# Contracting reproductive health services in rural Tanzania


## Marie Stopes Tanzania experience 2005-2011

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# 1 Executive summary

Since 1990 the Tanzanian government has promoted collaborative policy towards the private health sector to scale up access to health care. Contracting is one option available to decentralised health authorities to make the most of public and private health care provision at the district level but so far has been infrequently practiced. Typical barriers to contracting have included poor understanding of contracting mechanisms, mistrust between sectors, and general underfunding in districts.

*Contracting-out*: A contractual agreement by which the government pays a contractor to provide goods and/or services to the government or to a designated third party(ies) on behalf of the government. Provision/production takes place *outside* public facilities.

*Contracting-in*: A contractual agreement by which the government pays a contractor to provide goods and/or services to the government or to a designated third party(ies). Provision/production takes place *inside* public facilities.

- PSP-*One* (2006)

This health financing case study describes the contracting model that operated between Marie Stopes Tanzania and 13 Local Government Authorities from 2005 to 2011 including two no-cost extensions. The programme, which was predominantly financed by the Canadian International Agency for Development (CIDA), was envisioned with dual objectives: first, to increase access to comprehensive maternal, newborn, child and HIV/AIDS services in remote areas; and second, to design and implement a public-private partnership model of cooperation between a non-state health provider and decentralized Local Government Authorities. Marie Stopes International and Local Government Authorities also contributed financial and technical resources.

The programme reached more than 600,000 people with integrated services in 13 rural districts, as delivered by 8 Marie Stopes Tanzania (MST) outreach teams and 6 centres. Services included comprehensive family planning, voluntary HIV testing, STI services, antenatal and postnatal care, and newborn and under-5 services for a target population of underserved men, women and children.

The financing mechanisms used to pay for service delivery differentiated this programme from most Marie Stopes International outreach and centre models. CIDA extended the funds for MST service delivery related costs (i.e. fuel, medical supplies, per diems) through the Ministry of Finance and relied on standard public financial flows to reach the programme districts. At the district level, MST then entered Service Agreement contracts with 13 Local Government Authorities to receive payment. Service Agreements were cost-based, single-tiered contracts that allowed for both contracted-in (MST outreach in public facilities) and contracted-out (MST centre-based) services. Meanwhile, MST's programme management costs were financed directly by CIDA.

MST's contracting experience provides an interesting example of how donors can support national governments and non-state actors like Marie Stopes International to pilot new partnerships for the benefit of the population. The approach came with many lessons learned, including the need to proceed with caution during start-up to accommodate a steep learning curve around contracting procedures and PPP. Entering the Service Agreements was a challenge for all parties involved and caused considerable delays. Interviewees for this case study recommended others to ensure adequate inception of all partners from the outset, as well as development of a communication strategy that will build strong relationships throughout contract management. Despite the multitude of challenges, management problems did diminish overtime and the programme was able to deliver its results. Close relationships with government authorities and systems have since boosted MST's reputation in-country and the model was ultimately deemed worthwhile by all parties interviewed.

# 2 Case study methodology

This retrospective case study was produced on the basis of interviews with those working as the implementers, donors and Tanzanian stewards at various points between 2005 and 2011. Interviews were guided by the MSI contracting case study template. It also relied on desk review of available program documents, service statistics and financial information.

# 3 National context

## 3.1 National population and health status

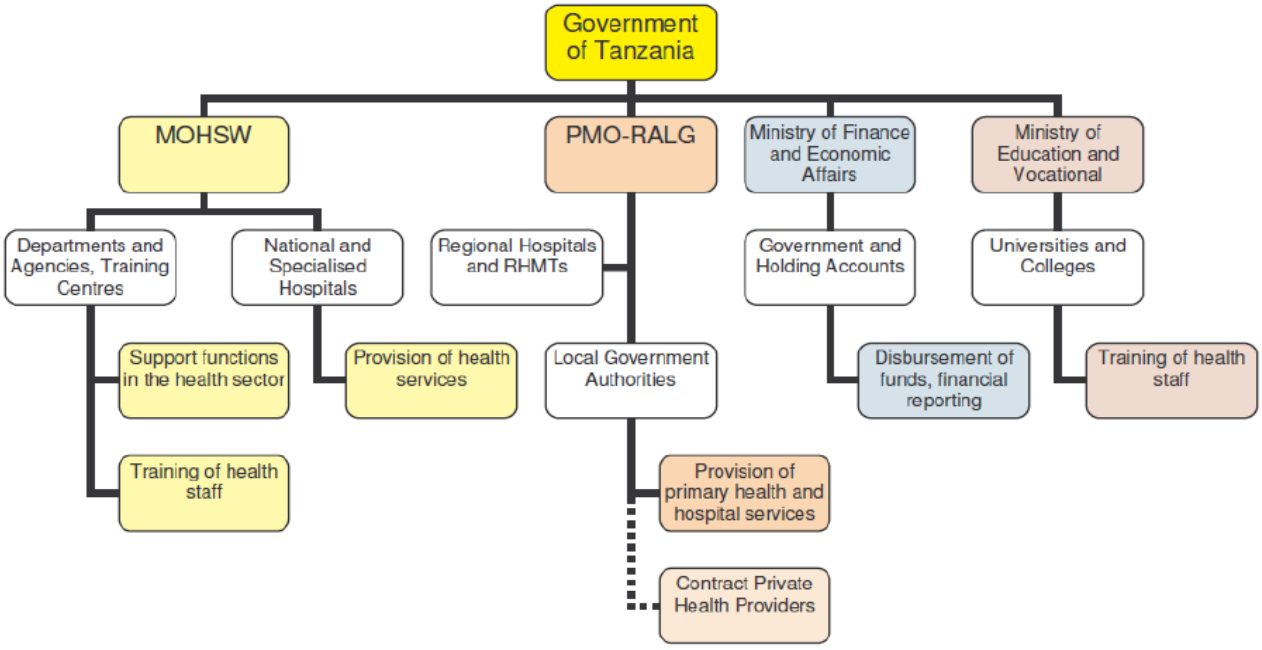
Tanzania faces significant challenges to improve health care access in rural areas where the majority of its population lives. Rural areas face the greatest burden of disease, especially in maternal and child health indicators, and have demonstrated slow progress towards achieving the Millennium Development Goals. This is due to a complex interplay of factors including those related to poverty, gender inequality and education. In addition to demand-side barriers, government and other health facilities in rural areas are constrained on the supply side by inadequate financial, infrastructural and health human resources to scale up service delivery.

