annex 8 , example checklist).

- Internal auditors of the RAS and DED to support RHMTs and CHMTs in processing and compiling financial and substantive reports of the project as part of their routine work and send them on a monthly basis to MoHSW, PMORALG and NACP/PharmAccess.
- NACP/PharmAccess in collaboration with partner organizations to establish an audit committee or allocate such responsibilities to existing committees to deal with financial matters of partner organizations with RHMTs and CHMTs. Members can be drawn from the Health Board, M&E or Assessment committees of the project and HIV/AIDS committees. Additional technical staff may be sought from relevant sections including accounting, planning and community development, CSOs and NGOs at local level plus a member of PLWHA. The committee will be chaired and accountable to the RAS. This will form part of strategies to support the Auditor from PharmAccess and relevant staff to ensure easy tracking of information on an efficient and effective manner.
- Increase allocation of budget to RHMT by the government and partner organizations including PharmAccess for QI activities in HIV C&T, including capacity development, supervision, assessment and certification of HFs, M&E and the quality assurance linked with these activities.
- NACP and MoHSW as a whole, in collaboration with partner organizations, to develop from within their level capacity of the regions and districts in supportive supervision and clinical mentoring and ensure reports are made available; compiled and filed in their offices and kept at an open and accessible place. Copies should be sent to the areas visited to improve feedback mechanisms.
- MOHSW, in collaboration with partners such as ICAP, EGPAF, AIDS Relief, RFA and FHI (Tunajali) programme, facilitate implementation of the project objectives especially on implementing capacity development on planning, budgeting, financial management and quality assurance components.
- Define job descriptions for the partners and individuals to ensure proper allocation of responsibilities.
- Use approved systems by the government of Tanzania on financial and substantive reports.
- Introduce a competition award and develop an incentive structure to reward good performance
- The MoHSW and PMORALG to facilitate execution of the newly endorsed and signed regional secretariat organization structure, herewith facilitating the regions to ensure timely dissemination of information, appointments and approval of relevant staff

# 1. Introduction

PharmAccess Tanzania supports the National AIDS Control Programme (NACP) in the roll-out of the National HIV/AIDS Care and Treatment Plan (NCTP).

PharmAccess' support has so far been provided from national level. With the expansion of the NCTP, a decentralization of responsibilities from national level to regional and district level, through Regional Medical Officer (RMO) and Regional Health Management Teams (RHMTs) and District Medical Officer (DMO) and Council Health Management Teams (CHMTs), is necessary, in line with the Health Sector Reforms.

Between 2007 and 2010 the Embassy of the Kingdom of the Netherlands (EKN) will support the NACP through PharmAccess with a gradual decentralization of HIV/AIDS Care and Treatment efforts to these lower levels in the health sector. This shift in responsibilities requires a re-definition of the roles of the various players related to HIV/AIDS - NACP, RHMTs and CHMTs. 'Service level agreements (LFAs) or Performance Based Agreements' (PBAs) may be introduced as part of an output based management approach. In order to help establishing a system of decentralization between the NACP and the regional health management teams it is first important to have a sound grasp of whether or not the regions are ready to assume new responsibilities and, if, so, whether the regions have the required capacity to implement the new responsibilities.

The overall objective of the project is to contribute to the expansion of good quality HIV/AIDS care and treatment services to as many HIV+ people as possible in a sustainable manner.

The following three components are covered by the project:

- Assessment and Certification, whose objective is to expand and strengthen a decentralized assessment and certification system for HIV care and treatment, integrated into the general Health system at regional, district and health facility levels;
- Monitoring and Evaluation for Care and Treatment, whose objective is to expand and strengthen a monitoring and evaluation system for HIV/AIDS interventions, integrated into the general health system at regional, district and health facility levels;
- Quality Assurance component, whose objective is to develop and implement a system of quality assurance through performance – based agreements related to assessments and M&E activities under the project.

Quality improvement (QI) is one of the challenges identified for provision of good HIV/AIDS Care and Treatment services in Tanzania. Currently, none of the various components of quality improvement is well functioning. These include issues of assessment, reassessment, certification and accreditation; monitoring and evaluation; supportive supervision; and quality assurance. PharmAccess in collaboration with University Research Company (URC) is looking at mechanisms to address the gaps in a coherent way, in line with the Tanzania Quality improvement Framework (TQIF) developed by the Ministry of Health and Social Welfare (MoHSW). Other partners include AIDS Relief, Elizabeth Glazer Foundation (EGPAF); Center for Disease Control (CDC), International Centre for AIDS Care and Treatment of Columbia University (ICAP) and many others as per consensus in many organized partnership forums. The partner organizations agreed that clear definitions of roles and responsibilities should be developed, use of the same indicators, targets and reporting tools.

In order to smoothly embark on the project, a study has been conducted to explore on various options for making agreements with regions. An assessment has been done to see the capacity of health care management at regional level to cope with the demand of the foreseen decentralization of HIV/AIDS Care and Treatment (C&T). Three regions have been selected for the study and within each of the regions; two districts have been selected for further analysis:

1. Coast (Pwani) - Bagamoyo and Mkuranga
2. Tanga - Korogwe and Lushoto
3. Arusha - Monduli and Karatu

This report presents the findings gathered through visits made to the three regions mentioned above. The visits were conducted in January and February, 2008 and Preparatory orientation at NACP, the Ministry of Health and Social Welfare (MoHSW) and PharmAccess.

The first part is an introduction to the subject; this is presented together with the purpose of the study, expected outputs and methods of gathering information. The second part presents administrative arrangements at the regional secretariat. This is followed by findings from the study including good practices and challenges. The fourth part is an assessment based on 5 criteria: relevance, efficiency, effectiveness, possible impacts and sustainability. The last part will entail recommendations to NACP, MoHSW, PharmAccess and relevant partners. Annexes 1 to 5 include information drawn from respondents and relevant documents seen to clarify the findings at each partner organisation visited;

### ***1.1 Purpose of the study***

- To collect information on the capacity of regions and districts in assuming their decentralized role of the HIV/AIDS care and treatment;
- Make recommendations for addressing weaknesses identified;
- Recommend appropriate steps to be taken in the decentralization of the responsibilities from the national level to the regional Health Management Teams;
- Make recommendations on modalities of specific contractual service agreements or performance based agreement between NACP/ PharmAccess and the RHMTs or the RAS.

### ***1.2 Expected output***

Comprehensive report submitted to PharmAccess, reflecting capacity of the three regions covered in the study with recommendations for the contractual agreement to undertake the HIV/AIDS Care and Treatment responsibilities.

### ***1.3 Methods of collecting information***

- Interviews with the Regional and Council Health Management Teams (RHMTs and CHMTs), Administrative secretaries, Planning Coordinators and Health Board members who were conveniently available.
- Reading documents such as policy guidelines, operational plans, activity plans of individuals carrying out HIV/AIDS and management responsibilities. Further review of periodic reports, visitors books, seniority list and relevant documents for the project.
- Interviews with staff of relevant partner organizations in the regions/districts
- Attending meetings such as RHMT and DHMT which were held during the visit/ requested the management to conduct the meeting.

Annex 10 provides a summary of methods used in gathering information

### **1.4 Limitation of the study**

One of the major challenges in collecting information is absence of ready compiled up to date information in the RAS offices, RHMTs and CHMTs on the inventory of equipment and list of staff. The solution to this problem was either to make physical counting of vehicles and computers or discussing with relevant staff of units; and for staff it needed looking at staff personal files in some cases. This resulted to long working hours for securing right information.

## **2. Administrative arrangements at regional level**

The approved functions and organization structure of regional secretariats in 2007 consist of seven sections and three units at regional offices and district offices and require 54 core staff, 64 support staff and 17 staff for the District Commissioner's offices. This replaces the previous structure of the Regional Administration Act, Number 1997 which had 5 clusters at Regional offices in order to cope with the Local Government Reform of 1998.

*The approved sections in 2007 include:*

- Planning and Coordination
- Social sector
- Regional Hospital
- Economic and productive sectors
- Infrastructure
- Local Government Authorities Management Services

*The units are:*

- Finance and Accounts
- Internal Audit
- Procurement Management

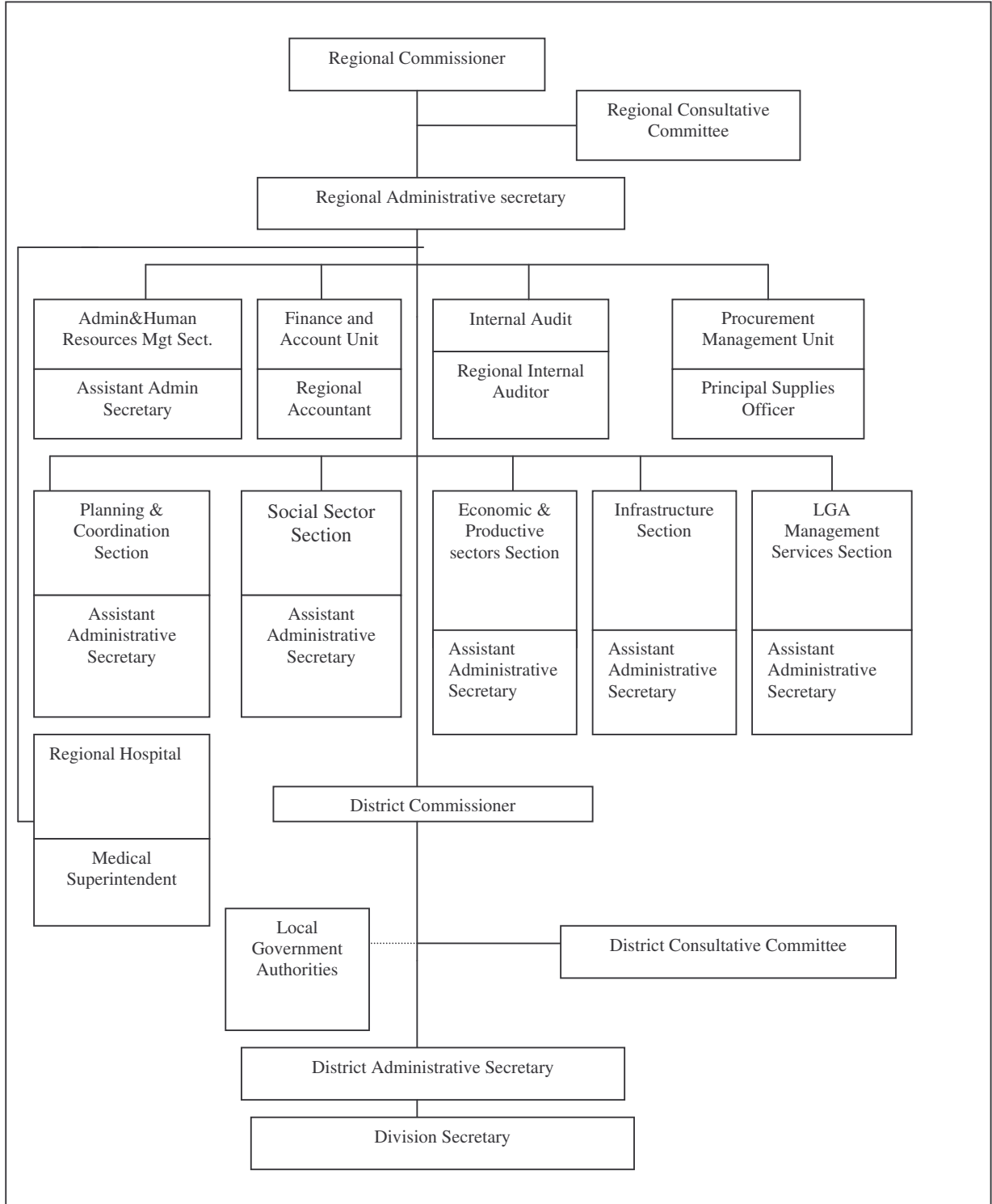
*Others are:*

District Commissioner's Office  
District Administrative Secretary  
Divisional Secretary

The administrative arrangement establishes essential controls of finances and assets in the organization. These controls require clear management structure, segregation of duties, authorization, physical controls and supervision. All these will be discussed through out the report for detailed clarity in line with the findings from the study.

See the organization structure below.

**Approved Functions and Structure of Regional Secretariats**



Source: *URT President's office, PSM (2008)*

From the organization structure above, the social section is made up of two sectors, namely health and education. The Assistant Administrative Secretary is responsible/accountable for this section.

The objective of the social sector section at regional level is to facilitate the provision of health preventive and educational development services including administering of primary and secondary schools and providing backstopping support during health epidemics in the region. Activities of the health sector section are:

- To coordinate and advise on implementation of health policy in the region,
- To provide a link between the Ministry of Health and Social Welfare (MoHSW) and Local Government Authorities (LGAs) on health matters.
- To build capacity to LGAs in health service delivery
- To provide technical advice to LGAs on preparation of HIV/AIDS fighting plans

The health sector under social sector will have 8 staff, they include: the regional Medical Officer (RMO), Dentist, Health Officer, Health Secretary, Nursing Officer, Pharmacist, Technician (Laboratory) and a Social Welfare Officer.

The regional hospital is an independent section where the Medical Superintendent has a direct accountability and reports to the RAS.

The objective of the Regional Hospitals is to provide referral hospital services to LGAs hospitals in the region. Their activities include:

- Provision of clinical services to inpatients and outpatients referred to by LGA hospitals;
- Provision of curative specialist services;
- Providing expert/technical backstopping service to LGA hospitals and health centers during major communicable diseases epidemics;
- Providing referral laboratory services for LGAs;
- Ensuring adequate availability of pharmaceuticals products for the hospital;
- Ensuring proper management of services at the hospital provided by the private hospitals.

The above structure has been already signed by the President (February 2008), but waiting dissemination and execution by relevant management of PMORALG, MoHSW and Regional Secretariat.



## **3. Findings of the study**

### **3.1 Introduction**

Part 2 above has given the administrative arrangements according to the recently approved organization structure of regional secretariats.

This part provides relevant information reflecting the real situation of the areas visited. Information on the RHMTs and CHMTs, sources of funding, existence of partner organizations dealing with HIV/AIDS care and treatment and general health; and existence of operational plans, implementation and reporting of supportive supervision, will all be dealt with in this part. Challenges will also be discussed.

### **3.2 Composition of RHMTs and CHMTs**

In the area of study, it has been realized that all RHMTs and CHMTs have qualified staff in accordance to MoHSW (1999) staffing levels guidelines and the government establishment circular (2002). The three regions have medical doctors with postgraduate training, and all have Health secretaries except one of the Coast region who is attending postgraduate studies. Four out of the six districts have Health Officers acting in the capacity of an in charge of the Health Sector due to temporary absence of the DMOs for attending postgraduate studies.

The RHMT is comprised of seven key members and other co-opted. Key members are: the Regional Medical Officer (RMO), Regional Health Secretary (RHS), Regional Pharmacist, Regional Nursing Officer (RNO), Regional Health Officer (RHO), Regional Laboratory Technologist (RLT) and Regional Dental Officer (RDO). This composition is almost the same as that mentioned in the recently approved structure, except that the 2007 structure has an additional core member (the Social Welfare Officer).

Co-opted members are the Regional Reproductive Coordinator (RCHC), Regional AIDS Control Coordinator (RACC) and Regional TB/Leprosy Coordinator (RTLCL). The same profession mix is found at the district level.

Most of staffs including RHMT and CHMT members do not have clear job descriptions to clarify their duties, as observed through staff individual files. Other problems include:

- excessive workload due to big number of attendance of patients
- poor working morale of staff due to delayed promotion
- inadequate mechanism to reward good performance has affected production of good quality data
- low remuneration package

During the visit, there was neither a RAS nor an RHMT member aware of the new approved structure of the regional secretariat, and therefore all of them linked their discussion with the 1997 and 1998 local Government Reforms which recognized only a Health specialist at the regional secretariat.

In accordance to COWI (2007)<sup>1</sup> evaluation report, composition of RHMTs and their mandate to district and health facility levels are not clearly stated in the process of Health sector and Local Government Reforms. Similar findings were realized by the Japan International Cooperation Agency (JICA) in its process of analyzing the challenges of RHMTs capacity to support the districts on health management.

It is therefore important for PMORALG and MoHSW to take action for creating awareness on the new Organization structure and facilitate its execution.

The next section will highlight on the existing partner organizations working with the regions and districts in supporting HIV/AIDS Care and Treatment and relevant health interventions.

### **3.3 Existence of Partner organizations**

In the three regions, different partner organizations are working in the area of HIV/AIDS for Care and Treatment. Partner organizations have a special focus on supporting data management, looking at data collection, data entry, data analysis and reporting as it was seen in various Centers for Care and Treatment (CTC).

The partner organizations are:

1. Coast (Pwani) - the International Centre for AIDS Care and Treatment of Columbia University (ICAP)
2. Tanga - AIDS Relief
3. Arusha - Elizabeth Glazer Pediatric AIDS Foundation (EGPAF)

The subsections below provide a description of each partner organization and other relevant NGOs present.

#### **3.3.1 International Centre for AIDS Care and Treatment of Columbia University (ICAP) in Coast region.**

ICAP receives funding support from the US Government Emergency Plan for AIDS Relief (PEPFAR) and Columbia University through the centers for disease control (CDC). ICAP is working with Coast region RHMTs, CHMTs, health facilities to support Care and Treatment services and partnership with 30 health facilities for PMTCT services. Currently, they have an agreement with Tunajali programme to smoothen coordination of its activities.

#### **3.3.2 AIDS Relief in Tanga region**

AIDS Relief is a five member consortium funded through PEPFAR. They work with the government and local partners in Tanga region to maximize in country capacity in programme management, provision of clinical care and monitoring and evaluation. Partnership activities include:

- On site mentoring and capacity building in the provision of family centered HIV/AIDS care and treatment;
- Building community networks for home based care and adherence support;

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<sup>1</sup> The composition of the team (RHMT) remains clinically oriented and does not reflect health sector reform initiatives such as the multisectoral approach, development of public private partnership; while RHMT is supposed to supervise the CHMTs, the latter has been extensively trained. Proposed seven members to form RHMT and giving the RMO back the previous team (COWI 2007, Joint External Evaluation of the Health Sector in Tanzania p.40)

- Quality assurance and improvement;
- Building the capacity of local partners to collect, analyze and utilize client information to improve their Antiretroviral Therapy (ART) programs;
- Collaborate with the government and the MoHSW to develop national treatment standards;
- Sustainability planning by supporting development and improvement of health systems and program management.
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In Tanga region, among the significant support include provision of technical staff for data activities (data clerk); clinical staff including Doctors, Nurses and Laboratory staff. Salaries and top up payments are provided to staff in line with contribution to extra duties of the project. Laboratory equipment and Computers have also been provided, supporting their maintenance and repair. The next plan has also included purchase of the vehicle to RHMT for supportive supervision.

### **3.3.3 Elizabeth Glazer Pediatric AIDS Foundation (EGPAF) in Arusha region**

EGPAF is a PEPFAR supported NGO to implement PMTCT program in Arusha and other regions in Tanzania. It has been supporting pediatric services for AIDS Care and Treatment in Arusha through diagnosis of 18 months children and recommends appropriate measures. The mother and father are also dealt with as a comprehensive support of the family in case a child has been identified HIV+. Under the regionalization of PEPFAR partner organizations, EGPAF will also support a wider scope of HIV/AIDS activities in the allocated regions.

### **3.3.4 Tunajali Programme in Coast region**

Tunajali is a Programme funded by PEPFAR through Deloitte/Family Health International and located in the RAS Offices Coast Region. They provide support to people living with AIDS (PLWA) through Home Based Care volunteers selected from every village. The focus is on identifying new cases and advises for testing; and advising PLWA on the right clinic to attend.

In every district of Coast Region, Tunajali works together with one local NGO or Civil Society Organization (CSO). Currently, it signed an agreement with ICAP (Columbia University) to assist sensitization of PLWA and other people within the community to attend Care and Treatment Centers (CTC). Management of its programme activities is using the government systems; and reports all findings quarterly to Regional and District AIDS Control coordinators (RACC and DACC), RAS and District executive director (DED) and the District Medical officers (DMO).

### **3.3.5 Regional Facilitating Agency (RFA) working in all regions**

Another relevant partner is the Regional Facilitating Agency (RFA) working with national or international organizations selected by the Tanzanian Government to support implementation of the Tanzanian Multi – Sectoral AIDS Programme (TMAP).

RFA is acting as an arm of the Tanzania Commission for AIDS (TACAIDS). The appointed RFAs are responsible for the smooth processing of funds granted by the Community AIDS Response Fund (CARF).

The RFA is present in all regions of Tanzania and is focusing on the following areas:

- To assess Civil Society Organizations of the respective regions, analyze their needs and capacities;
- Build capacity in the regional secretariats, local government authorities and civil society organizations;
- Monitor and evaluate sub-projects and Community AIDS Response Fund (CARF).

The RFA in Coast region is Action Aid, in Tanga GFA Medica is present, a German consulting company; and for Arusha region the RFA is Strategic Trainers Associates. Furthermore, a number of NGOs and CSOs have been established through community initiatives for HIV/AIDS interventions working at the door steps of the people; and through liaison with RFA, their information can easily be received.

### ***3.4 Existence of Annual Health Plans***

Every RHMT of the regions visited has an annual health plan, including supervision activities as part of M&E. The activities are not comprehensive to address the issues of quality assurance, data management and relevant M&E components. It is through additional work plans of partner organizations including ICAP, EGPAF and AIDS Relief where RHMTs and CHMTs have developed an operational plan with a budget for data collection, analysis, use and reporting. PharmAccess has been supporting the regions in the area of Assessments on the Care and Treatment through a centrally led plan and budget. Significant achievement by PharmAccess and relevant Partner organizations is the training conducted for RACCs and other RHMT staff in the area of assessment.