## 3.2 Tanzania health system and financing

Administration of the Tanzania Mainland health system is relatively decentralised. The Ministry of Health and Social Welfare is in charge of policy, quality control and regional and national referral hospitals, while the Prime Minister's Office, Regional Administration and Local Government (PMO-RALG) oversees the district system of hospitals, centres and dispensaries (1).

All public facilities within the district system are owned and operated by local government authorities (LGAs). As shown in Figure 1, the nature of decentralisation in Tanzania has designated its 161 LGAs as the primary agents charged with arranging the provision of primary health and hospital services, including the option to contract private providers as appropriate. While largely autonomous in many respects, LGAs are nevertheless affected by Ministry of Health policies, Ministry of Finance flows and PMO-RALG oversight.

**Figure 1: Organisation of the Tanzania Health System**




*Source:* Tanzania, MoHSW 2008, 12

**Note:** The Marie Stopes Tanzania contracting experience required the clear support of the MoHSW. However, financial flows were overseen by the Ministry of Finance, PMO-RALG and the Local Government Authorities. Actual Service Agreement contracts were signed between MST and 13 of the Local Government Authorities.

### Health financing in Tanzania

The Tanzanian health system is dominated by public sources of financing comprising national government and external funds. Recent increases in external funding have contributed to net increases in total health expenditure as well as the growing proportion of total health expenditure that is public (1).

Overall, Tanzania total health expenditure is estimated at $30.90 USD per capita which is only about two-thirds the minimum amount deemed necessary to assure essential health coverage (2). While progress is evident, absolute shortage of financial resources remains a current challenge. External support facilitates

about 60 percent of public expenditure and remains critical to the immediate sustainability of the national health system (see Table 1).

Given the large donor landscape, Tanzania adopted a sector-wide approach (SWAp) and an accompanying health basket fund to coordinate donor support more than 20 years ago. Between the basket fund and budget support, the government attracts the vast majority of external funding (as opposed to direct funding to non-state actors). As a result, the Tanzanian government is by far the biggest player in overall health resource allocation (3).

Meanwhile, an estimated 12 percent of public health spending reaches the poorest 20 percent of Tanzanians, which is considered inequitable (3). User fees in public facilities have been officially lifted from a few targeted health programmes such as HIV, TB, MCH and under-5 services, although this system is widely acknowledged to be imperfect in correcting for equity (4). Out-of-pocket health expenditure remains significant means of closing funding gaps and this disproportionately affects the poor.

In the face of these challenges, Tanzania has introduced a number of ambitious health reforms aimed at increasing risk pooling and prepayment for health care. These include a National Health Insurance Fund for public sector workers, voluntary Social Health Insurance Benefit for private sector workers and a Community Health Fund in each district intended to bring coverage to the informal and rural sector. At this time, the sum of these publicly administered insurance plans only covers about 8.6 percent of the population (1).

**Table 1. Tanzania health financing statistics**

| | |
|---|---|
| **Per capita total expenditure on health at average exchange rate (US$)** | **$30.90** |
| **Total expenditure on health (THE) as % of GDP** | **6.0 %** |
| **Public expenditure on health as % of THE** | **72.2 %** |
| Government spending on health as % of public expenditure | 38.9 % |
| Donor spending on health as % of public expenditure | 61.1 % |
| **Private expenditure on health as % of THE** | **27.8 %** |
| Other private sources as % of private expenditure | 14.8 % |
| Out-of-pocket expenditure as % of private expenditure on health | 85.2 % |

*Source:* Tanzania National Health Accounts 2008/World Bank 2010

A number of private insurance arrangements also exist, but private financing remains heavily dependent on out-of-pocket contributions (85.2 percent of all private expenditure). This phenomenon has been slowly shrinking alongside the reform efforts for greater participation in prepayment schemes.