### ***3.5 Planning and Budgeting***

RHMTs and CHMTs receive funding for their plans from the government through block grant and donor support through basket funding. Other sources include project support by partner organizations and NGOs such as EGPAF, AIDS Relief, BMAF, World Vision, PATH, ICAP, CDC and Medicus Del Mundo. Development partners including DANIDA, USAID, SIDA and many others are not in isolation. All RHMTs have adequate and trained staff available to implement their role as mentioned in part 3.2 above. The key challenges identified remain upgrading skills on planning and budgeting, financial management and Monitoring and Evaluation. Most of the activities and objectives are not Specific, Measurable, Achievable, Realistic and Time Bound (SMART). See table 2 for further clarification.

### ***3.6 Management of finance for Health at Regional and District levels***

This part is seeking to clarify how the areas visited have instituted various control mechanisms on financial management. It concentrates in reporting the internal control mechanisms in place. These include: Segregation of duties such as how recording, checking, authorization and processing are split among different executives. It also looks at if authorization and approval done by proper authority; existence and practice of internal audit, execution of supervisory role; and overall control of management accounts. See the findings below:

RHMTs receive their funds through different accounts like the HIV/AIDS or TB/L accounts. Other donors such as DANIDA by HSPS of the MoHSW use the Deposit Account managed by RAS and Sub-Treasury

- For the HIV/AIDS account in most regions the following procedure is followed, the RMO and RACC endorse a cheque as signatory A, and the Health Secretary, Pharmacist or Medical Officer in charge of the regional hospital as signatory B. All approval ends in the health sector. By having signatories A and B, it is part of implementing internal control mechanisms to widen transparency by segregating responsibilities to different executives to oversee what is happening in the region or district. It is through this approach where if two signatures endorsed, a cheque can be paid by Bank. For more transparency, Signatories have to come from the top management, in this case the RAS or his/her delegate to sign as signatory B and the RMO, or his or her delegate from the health sector to sign as signatory A.
- For the TB/L account the Regional TB and Leprosy Coordinator operate as signatory A and RNO as signatory B. All approval ends in the health sector.
- For the Deposit Account, the Head of Sub-Treasury appoints a signatory from his/her office and on the other side the Head of Accounts of the RAS appoints an accountant to endorse the cheques. The RAS is final responsible for the approval of payments and expenditure requisitions.

The internal and external audits at regional level are most of the time delayed and sometimes does not even take place. In Coast region for example, there was no internal auditor present in 2007 and therefore no internal audit was conducted. In Arusha an external audit was conducted in December 2004 and the next audit took place in February 2008.

In every district, a health account is maintained by the District Executive Director for Health Finance. The DMO, Health Secretary or Health Officer is signatory A; and DED or District Treasurer is signatory B. The approval of payments is done by DED through DMOs. EGPAF and AIDS Relief have opened an account at each district with approval of payments done and cheque endorsed by Health Sector officials only, with exception of Karatu and Korogwe districts whose signatories and approval of payments involve the DED and the district Treasurer.

In all districts and regions, there is at least one internal auditor for RAS and DED offices supporting RHMTs and CHMTs to oversee the accuracy of financial transactions and its general management. In all districts, CHMTs reported that internal audits are done on a quarterly and occasionally on a monthly basis; while, some internal auditors could not even indicate the major problems in the management of the public fund in the health sector. The auditor in Karatu district for example could not mention a single problem as she had not done any visit in the health sector since July 2007. Similarly, in all other regions and districts, internal audit schedule are not implemented as planned and reports of the last two quarters are hardly available.

External audits at district level take place on an annual basis and the final report is available at each district and is executed by the basket fund auditor (PriceWaterhouse Coopers). Copies of the audit reports are distributed as well to the regional level, MoHSW, PMORALG and the basket funding committee.

On the other hand, internal and external audit at regional level is always delayed. In the Coast region for example, the internal auditor was not available in 2007, hence in that year no internal audit was conducted. Likewise, Arusha RHMT received external auditors for the exercise in December 2004, and next audit was on February 2008.

According to the audit report by PWC (2007)<sup>2</sup>, all sources of funding are classified under account number 6 (health account). The observation was made that the council was not able to retrieve a complete and accurate list of basket fund related payments from the Epicor system; hence reports were not disaggregated to describe each activity payments.

### **3.6.1 Challenges in management of finance for health**

- Epicor is software used in implementing various financial transactions including reporting receipts and expenditure. Despite of using this system, it is still difficult to establish disaggregated reports for each and every RHMT item as reflected in the analysis, especially for Arusha and Tanga regions.
- Neither project accounts for the Health sector such as AIDS and TB/L account, nor EGPAF and AIDS Relief use the Epicor reporting system.
- Payments through Deposit accounts can be efficiently made within 3 days in Coast region, but take 14 to 28 days in Tanga and Arusha. Otherwise, it takes 1 to 2 days through AIDS/TB and other project accounts to effect payments. See annex 9 for details analysis of alternative accounts.
- Maintenance of the Epicor and sub treasury accounting system in case of defects, as observed in Tanga is done by technicians from Arusha or Dar es Salaam due absence of technicians at their locality, thus taking about one to four weeks; this affects timely receiving of fund and execution of work.
- Various reporting formats are used for the reporting requirements on finance and activities done. Common features of the approved format by the government is demonstrated through the Epicor and related systems. Axios Foundation has a similar reporting format with minor differences. Common items covered in the format, include but are not limited to the Title, Account Code, Description of the activity, Budget, Period, total Receipts and Expenditure. See annex 2 for the sample of Axios financial report format for Arusha RHMT.
- Several RHMTs complained about the behavior of staff of the Sub-Treasury to request a favor of being included in a list of beneficiaries of the processed payments for any activities of which the funding is channeled through the Sub Treasury Deposit Account.
- The Health Sector and partner organizations do not have access to the cash balances and reconciliation of the Deposit account, except Sub-Treasury staff who have access. This limits partners to audit output, accuracy and validity of information contained in the accounting records or financial statements.
- All three regions faced difficulties to draw funds from Deposit accounts due to reconciliation procedures in the months of July and August 2007.

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<sup>2</sup> Karatu District Council maintains one consolidated bank account ie. Account number 6 where funds from different sources for health activities including basket grants are commingled. For ease of tracking of donors' funds the council was required to implement expenditure coding system using EPICOR to be able to identify each expenditure and payments related to each source of fund. The council is not able to customize the system to enable it to produce a complete and accurate list of Health Basket Fund related payments (PWC 2007)

- In all regions and districts visited, internal and external audits have not been done routinely. In Arusha RHMT for example, external audit was done in 2004, and the next done in February 2008. Among other reasons, absence of Auditors, as for Coast Region in the year 2007, is a reason for not conducting an audit. Heavy workload due to inadequate number of auditors as compared to need; who are either one or two, supporting all departments in the RAS offices. In addition, the audit processes according to reports, are not comprehensively giving clarity on all types of audit: System Audit for detailed review of controls, Value for Money Audit to review management arrangements and Computer Audit.
- All management staff at the MoHSW, partner organizations including RHMTs have not made a Manager's Checklist to ensure good financial control; for control of receipts, Fixed assets, expenditures and for controlling liabilities.

### ***3.7 Supportive supervision***

All RHMTs and CHMTs visited have reports for supportive supervision. However, their reports are not processed from the supervision checklists, and so are not compiled to form one comprehensive report for easy reading and compilation. Bagamoyo was the only CHMT who have compiled reports, extracted from the checklists and a copy sent to the health facilities visited for feedback. The supervision reports for other RHMTs and CHMTs are not always kept in the files and are out of date and therefore not reliable in the decision making processes. For example, the file for RHMT Coast region contains only one report for 2006 and one for 2005. The same counts for Tanga and Arusha, no current reports filed and staffs need a lot of time to trace the file.

Similarly, in all RHMTs visited, there were no copies of supervision reports compiled as a result of visits from the MoHSW, despite the fact that many visitors signed the visitor's book in their respective areas. Due to the fact that supervision reports are not always compiled and filed, it is difficult for RHMTs to remember and describe the purpose of each visitor.

One of the major challenges for RHMTs is to solve the problem of low implementation coverage of the supervision schedule due to inadequate budget for the activity. Tanga RHMT reported not having done a single visit for the period of July to December 2007 according to their schedule; instead they accompanied officials from the MoHSW and partner organizations. This could not provide adequate time to implement comprehensive supportive supervision for their priority areas. RHMT for Coast Region and for Arusha indicated that they did more than 80% of the planned supportive supervision, but reports do not match the visits, and therefore not seen to justify output of the work. Furthermore, ad hoc activities and political events such as Uhuru torch (Mwenge) in the Coast region affect the schedule. All RHMTs have at least one vehicle used for supportive supervision. One of the challenges is that, the available vehicle have dual role, which is implementation of administrative duties and supportive supervision. This problem has been raised by all RHMTs and CHMTs.

### ***3.8 Availability of Computer and internet services***

The RHMT in Arusha and Tanga have adequate and functioning computers available including access to internet. The Coast region has only one working computer which is used for general administrative work including data activities, but lack internet access. Maintenance and repair is contracted out to contractors of the RAS and DED.

### **3.9 Community involvement in HIV Care and Treatment**

Every region established HIV/AIDS committees across the districts and village levels. Most members lack adequate knowledge on general issues regarding HIV/AIDS intervention. The operational plans have not incorporated a budget component to include training on this subject.

### **3.10 Modalities of making contracts**

The present partner organizations in the regions already have contracts with either a Memorandum of Understanding or have developed Terms of Reference with RHMTs and CHMTs; but some do not. This experience can be used by PharmAccess in the process of developing agreements.

RAS, RHMT and CHMT had the following recommendations on the subsequent cooperation and agreed to:

- have a contract with PharmAccess to support implementation of HIV/AIDS
- A focal point for assessment of health facilities for Care and Treatment have been already identified following the trainings and on going activities since 2007
- RACCs in the regions visited have been appointed as focal person to oversee operation of the assessment activities for HIV/AIDS Care and Treatment.

ICAP signed Terms of Reference with Coast Region RHMT and also made sub contracts with CHMTs. Tunajali Programme and Action Aid signed a contract direct with recipients of funds and implementers such as community NGOs and CSOs. EGPAF and AIDS Relief signed a Memorandum of Understanding in Tanga and Arusha regions with RAS and DED.

The following common particulars are mentioned in the agreements:

- Signed by the funding agent, RAS/RHMT/DED or any other recipient
- Duration of agreement
- Scope of cooperation or project summary attached
- Clear description of the responsibilities of each part involved: role of the MoHSW (NACP), RAS/DED /DMO/partner organizations such as NGOs and CSOs involved.
- Accountability of parties involved; provision of space, technical support, equipment, transport facilities, number and skills of staff, the issue of planning, follow up visits and reporting requirements on the progress of work.
- A detailed Terms of Reference for the recipient of funding

### **3.11 Assessment to justify implementation of the project**

In this part, before further discussion on analyzing the importance of implementing the project to the regions, it is important first to remember the objectives of the project.

The overall objective of the project is “to contribute to the expansion of good quality HIV/AIDS C&T services to as many HIV+ people as possible in a sustainable manner”. This will consider improvement of Quality Assurance and M&E of the National HIV/AIDS Care and Treatment Plan (NTCP), including assessment of the readiness of health facilities to start providing services. A major objective is that this quality assurance function should be decentralized to regional and district levels.



As a result of the assessment done, this chapter will indicate if implementation of Service Level Agreements with the regions is feasible based on the findings of the study. The following criteria are used to decide the feasibility of the implementation of the project support with the regions: Relevance, Effectiveness, Efficiency, Impact and Sustainability. For clarification of each criterion see the glossary.

### ***Relevance***

The project is viable and relevant due to the following reasons:

The Monitoring and Evaluation Framework and Quality Improvement are important to the MoHSW. It is also a priority of local and international efforts to combat HIV/AIDS.

- The goal of the Tanzania National Care Treatment Plan (NTCP) is focused on strengthening the general health care system and it conducts assessment to measure the readiness of health facilities to start providing services, prepare Health Facilities to provide ARV in a correct manner, monitor their use and analyze the disease progression.
- Partner Organizations such as AIDS Relief, EGPAF, CDC and ICAP have also realized this demand and have joined hands with the MoHSW. The UNAIDS (2000), has given accord to M&E systems, insisting M&E unit to exist, clear goals set and priority indicators identified. Data collection and data dissemination all together have been given due emphasis and consideration by UNAIDS (2000); WHO (2006) on patient monitoring for HIV care and Antiretroviral Therapy (ART).
- Furthermore, a number of gaps have been identified at all levels. The national level has not made a conclusion on relevant indicators to measure the quality on the area of Care and Treatment for HIV/AIDS to be used by the regions and districts including health facilities.
- The regional levels have been requested by the MoHSW to support the Districts to implement the strategies in a correct way and provide them with on the job training through supportive supervision.
- As mentioned in the problems, shortcomings in terms of inadequate capacity on Planning reflected in operational plans that objectives are not SMART; Monitoring and Evaluation, data and quality assurance that they have not been part of priorities of the RHMTs and CHMTs; all together need attention and call for specific intervention. The project proposal and its priority interventions have been focused to address such problems; a justification for the relevance of the project.

### ***Effectiveness***

The project promises to be effective due to the fact that, the target group is known, strategies are set, and staffs at the MoHSW, PharmAccess, Districts and Regions have shown interest to contribute in the achievement of the project objectives.

### ***Efficiency***

The project promises to be efficient due to the reasons raised below: Human capacity at NACP, PharmAccess and specialists at CDC and other partner organizations is in place. It is assumed that the expertise available will assist in making decisions appropriately from designing systems, planning, monitoring and the impact of assessment.

Every Health facility as well as regions and districts have at least one computer for data management, report writing and general administration with an internet service in all RHMTs except for Coast Region. All established CTCs have computer and a budget for maintenance and repair with a trained data person. These are opportunities in supporting implementation of project objectives.

### ***Impact***

The overall goal, as stated at the beginning of this part is expected to be realized after completion of the project in three years. Currently, the plan is already integrated in the project proposal and the Embassy of the Kingdom of Netherlands has commenced provision of funding.

In all regions, Regional Aids Control Coordinators or other RHMT persons have been trained on doing assessment. Recommendations of the study will also influence disbursement of funds to regions and districts for easy accessibility and use. Hence, objectives are expected to be achieved.

### ***Sustainability***

The training plans, especially to strengthen the capacity of RHMTs and CHMTs and relevant executives on the area of assessments and M& E, in the approved proposal aim to establish sustainability. Besides, The United Republic of Tanzania MoHSW(2008) Human Resource for Health Strategic Plan for 2008 – 2013 is guidance for proper planning of human resource with a clear vision of staff development for health objectives. It is assumed that such good initiatives will lead to availability of competent staff at all levels of health care to take over the activities of the project.

Information is presented in table 1 below which was drawn from objectives and strategies from operational plans prepared by RHMTs and CHMTs of the areas visited  
This clarifies as well the need for implementing the project.

**Table 1: Sample of activities drawn from operational plans**

Activity	Source of activity	Targets, assumptions and risks	Remarks
To conduct 5 days training to in charge of Health center and dispensaries on cascade supervision	Comprehensive Council Health Plan (CCHP) 2007/08 – Korogwe CHMT	Supervision coverage raised to 100% With assumption that fund is available; risk not described in CCHP	The activity answers what to be done and for who; but no baseline data to link with 100% increase; and target may be ambitious with difficult to achieve
To purchase additional HIV/AIDS kits	Comprehensive Activity from Council Health Plan (CCHP) 2007/08 – Korogwe CHMT	HIV/AIDS Prevalence rate reduced from 7% to 5% With assumption that fund will be available; risk not clarified	The activity answers what to be done; but no clarity as for who or which facility; The period of baseline/end line not mentioned to know when 5% was and when to meet 7%. If in one year, ambitious target is set to meet
1. Efficient data management system established and operational in RS/RHMT by the end of 2010 2. 13 member of RS/RHMT are skilled in basic computer operation by June 2008	The first is long term Objective and second short term objective from Tanga RHMT Operational Plan for 2007/08	Trained 4 member of staff; assumption is availability of fund  Risk: Untimely receiving of fund	Long term objective aligned with short term objective gives a picture for deciding on targets; but the objectives do not tell the current status of computer literacy as at the site staff were observed using computer
To strengthen smooth running of RMO officer; purchase of stationery; purchase of L/C vehicles	Objective from the RHMT Coast Region operational plan for 2007/08	No targets, assumptions and risk	The objective does not give time frame and do not tell the quantity especially on the number of vehicle to be purchased; no clarity on current status
To improve services and reduce HIV/AIDS infection	Objective from CCHP Mkuranga CHMT for 2007/08	Target set: Reduction of incidence of STI/HIV/AIDS infection from 17% to 15.5% by June 2008. No assumption and risk clarity	The objective and target do not tell the target group, if reduction to certain age group, sex or general population. It is not clear when was 17% met; if in previous year, target may be ambitious and unrealistic
Conduct supportive supervision to seven councils quarterly by June	Activity from RHMT Arusha Operational Plan for 2007/08	Three Regional secretariat and RHMT per diems; No assumption and Risk	The objective tells what to be done, for whom, with time set. No clarity on the current level of achievement
To conduct training for ward multisectoral AIDS committees	Activity from CCHP Karatu District	No target, risk and assumptions	The objective tell the target group, but no time frame; and no baseline information to clarify the current situation of the committees

Analysis on the knowledge of the RHMT and CHMT on planning, monitoring and evaluation informs that the capacity is low, needing attention to cover the gap.

## 4. Conclusions and Recommendations

### 4.1 Conclusions

The first three parts have dealt with assessment of the current situation of the RHMTs and CHMTs and their entire surroundings. The last part puts forward the general conclusions and provides recommendations on the way forward for NACP, MoHSW, PharmAccess, RHMT, CHMT and relevant stakeholders. See conclusions in the following section.

The three regions visited have relevant NGOs ranging from international to local levels such as EGPAF, ICAP and AIDS Relief; CSOs coordinated by RFA and other programmes providing support for AIDS Care and Treatment services.

Through dialogue held, the partners have shown interest to join hands with PharmAccess and relevant partners to work alongside the quality improvement objectives for HIV/AIDS Care and Treatment.

All regions and districts including RHMT and CHMT have practiced signing a contract or any form of agreement with development partners for certain services including HIV/AIDS issues. The experience is an opportunity to develop and make similar agreements with PharmAccess.

Regions and districts have practice with opening additional accounts for development projects with partner organizations. Limiting authorization and approval of payments within health department such as for TB/Leprosy and AIDS accounts have a negative implication toward transparency and internal control practices. However, the study set aside such experience as an opportunity towards improvements for new accounts to be opened.

None of the Regions and districts (RHMTs and CHMTs) have a comprehensive budget to address the problem of HIV/AIDS for data management, supportive supervision and the entire M&E activities. It is through development partners' support where such objectives are executed as supplementary activities or vertical programmes through CTCs.

Plan of operations for RHMTs and CHMTs have been developed and used as a monitoring and evaluation tool. Most of their objectives are not specific, Measurable and not time bound with some difficult to describe whether can be achieved or not. This constitutes a gap in the general knowledge on planning and establishment of M&E systems.

More attention is required for the regional level as the situation is worse for RHMT operational plans when compared to those of the CHMTs. Besides, the RHMT plans are not uniform in their format as compared to the CCHP which have the same format in districts visited.

## **4.2 Recommendations**

Having made the conclusions above, find below a list of recommendations:

### **1. Contractual Agreement**

1.1 A contractual agreement between NACP/PharmAccess and the Regional authorities, should be developed.

1.2 The contractual agreement should include the RAS as part of the detailed Terms of Reference attached

1.3 The specific contract should be signed between NACP/PharmAccess and RHMT/CHMT as advised by RHMTs and CHMTs during the study.

1.4 The contract has to describe the purpose and period of service, total budget amount and payments; delivery of product; inspection or audit; obtaining permits and approvals such as opening any special accounts; reporting and evaluation responsibilities.

1.5 Relevant documents have to be attached with the contract, such as the Programme/project description, work plan, budget, with indicators and targets, as well as terms of reference to describe responsibilities of each party.

### **2. Accounting**

2.1 A special account for the project to be opened, not being a “deposit account” given the delayed payment and the restrictions to partner organizations to access bank balance, bank statements and bank reconciliation, which are important elements to describe and justify expenditure against receipts. See annex 9 for analysis of alternative accounts.

2.2 Special resolution will be required at regional and district levels in accordance to the United Republic of Tanzania (1997)<sup>3</sup> local Authority Financial Memorandum part ix item 177 which allows technical assistance projects to open bank accounts. The memorandum also restricts cheques to be drawn from bank accounts only if they bear not less than two signatures as stated in item ix part 181; one being of the Council Director or Treasurer. It is therefore advisable that one signatory be the RAS/Assistant RAS or the Regional Accountant at regional level; the other will be the RMO, Regional Health Secretary or any reputable member of the RHMT.

2.3 At the district level signatories will include the council Director or the Treasurer; and either the DMO, District Health Secretary or any reputable member of the CHMT. All signatories have to be approved by the relevant Finance Committee. The mentioned above and subsequent steps below are meant to widen transparency in execution of financial transactions and reduce chances of fraudulent practices.

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<sup>3</sup> No bank account shall be opened in the name of the council without specific resolution of the council. This includes accounts with other organizations (eg. For technical assistance projects) and third party charitable deposits eg. Trust funds (URT 1997 financial Memorandum P.39 ; ) No public or official account shall be opened in any bank without the authority of the Treasury (URT 1983; Financial Orders Part II item 6.p.103)

2.4 Whenever it is necessary to use Deposit Accounts and Health Accounts, ensure that the contract has a clause for permission of PharmAccess auditor and management staff to have access to books of accounts, get copies of bank balance and bank reconciliation for every month. Request for approval of work to be processed at least two to four weeks before implementation of work to avoid the effect of delayed payments as experienced in Tanga and Arusha RHMTs.

2.5 The MoHSW Permanent Secretary or the Programme manager of the NACP is advised to write a letter to PMORALG to request approval of the minister for opening additional accounts on behalf of the regions and districts as per URT (2000) local government laws, Principal legislation; revised edition.

2.6 The contract has to state the responsibility of contractors (RHMT and CHMT) to maintain separate books of accounts for easy tracking of transactions. Various items for consideration will be maintaining a cash book for PharmAccess with monthly bank statements, bank reconciliation, vouchers and receipts of payments. Further more, the contract should state that auditors and relevant management staff from PharmAccess will have full and unrestricted access to all system records, property and personnel of the contractor.

### **3. Monitoring and financial control**

3.1 Ensure all essential internal control Mechanisms are instituted. This will be done by ensuring that monthly follow up through visit done to regions by PharmAccess project Auditors to oversee implementation of financial transactions and performance of agreed objectives. During such visits, ensure that, all types of Audit are conducted; these include System based Audit, Value for Money Audit, and Computer Audit. In collaboration with NACP, ensure that Manager's checklist as part of financial control mechanism is developed and used in the process.

3.2 NACP with support of PharmAccess should develop a Manager's Checklist (or SoP) for ensuring good financial control and use it to guide in developing a supportive supervision checklist (see annex 8, example checklist).

3.3 Internal auditors of the RAS and DED to support RHMTs and CHMTs in processing and compiling financial and substantive reports of the project as part of their routine work and send them monthly to MoHSW, PMORALG and PharmAccess.

3.4. Implement awareness workshops on financial management and control mechanisms to RHMT and CHMT including RAS, DED and relevant stakeholders of the project.

3.5. NACP/PharmAccess in collaboration with partner organizations to establish an audit committee or allocate such responsibilities to existing committees to deal with financial matters of partner organizations with RHMTs and CHMTs. Members can be drawn from existing committees such as the Health Board, M&E or Assessment committees of the project and HIV/AIDS committees. Additional technical staff may be sought from relevant sections including accounting, planning and community development; and CSOs and NGOs at local level plus a member of PLWHA.

The committee will be chaired and accountable to the RAS. This will form part of strategies to support the Auditor from PharmAccess and relevant staff to ensure easy tracking of information on an efficient and effective manner.

Responsibilities of the committee will involve reviewing financial statements, review of practice in compliance with policies; review periodically the effectiveness of the system of accounting and internal control. Other duties include the review of effectiveness of internal audit and discussing the scope and timing of the internal audit work; review the external auditors' findings and advise relevant managements on execution of advice raised. The committees have also to oversee performance against targets set on various objectives of the project as described in the operational plans and Terms of reference. This will form part of strategies to support the Auditor from PharmAccess and relevant staff to ensure easy tracking of information on an efficient and effective manner.

#### **4. Capacity development**

4.1 The MoHSW Involve the available NGOs at RAS office such as Tunajali programme in the Coast Region and RFA available in all regions for capacity development on financial management, reporting and other technical support at regional and district levels.

4.2 NACP/PharmAccess to facilitate implementation of capacity development of RHMTs and CHMTs in planning, financial management, and monitoring and evaluation in line with the project objectives.

4.3 The MOHSW is advised to collaborate with NGOs and CSOs and relevant programmes such as Tunajali programme in Coast region to facilitate sensitization of communities and individuals to create more awareness on the HIV/AIDS issues and the importance of accessing Clinics for testing.

4.4 Ensure that, trainings are conducted beyond health sector personnel; to involve members of the Regional AIDS Committee chaired by RAS, and the District committees for better results of multi sector response. Other committees at ward and village levels are equally important.

#### **5. Human resource management**

5.1 Ensure that clarity of job descriptions for people dealing with HIV/AIDS Care and Treatment and relevant activities within the Health and out side the health sector is made. This will complement the audit process regarding input – output - assessment components.

5.2 Recognize and draw some lessons from the proposed public sector mechanism to allocate and evaluate performance of staff through open performance appraisal system (OPRAS) where allocation of responsibilities is based in supervisor supervisee dialogue and availability of resources agreed.

5.3 Provide an incentive structure in line with extra duties related to PharmAccess activities.

5.4 Use reporting systems approved by the government of Tanzania with any extra information drawn from other partner organizations which are already in use like that of Axios for financial and activity reporting. See annex 2.

5.5 Establish a competition award to recognize good performance on assessment issues, M&E and general quality assurance components. Among other strategies, assess quality of operational plans by looking how objectives are SMART, how M&E responsibilities are clarified for individuals at different levels, and generally see at their implementation and how impact is assessed at the field level.

5.6 The MoHSW and PMORALG to facilitate execution of the newly endorsed and signed regional secretariat organization structure, herewith facilitating the regions to ensure timely dissemination of information, appointments and approval of relevant staff



**Annex 1: RHMT Capacity Development Assessment – Comparison of regions**

Capacity item	Capacity Check point	RHMT Coast	RHMT Tanga	RHMT Arusha
Planning	Availability of annual Health plan with SMART objectives and indicators which can accurately express the intended meaning	<p>The annual health plan for 2007/08 is available. Objectives have no time frame and cannot be easily measured; Indicators and targets also are not clear and means of verification or source of information is not stated; e.g.: To conduct annual RHMT/CHMT meetings to discuss implementation of CCHP and rehabilitation of Health facilities</p> <p>Sources of funding include:</p> <p>Government of Tanzania, Donor/basket fund, Health Sector support Programme (HSPS) MoHSW, TB and Leprosy Organizations such as ICAP, Delmundo, PharmAccess and many others</p>	<p>The annual health plan for 2007/08 is available with clear targets and indicators. Besides, a well descriptive SWOT analysis done to support setting priorities; unlike the other two RHMT who do not have similar analysis. However, some of the targets are not achievable due to inadequate budget. e.g.</p> <p>Supportive supervision frequency increased from two to four times in a year. Execution in the two previous quarters is zero; and supervision done in the period was meant to accompany other teams from the MoHSW or partners from the central level</p> <p>Funding is through:</p> <p>Government/ Block grant, donor through vertical programmes such as TB/L project, HIV/AIDS and EPI, GTZ; NGO such as AIDS Relief and basket fund</p>	<p>The annual health plan for 2007/08 is available.</p> <p>Activities have clear targets and time frame; e.g.: conduct supportive supervision to 7 councils quarterly by June2008.</p> <p>However, some activities are not specific and timing is not clearly stated; e.g.: To conduct RHMT/CHMT peer – semi annual review meetings.</p> <p>Sources of funding:</p> <p>Government through Block grant, PMORALG (Basket and Joint rehabilitation supervision fund), NTLP, Acquire project</p>
	Partnerships and collaborations with donor partners	Partner organizations are not involved in the planning sessions; and their budgets are not timely received resulting extra and supplementary work plans	Partner organizations are not involved in the planning sessions; and their budgets are not timely received resulting extra and supplementary work plans	Partner organizations are not involved in the planning sessions; and their budgets are not timely received resulting extra and supplementary work plans
	Availability of M&E plan and budgets	Inadequate budget to implement supervision and data management activities and relevant M&E objectives;	Inadequate budget to implement supervision and data management activities and relevant M&E objectives.	Support from partner organizations - AIDS Relief provided technical assistance through funding; staff like data manager, doctors, Nurses; equipment such as computers and many others to supplement the RHMT efforts
Impleme	Financial	ICAP with RHMT developed and signed	AIDS Relief with RHMT signed a Memorandum	EGPAF developed and signed

ntation process	management	<p>terms of reference to reflect roles of each partner and budget ceiling. Special account opened with all signatories and payment approval from the health department.</p> <p>RMO/AIDS and TB Accounts get approval of payments and cheque endorsed in the health sector</p>	<p>of understanding to reflect roles of each partner and budget ceiling. Special account opened with all signatories and payment approval from the health department.</p> <p>RMO/AIDS and TB Accounts get approval of payments and cheque endorsed in the health sector</p>	<p>Memorandum of understanding to reflect roles of each partner and budget ceiling. Special account opened with all signatories and payment approval from the health department.</p> <p>RMO/AIDS and TB Accounts get approval of payments and cheque endorsed in the health sector</p>
		<p>Deposit account with all approval of payments and signatories involving RAS, RMO and Accountants of the sub treasury.</p> <p>This is used for government money and was rarely used by donor funds such as DANIDA through MoHSW HSPS unit</p>	<p>Deposit account with all approval of payments and signatories involving RAS, RMO and Accountants of the sub treasury.</p> <p>This is used for government money and was rarely used by donor funds such as DANIDA through MoHSW HSPS unit</p>	<p>Deposit account with all approval of payments and signatories involving RAS, RMO and Accountants of the sub treasury.</p> <p>This is used for government money and was rarely used by donor funds such as DANIDA through MoHSW HSPS unit</p>
	Capacity to open and manage different accounts	<p>RHMT has opened different accounts and expenditure and balances are maintained through books of accounts; reports sent quarterly to RAS, MoHSW, PMORALG and relevant partners.</p> <p>In 2007, there was no internal auditor; and audit was not done.</p> <p>External audit done once in a previous year.</p>	<p>RHMT has opened different accounts and expenditure and balances are maintained through books of accounts; reports sent quarterly to RAS, MoHSW, PMORALG and relevant partners.</p> <p>There is an internal auditor and audit was done twice in 2007, but reports are hardly accessible to every RHMT member</p> <p>External audit done once in a previous year</p>	<p>RHMT has opened accounts; expenditure and balances are maintained through books of accounts; reports sent quarterly to RAS, MoHSW, PMORALG and relevant partners. There is an internal auditor but audit has no specific schedule causing difficulty to track reports of the previous year; and members of RHMT are not adequately informed on the audit reports except the accountant and a Health secretary.</p> <p>Thorough external audit done in December 2004; and this February 2007</p>
	Availability and use of computer	<p>5 computers are available; three of them are not working except two for the RMO secretary and the RTLK used for general administration and data management respectively.</p> <p>Maintenance and repair is contracted out; the budget is inadequate for</p>	<p>7 computers available and have internet at RMO and RHS and MO i/c offices.</p> <p>Maintenance and repair is done by the hospital and the RAS IT specialists. For major repair the task is contracted out. The systems are used for data management and general administration.</p>	<p>6 computers available and have internet service at RMO and RHS offices.</p> <p>Maintenance and repair is contracted out and have budget.</p>

		<p>matching with current demand. No internet services.</p> <p>The RAS accounting unit has computers using Epicor software to develop reports of all sectors using sub treasury accounts including deposit account.</p>	<p>Like in Pwani, the RAS accounting unit has computers using Epicor software to develop reports of all sectors using sub treasury accounts including deposit account.</p>	<p>Like in Coast and Tanga the RAS accounting unit has computers using Epicor software to develop reports of all sectors using sub treasury accounts including deposit account.</p>
	Supportive supervision	<p>Coverage of supervision schedule is 100% according to RHMT response. Contrary; One report for one visit of the year 2006, and one for 2005 are available in the file. This indicates that reports are not maintained up to date with inadequate feedback to the field.</p>	<p>Supervision schedule was not implemented as planned. Visits done were mostly ad hoc for joining teams from the MoHSW and relevant programs. It is difficult to inform how many visits were implemented and reports are hardly seen and inaccessible. The problem is linked to inadequate budget.</p>	<p>The average of 6 routes done per month in 2007; reports are available and shared to all RHMT members. Inadequate feedback is given to the field due to inadequate budget and lack of stationeries</p>
	Availability of transport facilities	<p>The RHMT have two cars; one for supervision and general administration; and the other for TB/L with little support to AIDS activities</p>	<p>RHMT has 3 cars for supportive supervision; but only one is well maintained and functioning</p>	<p>RHMT has four cars; one is allocated for general supervision. The other three are used for AFP surveillance, Reproductive and TB/L projects only</p>
RHMT members and other Human Resources for Health (HRH)	Technical competence and number required	<p>The number of RHMT members match with the guidelines and demand. The RMO and other RHMT members have long experience and relevant professional qualifications; except the Health secretary who is absent for further studies.</p> <p>Inadequate skills on planning, monitoring and evaluation; including data management and use were noticed through reading documents including work plans; supervision and periodic reports.</p>	<p>The number of RHMT members match with the guidelines and demand. The RMO and other RHMT members have long experience and relevant professional qualifications</p> <p>Inadequate skills on planning, monitoring and evaluation; including data management and use were noticed through reading documents including work plans; supervision and periodic reports.</p>	<p>As for Coast and Tanga; the number of RHMT members match with the guidelines and demand. The RMO and other RHMT members have long experience and relevant professional qualifications</p> <p>Inadequate skills on planning, monitoring and evaluation; including data management and use were noticed through reading documents including work plans; supervision and periodic reports.</p>







**Annex 3: Summary of Findings and Recommendations (SWOT analysis –Tanga region)**

Findings					
Area	Strength	Weaknesses	Opportunity	Threats	Recommendations
Availability and use of guidelines for HIV/AIDS Care and Treatment	Recommended guidelines by MoHSW on HIV/AIDS are available and kept at an open shelf and accessible	Most complained on Inadequate orientation to have common understanding on using the guidelines	Technical support by Development partners who have employed staff working at CTC supported by AIDS Relief; Others are GTZ with financial and technical support on general Management of health care	High demand of the guidelines by every unit, but low supply	Advise the MoHSW to produce adequate number of copies to match the demand
Availability of Annual Health Plan with Budget integrating M&E Plan and Budget	The operational plan is available with supervision budget as part of M&E; plan is supported with strong situation analysis through SWOT	Inadequate budget according to need; M&E activities are not given priority and not covered; some objectives are not SMART with ambitious targets	Development partners such as AIDS Relief and GTZ provide technical and financial assistance; RFA facilitates coordination of CSO and NGOs at local level; and working with community volunteers	Inadequate mechanism to accredit local CSOs and NGOs to know their level of performance.	Improve the budget allocation from Block grant, basket funding and other sources to the RHMT;  Conduct more trainings to RHMT and relevant staff on planning, budgeting and on developing M&E system
RHMT/CHMT members and other HRH	All RHMT members and relevant staff have the basic qualification as per MoHSW guidelines.	RHMT have in adequate skills on Planning, budgeting, monitoring and evaluation as reflected in their operational plan	Availability of MoHSW Strategic plan to support regions and other levels for Capacity development and recruitment of new staff, and other priorities; also visitors from MoHSW and development partners share knowledge and practice	AIDS, Malaria and other diseases killing the labour force, and some staff shift to other employers; de-motivated staff	Implement training through workshop and relevant on job training mechanisms; and give wide chance for joint supportive supervision with development partners and RCHMT for exchange of knowledge
Involvement of technical staff out of health sector and other stakeholders in planning, monitoring and evaluation	Planning for the government is participatory	Most of the development partners except GTZ do not offer such information timely causing extra plan; some partners like World vision do not at all offer information on their budget	People from the planning department and accounting unit such as community development and planning specialist; and Accountant;  GTZ management expert	Existence of other health problems such as malaria and water bourn diseases such as cholera pulls the fund from HIV/AIDS priorities. Other sectors than health pull resources	RHMT and RAS to be advised to provide early the planning schedule to development partners and invite them by letter one month before planning period

IT/Computer and internet systems	7 computer with internet system available and working	Maintenance and repair is donor dependent	GTZ and AIDS Relief have budget for the activity	IT in the RAS is working for other sectors than health and not timely available when needed	Other source of funding such as Block grant to be used for purchase, maintenance and repair for sustainability
Supportive supervision	A schedule for supportive distribution is integrated in the operational plan	Zero coverage of the schedule in the two previous quarter except through accompanying visitors from MoHSW and other development partners due to inadequate budget	Many visitors from the MoHSW and development partners for supportive supervision	Ad hoc activities interrupt smooth functioning of the RHMT to meet their schedule.  The available vehicle are used for other administrative works	Support the RHMT to adequate budget for supportive supervision
Maintenance of transport facilities, Computer and relevant equipment	The budget is allocated for maintenance and repair and integrated in the operational plan	The budget is donor dependent	Development partners support and availability of contractors/ technician at local level	New technologies on computer and other equipment need up dated knowledge which is not easy to cope all time	Strengthen maintenance unit in the health sector to implement day to day maintenance; and allocate more budget from local sources such as block grant
Management of Finance for Health	The Health sector have experienced opening and managing fund by making approval of work in the sector, and maintaining books of accounting from government and development partners fund;  Financial reports including audit reports are sent quarterly to MoHSW,  PMORALG and relevant donor	Some approval of work and payments especially for TB/L and AIDS accounts end in the health sector with inadequate transparency and low internal control;  Internal and external auditors are available at RAS but do not work closely with RHMT to rectify mistakes	RFA have expertise and ready to offer training on budgeting and general management of public fund,  GTZ and AIDS Relief can do the same.  Supportive supervision from MoHSW offer part of on job training	Not all reports of supportive supervision are shared for further improvement;  Bank balance and Reconciliation can not be accessed by any other party except staff from sub treasury for deposit accounts.  Competing reporting format by different funding agencies	Improve auditors visit in the health sector to facilitated understanding and rectify mistakes;  Harmonize reporting format to cope with government requirements and reporting format



#### Annex 4: Summary of Findings and Recommendations (SWOT analysis – Arusha region)

Findings					
Area	Strength	Weaknesses	Opportunity	Threats	Recommendations
Availability and use of guidelines for HIV/AIDS Care and Treatment	Guidelines are available and used	Some guidelines are less in number according to requirements	CEDHA provides some guidelines whenever it has in excess and facilitate their interpretation	Cost of producing copies are high for the RHMT to reproduce	The MoHSW to provide enough copies according to need
Availability of Annual Health Plan with Budget integrating M&E Plan and Budget	Plan is available with M&E activities	The budget ceiling is not enough to cover all identified priorities	Regional Hospital and the municipal budgets supplement the RHMT	Competing demand by other sectors and professions pool the resources	Improve the budget ceiling from PMORALG, MoHSW and partners
RHMT members and other HRH	RHMT members are adequately trained and available according to staffing levels and relevant guidelines	Low working morale due to inadequate resources to implement their activities. specific skills on M&E are lacking	Availability of training institutions such as CEDHA, Arusha university, Mount Meru university supplement HRH	Change of policy from HSPS as the main funding agency to basket	Special allowance as a top up, and equipment such as photocopiers, scanner, etc be provided
Involvement of technical staff out of health sector and other stakeholders in planning, monitoring and evaluation	Regional secretariat technical advisors are involved in planning processes	Most of the partners do not offer such information timely causing extra plan; some partners like World vision do not at all offer information on their budget	People from the planning department and accounting unit such as community development and planning specialist; and Accountant; Are involved	Existence of other health problems such as malaria and water bourn diseases such as cholera pulls the fund from HIV/AIDS priorities. Other sectors than health pull resources	RHMT and RAS to be advised to provide early the planning schedule to development partners and invite them by letter one month before planning period
IT/Computer and internet systems	<i>6 computer and have internet at RMO and RHS offices Maintenance and repair is contracted out and have budget</i>	Donor Dependence on computer maintenance, No computer audit done	Availability of contractors for maintenance and repair in the local city	The budget is inadequate to cover the M&E activities and data is hardly covered. No specific agency to fund HIV/AIDS activities	Sensitize the RAS to identify more sources of funding to increase budget
Supportive	The average of 6 visits		Supervision done by MoHSW	Funds are pooled by other	Ensure report are available, compiled

supervision	done to different districts and health facilities per month	Reports do not describe the number of visit planned to establish percent of achievement; and not well filed, and no feedback to areas visited	and partner organizations supplement to un met visit	departments affecting securing adequate money according to need	and filed and accessible to all stakeholders; improve feedback mechanisms to areas visited
Maintenance of transport facilities, Computer and relevant equipment	The budget is allocated for maintenance and repair and integrated in the operational plan	The budget is donor dependent	Development partners support and availability of contractors/ technician at local level	New technologies on computer and other equipment need up dated knowledge which is not easy to cope all time	Strengthen maintenance unit in the health sector to implement day to day maintenance; and allocate more budget from local sources such as block grant
Management of Finance for Health	The internal auditor from the RAS office and MoHSW provide supportive supervision	Inadequate stationeries and software to produce copies of reports to relevant staff and stakeholders	Availability of institutions at local level for trainings	Due to heavy workload by auditors, most of the audit are paper based, and visit are not routinely done- Last external audit done December 2004, next done February 2008	Improve internal audit mechanisms

**Annex 5: Contact list for Coast region, Tanga and Arusha for EKN project**

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**Annex 6: Sample contract to be made**

CONTRACT AGREEMENT

BETWEEN

PHARMACCESS AND ARUSHA REGIONAL ADMINISTRATIVE SECRETARY

FOR FOLLOW COOPERATION OF THE PROJECT ON SUPPORT TO THE

NATIONAL HIV/AIDS CARE AND TREATMENT PLAN OF TANZANIA PHASE III

Date:

SERVICE AGREEMENT

This Agreement made and entered into this day of \_\_\_\_ Month of \_\_\_\_\_ 2008 by and between: PharmAccess Foundation, duly represented by its country Director M/S\_\_\_\_\_ (hereinafter referred to as “PharmAccess”) of one part, and M/S\_\_\_\_\_ Regional Administrative Secretary \_\_\_\_\_ (hereinafter referred to as “the contractor”) of the other part.

WITNESSETH:

WHEREAS, PharmAccess is desirous that a consulting service for the support of the regions and districts health care management to undertake the decentralized role of the HIV/AIDS care and treatment in Arusha (for example) (hereinafter referred to as the service will be rendered by the contractor;

WHEREAS, the contractor is willing to render the service to PharmAccess in accordance with the terms and conditions contained hereinafter;

Now, THEREFORE, in consideration of covenants and agreements herein contained, there parties hereto hereby agree as follows:

Article 1: DEFINITIONS

1.1 In this Agreement, the following terms have the following meaning, except where the context otherwise defines:

1. “Terms of Reference” – the document of its title annexed to and shall constitute an integral part of this Agreement. The terms of Reference give the detailed terms of rendering the service.
2. “Product” – means the reports, work products, software, or any other documents specified in the terms of Reference, which the contractor shall produce in the course of or as a result of the service.
3. “Inspection personnel” – means the personnel designated by PharmAccess to carry out an inspection
4. “Force Majeure” – means any Act of God, Strikes, lockouts or industrial disturbances, acts of the public enemy, wars, blockades, earthquakes, storm, lightning, floods, washouts, civil disturbances, explosions, and other similar events beyond the control of either part and which by the exercise of due diligence neither of the parties is due to overcome.

1.2 In this Agreement, unless the context requires otherwise, the singular includes the plural and vice versa

#### Article 2: SERVICE

The contractor shall render the service in accordance and subject to the terms and conditions hereinafter set forth, or where not specified hereinafter, in accordance with such instructions, and orders as PharmAccess may from time to time give. It is expressly agreed that the contractor is acting as an independent contractor in performing the service hereunder.

#### Article 3: COMMENCEMENT AND COMPLETION OF SERVICE

The contractor shall commence the service on the \_\_\_\_\_ of \_\_\_\_\_ 2008 and complete it on the \_\_\_\_\_ of \_\_\_\_\_ 20\_\_\_\_\_.

#### Article 4: INSPECTION AND DELIVERY OF THE PRODUCT

PharmAccess or the inspection personnel will inspect the product to confirm whether it conforms to the Terms of reference herein set forth. PharmAccess will notify the contractor on the result within 14 working days after PharmAccess receives the product.

If the contractor is requested to revise or correct the product as a result of the aforementioned inspection, the contractor shall make the revision or correction without delay at its expenses, to the satisfaction of PharmAccess. The contractor shall notify PharmAccess in writing of completion of the revision or correction and present the revised or corrected product for re-inspection. In such case, PharmAccess will notify the contractor of the result of the re-inspection within five (5) working days after PharmAccess receives the revised or corrected product.

#### Article 5: CONTRACT AMOUNT

5:1 the contract amount for the service shall be Tsh. \_\_\_\_\_ in the figure  
Of

5:2 No extra payments with respect to overtime, holiday work, additional equipment, Materials and facilities, or special conditions of hardship shall be claimed by the contractor beyond the contract amount.

#### Article 6: PAYMENT

The payment for the service shall be made by PharmAccess to the contractor in the following manners:

(1) The Regional Administrative secretary shall be responsible for security and accounting of the contract money.

(2) The Regional Administrative Secretary will request and open a special Account for the RMO for the project assistance and notify PharmAccess of the bank account to which this contract money will be transferred and signatory of the account by submitting a letter before the payment shall be made.

(3) The payments shall be made quarterly/six months commencing the day of \_\_\_\_\_ Month of \_\_\_\_\_ 2008 and subsequently on receiving the progress report of the former quarter/ six months period.

(4) The quarterly payment shall be paid in accordance with the figure showed in the APPENDIX x.

(5) The payments shall be made in the mutually acceptable form of bank cheque.

#### Article 7: OBTAINING PERMITS AND APPROVALS

The Contractor shall obtain all necessary permits and approvals from the Government Of Tanzania and other competent authorities required for executing the service, and if necessary shall acquire all the necessary rights and privileges for access of the Worksites for the purpose of executing the service.

#### Article 8: PRESERVATION OF PEACE

The contractor shall take all reasonable precautions for preventing any unlawful, riotous or disorderly conduct in order to preserve the peace and protect persons and property on the worksite and the area adjacent thereto.

#### Article 9: INCOME TAX AND OTHER TAXES AND DUTIES

The contractor shall hereunder be liable for any and all taxes including income tax, duties, and contributions and other taxes and charges which may be levied on the contractor in accordance with the laws and regulations of Tanzania.

#### Article 10: RISK OF LOSS

The contractor shall bear all the risks involved in rendering the service, and shall at its own expense effect accident and injury insurance for the contractor for the rendering of the service. The contractor shall at its expense insure the equipment, materials and facilities to be provided by the contractor and keep each part thereof insured for its full value against loss, damage or fire. The contractor shall indemnify and hold PharmAccess harmless from and against any and all claims and disputes which may arise in connection with the compensation of such accident, injury, loss, damages, and/ or fire.

#### Article 11: WARRANTY

The contractor guarantees that the service shall conform to the terms and conditions of this agreement. In the event that the service fails to conform to the terms and conditions of this Agreement, the contractor shall incur the pertaining liability and shall remedy the situation at the contractors' expense as soon as possible to the satisfaction of PharmAccess in accordance with the terms and conditions of this Agreement. PharmAccess shall not, however, refuse to accept the completed conditions of the service without reasonable justification and shall make its best effort to inform the contractor of its reasons for not accepting the completed conditions of the service.

#### Article 12: INTELLETUAL PROPERTY RIGHTS

The ownership of all copyrights and other intellectual property rights with respect to any data compilation, reports, designs, work products, software, or any other documents developed in connection with this Agreement are the copyright of PharmAccess unless otherwise expressly agreed by the parties hereto.

#### Article 13: LIQUIDATED DAMAGES FOR BREACH OF CONTRACT

13.1 If the contractor should commit any breach of this Agreement, PharmAccess shall give written notes of the breach to the contractor. The contractor shall make every reasonable effort

to correct the breach upon receipt of such a notice from PharmAccess. Failure to do so may result in termination of the Agreement as set forth in Article 14.

13.2 If the breach is not corrected within a reasonable period of time, the contractor shall pay PharmAccess liquidated damages for each breach of contract of the amount equivalent to 30 percent of the contract amount. Payment of the liquidated damages shall be made by the contractor to PharmAccess within 30 days after receipt of the notice

#### Article 14: TERM AND TERMINATION OF CONTRACT

14.1 This Agreement shall come into force on the date above, and unless earlier terminated, shall remain in force until the completion date as set forth in Article 3. Both PharmAccess and the contractor shall retain the right to terminate this Agreement at any time upon giving written notes to the other party at least 30 days prior to the intended termination date.

14.2 PharmAccess has the right to terminate this Agreement by giving a written notice to the contractor, if any of the following is applicable:

1. If PharmAccess judges that the service or product cannot be completed due to causes attributable to the contractor within the time set forth in Article 3.
2. If the contractor fails to complete the service or product in accordance to the Agreement and the Terms of Reference and there are no justifiable reasons for such failure, which shall be decided by PharmAccess by its sole discretion.
3. If the contractor does not commence the service or if it suspends the service after the effective date of the agreement for a certain period without justifiable reasons, which shall be decided by PharmAccess in its sole discretion.
4. If the contractor violates any provision of this Agreement and does not rectify it within 10 days after the contractor has received the notice of the breach from PharmAccess.
5. If the contractor becomes insolvent or any proceedings are instituted by or against the contractor seeking to declare it bankrupt, liquidation or insolvent.
6. If the contractor takes any action to injure PharmAccess's credit or to influence the trust between PharmAccess and the contractor.

14.3 Termination of this Agreement shall not in any way terminate, limit or restrict the right and remedies of party hereto against the other part which has breached or failed to perform any of the representations, warranties, covenants, or Agreements of this Agreement prior to termination thereof.

#### Article 15: SET-OFF

If the contractor defaults with respect to this Agreement with PharmAccess including, but not limited to, the contractor's failure to perform its obligations under this Agreement, then PharmAccess may, in its sole discretion, set-off any payments due and owing PharmAccess against such payments due and owing the contractor pursuant to this Agreement, and/or terminate this Agreement.

#### Article 16: FORCE MAJEURE

16.1 If either part is temporarily un able by reason of Force Majeure, or the laws or regulations of Tanzania, to perform any of its obligations under this Agreement, and if either part notifies the other party in writing the details of the event within 14 days after its occurrence, such obligations of the party shall be suspended as long as the inability continues.

16.2 Neither party will be liable to the other party for losses or damages sustained by the other party if the loss or damage arises from any event of Force Majeure.



## Article 17: ASSIGNMENT

The contractor shall not assign this Agreement or its rights under this Agreement, nor delegate its obligation under this Agreement without PharmAccess prior written consent, which consent shall not be unreasonably withheld.

As part of facilitating efficiency in executing the Agreement, the delegation consent below have to be made.

The Regional administrative Secretary has to open a special account for the project as stated in Article 6 part 2 of this Agreement to be under its administration and delegate their management accountability to the head of the health department (RMO).

With the above suggested delegation, approval of work has to be done within the Health department to facilitate efficiency so as to shorten time of effecting payment.

For the cheque to be drawn from the bank, it should bear two signatures, one being of the RAS/Assistant RAS or the Regional Accountant at regional level; the second to be of the RMO, Regional Health secretary or any reputable member of the RHMT.

The RAS has to ensure approval of all signatories by relevant Finance committee.

In the event of such assignment or delegation, the assigning or delegating party shall remain liable to the other party and shall not be relieved of any obligation under this Agreement

## Article 18: NOTICE

18.1 English shall be used in all written communications between PharmAccess and the contractor

18.2 Any notice given to the contractor shall be served by sending the same by fax or delivering the same to the contractor's principal place of business as stated herein. Any notice given to PharmAccess shall be served by sending the same by fax or to the same at PharmAccess's address as stated herein.

### (1) Country Director

PharmAccess Foundation Tanzania Office  
Skyways Building 3<sup>rd</sup> floor  
Ohio Street/Sokoine Drive  
Dar es Salaam  
P.O Box 635  
Dar es Salaam  
Tel. +255 222124888  
Fax. +255 222124889

### (2) Contractor Address

If either PharmAccess or Contractor changes its address at which notes to be received, the other party shall be notified of such change without delay.

## Article 19: ENTIRE AGREEMENT

This Agreement constitutes the entire and only Agreement between the parties hereto with respect to the subject matter hereof, and supersedes, cancels and annuls all prior or contemporaneous negotiations or communications.

## Article 20: VARIATIONS

The contractor shall not alter any part of its execution of the service except as directed in writing by PharmAccess. PharmAccess shall have full power, from time to time during the term of agreement; to direct the contractor to alter, omit, add to or otherwise vary any of the services by written notes, and the contractor shall carry out such variations.

If an alteration in the conditions of the service is ordered by PharmAccess, such alterations shall not constitute any grounds for claims of damage or loss of anticipated profits for the service. All extra and additional work shall be performed in accordance with the terms of this Agreement and with the same materials and workmanship as employed for the service of similar character in the Agreement, as far as they are applicable thereto. If the costs for such extra and additional work exceed the contract amount, PharmAccess and the contractor will consult each other to decide how such costs and expenses shall be shared between them.

#### Article 21: AMENDMENT AND MODIFICATION

Any amendment and modification of this Agreement, other than the variation set forth in Article 20, may be negotiated between the parties hereto and shall be agreed to by a written document signed by both parties hereto.

#### Article 22. SECRECY

During the term of this Agreement and thereafter the contractor shall not disclose or divulge any information it may acquire in connection with the service, this Agreement or performance hereunder.

#### Article 23: SEVERABILITY

If any provision of this Agreement is held to be unenforceable, invalid or illegal by any court of competent jurisdiction, such unenforceable, invalid or illegal provisions shall not affect the remainder of this agreement.

#### Article 24: GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted under the laws of Tanzania.

#### Article 25: JURISDICTION

The parties hereto agree that all the lawsuits hereunder shall be exclusively brought in the District court of the contractors' region.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be signed by their duly authorized representatives in duplicate as of the day and year first above written, each part retaining one (1) copy thereof, respectively.

Terms of reference, Project description summary and budget are attached.

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Jan van den Hombergh  
Country Director  
PharmAccess Foundation  
Tanzania

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M/S  
Regional administrative secretary  
Arusha

**Annex 7: Reporting format of Axios foundation in Arusha**

Axios Foundation Tanzania financial reporting format

Quarterly Financial Report: CARE VCT Programme

Period: April 2005 to June 2005 Project Number: \_\_\_\_\_

Partner: Mount Meru Hospital Project Title: CARE-VCT Regional Hospitals

SECTION A:

CASH FLOW:

Balance brought forward	Local Currency
Grants Disbursed this Period	_____
Less: Expenses for period	_____
Balance at end of Period	_____

SECTION B:

Classification of expenses by budget line item in local currency

Activity number \_\_Activity PA- Annual Budget - Cash transferred/Balance -Expenses -  
from previous period - Expenses for the current period - Accumulative expenses -Total

Available budget

Bank reconciliation as at 30 June 2005

Balance as per Bank statement as at 30 June 2005

Less: Payment made but cheques not presented to the bank

Less Payment for e.g. purchase of TV set

## ***Annex 8: Sample Manager's checklist to ensure good financial control***

### ***Controlling Receipts***

- Issue pre-numbered receipts for all cash received.
- Keep all cancelled receipts.
- Keep control over all receipt books that are bought and used.
- Bank all money promptly and intact. (Don't use any money received by the organization from different sources before the entire sum received has been deposited in the bank).
- Perform monthly bank reconciliations.
- Use a register to record cheques received.
- Do not cash personal cheques from petty cash.
- Lock up all unused receipts books.
- Use a register to record all pledges and donations to the organization.

### ***Controlling Assets***

- Maintain a fixed assets register.
- Maintain up-to-date maintenance and inspection records.
- Provide permanent identification marks on all equipment.
- Protect against loss or theft with appropriate security and insurance.
- Keep usage records (log books, work tickets).
- Monitor advances and get them reimbursed within a short period of time.
- Invest cash reserves to generate the most income possible.
- Monitor Accounts receivable to ensure that cash is received on time, and institute special procedures for overdue amounts.

### ***Controlling Expenditures***

- Obtain written bids or quotes for the costs of all purchases and file them with the purchase order.
- Use a local purchase order for all local purchases.
- Check that goods and services which have been reported as delivered have actually been received.
- Check that the quality, quantity, and price of the good or services received corresponds to what was purchased.
- Make all payments by cheque.
- Require supporting documentation for all purchases.
- Make sure that all expenditures are genuine, reasonable, and for the benefit of the project.
- Monitor your budget against expenditures.
- Review all expenditure. Ask, "Why are we spending this money on this item?"
- Check that funds are available.

### ***Controlling Liabilities***

- Keep Accounts payables to a minimum.
- Maintain control of suppliers invoices; know what supplies you have paid for and when they will be delivered

## Annex 9: Assessment of Alternative Accounts for EKN project with RHMT

Assessment check point	Type of account			Remarks
	Deposit	RMO/HIV/TB	Project Accounts by AIDS Relief, EGPAF and ICAP	
Opening of Bank Account	Approved by Treasury and operated by Accounting officers (RAS) in the regions for all departments	Supposed to be approved by Treasury, but most were not; and are operated by RMOs	Recommended by regional finance committees and approved by Treasury; operated by RAS/RMOs	NACP/ PharmAccess to open project account with an approval of Treasury for RAS/RHMT
Appointment of internal Auditor and accountability	Appointed by Management of Treasury and reports to the RAS	Not well stated	Appointed by and reports to management of partner organizations	NACP/ PharmAccess to identify project internal auditor
Appointment of External Auditor and accountability	Appointed by Secretary of state and reports to the Paymaster-General/ Controller and Auditor General	Appointed by and reports to management of partner organizations or DPs	Appointed by and reports to management of partner organizations	NACP/ PharmAccess to identify external auditor for the project
Internal control obligations	RAS internal auditor reviews operations of internal control systems on compliance with public financial regulations	No clarity of responsibility at regional level; except for TB/L project who allocates an auditor from national level	Project auditors make monthly visit to review operations of control systems on compliance with financial regulations	NACP/ PharmAccess to make monthly visit for audit purpose
Approval of Payments	Approved by RAS and cheques endorsed by Sub Treasury accountant and RAS accountant	Payments approved by RMO and cheques endorsed by RMO and Health secretary or RHMT member	Payments approved by RMO and cheques endorsed by RMO and Health secretary or RHMT member	RAS to delegate approval of payments to RMO, cheques endorsed by RAS/appointee and RMO/HS
Timeliness of effecting payment	About 3 days in Coast and 2 to 4 weeks for Arusha and Tanga	1 to 2 days in all regions visited	1 to 2 days in all regions visited	Speed for Deposit account depends with behavior of sub treasury accountants/RAS
Guidance and scope of work	Determined by government financial orders; work determined by RAS and management	Determined by RHMT/ government standards and partner organizations	Determined by government financial orders and partner organizations	NACP/ PharmAccess to use government financial standards; and to determine work for audit

**Annex 10. Table 1: Summary of data gathering methods**

Places of getting information	Type of data collected	Means to search information	Number of documents found
MoHSW central office	HRH guidelines and strategic plan and financial arrangements	Interview with HRH and Finance officials,	2 were found out of 2 requested; Staffing levels guide and HRH strategic plan; 2 Admin. and 1 finance official consulted
PMORALG – Dar es Salaam	Organization Structure	Given by official	1 approved functions and regions' Organization structure
NACP central office	Guidelines and reports on M&E plans for HIV/AIDS C&T	Provided by M&E focal person	12 periodical reports of 2007, 8 guidelines and 1 National M&E of ART services PowerPoint for M&E team and supervisors; and proposed HIV/AIDS patient C&T indicators action plan
PharmAccess Dar es Salaam	Implementation status report, and project proposal on the requested cooperation on M&E and Quality Assurance	Interview with relevant staff, reports and project proposal	1 project proposal received, and 1 report on the level of implementation on assessment and M&E
RHMT and CHMT offices	Periodical reports, operational plans, and visitors books	Interviewed staff; reports and operational plans	3 for RHMT and 6 for CHMT operational plans were found; several supervision and periodical reports were found for 2002 to 2007
RAS and DED offices	Courtesy call and requested on possibilities for cooperation	Interviewed on contractual and financial arrangements	3 RAS and 3 Accountants from the 3 regions; 2 staff of sub Treasury in Tanga and Arusha; and auditors consulted
International source	Guidelines on M&E, Patient Monitoring for ART; guide to indicators for M&E ARV Programs	Collected from the Consultant home library; requested and received from WHO Geneva	5 Guidelines provided and 2 were purposively used for the study
Partner organizations	Mandate and clarity on agreement made	Interviewed staff	At least 1 staff in every region was interviewed for partner organizations; ICAP, EGPAF, AIDS Relief, RFA and Tunajali

Source: Consultant (2008)

## **Annex 11: Glossary**

### ***Audit***

An independent, objective assurance activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to assess and improve the effectiveness of risk management, control and governance processes.

There is a distinction between regularity (financial) auditing, which focuses on compliance with the applicable statute and regulations; and performance auditing which is concerned with relevance, economy, efficiency and effectiveness. See also external and internal audit.

### ***Bank reconciliation***

Adjusting the balance of a bank account according to the bank statement to reflect deposits made and cheques that have been drawn but not yet cleared by the bank

### ***Bank Statement***

A bank statement is a list of transactions produced by a bank, showing all the payments and receipts on an account over a period of time and the amount held at the end of that period

### ***Controls ("Financial" or "Internal")***

All procedures and rules that guard against corruption, theft, misuse, and inappropriate utilisation of funds or other resources

### ***Economy***

Acquiring resources of appropriate quality and at the lowest cost; the measure of input

### ***Effectiveness***

The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance. It is used as an aggregate measure or judgment of the merit or worth of an activity; the extent to which an intervention has attained, or is expected to attain its relevant objectives efficiently, in a sustainable fashion and with a positive institutional impact.

### ***Efficiency***

A measure of how economically resources or inputs (funds, expertise, time etc.) are converted to results. It is concerned with maximizing the useful output from the resources used, or minimizing the level of work in producing a given level of output. It measures the relationship between input and output.

### ***External Audit***

Is an independent examination of the financial statements of a body in order to provide an assurance to members that financial statements have been prepared in accordance to the law and that they show a TRUE and FAIR view of the body's affairs.

### ***Evaluation***

It is a systematic and objective assessment of an on going or completed project, program or policy, its design, implementation and results. The aim is to determine the relevance and fulfillment of objectives, development efficiency, effectiveness, impact and sustainability. To be useful, evaluation

should provide information which is credible to enable lessons learned to be used in the decision making process of both recipient and donors

### ***Financial Statement***

The financial report covering a period of time (month or year) that summarizes the income and expenses ("Income and Expense Reports") and assets and liabilities ("Balance Sheet")

### ***Internal Audit***

An independent appraisal functions within an organization for the review of activities as a service to all levels of management. It is a control which measures, evaluates and reports upon the effectiveness of internal controls, financial and other, as a contribution to the efficient use of resources within an organization.

### ***Internal control***

It is a whole system of controls, financial and otherwise, established by management in order to carry on the business of the enterprise in an orderly and efficient manner. This contributes to ensuring adherence to management policies to safeguard assets and to secure as far as is possible the completeness and accuracy of the records.

There are different types of internal controls: These include:

- Segregation of duties – involves splitting roles to different staff on recording and processing; checking and authorization; execution and custody of finance and assets.
- Organization – involves defining allocation of responsibilities, lines of reporting and delegation of authority.
- Authorization and Approval – involves ensuring that authorization and approval of work and payments is executed by proper authority
  
- Physical – involves limiting access to assets and systems
- Supervision – involves ensuring that there is proper arrangements for communication and support
- Personnel – involves ensuring that there is good mechanism for recruitment of competent personnel and continuous strategies for career development
- Arithmetic – involves checking all processed transactions are included and correctly authorized and arithmetically correct.
- Management general – involves existence and application of overall controls including management accounts and internal audit.

### ***Monitoring***

Is a continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress in the use of allocated funds.

### ***Relevance:***

One of the five evaluation Criteria, refers to the extent to which the objectives of a development intervention are consistence with beneficiaries' requirements, country needs, global priorities, and partners' and donors' policies. It examines appropriateness of strategy or approaches taken by a project, as well as whether it has a legitimacy to be implemented through assistance (in this case by PharmAccess/Embassy of the Kingdom of Netherlands).

### ***Systems based audit***

It is a structured analysis and evaluation of the controls in a system, or department, in relation to the department, and in relation to the objectives of that system. It allows conclusions to be drawn in relation to the objectives of the organization and for pertinent recommendations to be made. Three



types of external audit exist; they include System based Audit, Computer Audit, Contract Audit and Value for Money Audit

***Value for Money Audit***

An audit methodology in which auditors are either required, or exercise discretionary power, to satisfy themselves by examination of the accounts and otherwise, that the audited body has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The value for Money Audit deals with reviewing the overall management arrangements and reviewing the overall project and the performance indicators.

The techniques it uses include: Input based reviews for input – output comparison; system based review to identify areas for improvement; and output based review to see how policies lead to effectiveness in achieving objectives.

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