## Private sector role in the health system

Private provision of health care was made legal in Tanzania during economic liberalization during the 1980s. Compared to Tanzania's East African neighbours, the private sector contributes a relatively modest proportion of all health services at 33 percent (30 percent private in rural areas and 40 percent private in urban areas) (3). However, private provision is greatly oriented towards curative care and the private share of prevention is estimated at only 10 percent (3).

Private sector providers are reportedly popular amongst Tanzanians. In a survey of rural farmers, more than two-thirds of respondents preferred private providers and drug dispensaries, citing convenience, courteousness, and quality of care (3). The role of the private sector is expected to grow in Tanzania given its popularity and relatively young history.

## Public Private Partnerships policy

Tanzania's inclusive official policy towards private health providers emerged in 1990 when the first national health policy called for private sector collaboration (5). However, there was little technical detail about how collaboration would be implemented and most concrete examples arose from existing good relations between public and faith-based tertiary hospitals (6). Further elaborations of the health sector strategy have since clarified that LGAs are responsible for contracting all types of private providers through Service Agreements. A PPP support unit has been established within the MoHSW, and has recently issued Service Agreement templates to facilitate the LGA contracting process. Alternative purchasing arrangements are

achieved through private provider accreditation into several existing publicly administered insurance schemes.

Real relations between the public authorities and private providers are not as fluent as the policy would lead to believe, especially those with non-faith-based private providers (7). In fact, PPP implementation with non-faith-based private providers has occurred in just a handful of examples during 22 years of this positive policy environment.

### MST market niche

Outreach is a particularly appropriate service delivery channel to fill health service supply gaps to the most underserved rural populations. The 2011 mid-year sector review coordinated by the Reproductive and Child Health Section of the Ministry of Heath concluded that mobile outreach services will continue to be necessary in the short-term to meet current government health coverage targets. MST is one of the largest providers of mobile outreach services in Tanzania and is therefore well positioned to scale up its contribution to the public sector. Meanwhile, MST centres are positioned to address inadequate supply of quality sexual reproductive health services as specialist providers.

# 4 MST's contracting model

## 4.1 Ground work prior to contracting

### Earlier funding arrangements and status of PPP

The contracting approach was new to all parties at inception: MST had not previously been contracted by Tanzanian government authorities, nor had the participating LGAs practiced contracting with non-state actors. CIDA had a long history of financing both Tanzanian government and non-state actor programmes but had not attempted to fund the latter through government channels before.

> "No one was actively addressing the barriers in getting Service Agreements to move. They were just pointing to the Service Agreement policy and saying 'that's the solution to bring in the private sector' – still, nothing would happen."
>
> - Former CIDA representative

LGA Service Agreement contracting had been made politically possible years earlier (see Context). However, this policy had not moved to practice because district authorities and the non-state actors lacked either skills or motivation to contract. Interviewees felt that mistrust between sectors was an issue, while poor understanding of the actual PPP mechanisms perpetuated low expectations of the likely benefits. Furthermore the LGAs faced funding gaps when managing existing public facilities and Service Agreement contracting had fallen to second priority.

A former CIDA representative recalled observing the failure of PPP policy to take off and came to believe that PPP in Tanzania was suffering from what he called 'a dichotomy of expectations'. In his experience, local government stewards and private implementers both assumed that the other party should source funding for the partnership. The government expected the private sector to mobilize its networks and bring in more resources, while the private sector turned to the government for inclusion in public financing. Therefore negotiations would go nowhere and PPP was stalled. He said, "No one was actively addressing the barriers in getting Service Agreements to move. They were just pointing to the Service Agreement policy and saying 'that's the solution to bring in the private sector' – still, nothing would happen."

### A primed environment for contracting

During the original Phase I (2002-2004) programme, MST similarly delivered integrated services through outreach and centres but operated on direct CIDA funding (see Figure 2A). Phase I demonstrated success in delivering high volumes of quality services to rural and underserved populations. Outreach teams had worked particularly closely with the district health system to overcome health human resource gaps that MST and other private health providers were experiencing at that time. The resulting collaboration between MST and districts was noted as a positive outcome and additional success of the programme.

In 2005, the Paris Declaration on Aid Effectiveness was the hot topic and it was also the year that Phase II was set to begin. CIDA was motivated to renew the MST programme but also honour commitments to support government stewardship over the health sector. As a result, thinking evolved to formalise the collaboration into an official PPP between MST and the Tanzanian Authorities in Phase II such that the funds used to purchase MST delivered services would be extended through the Ministry of Finance and rely on

standard public financial flows. This approach allowed CIDA to contribute towards indicators for direct funding to Tanzanian government while ensuring continuation of MST's successful rural programme in integrated services. It also allowed an opportunity to test Service Agreements in action.

## Advocacy steps

With the concept agreed between donor and implementer, CIDA and MST turned to the government and other health sector partners to get their buy in. However, extending funds to government for specified use (earmarking) was not preferred in the policy environment. CIDA received some criticism from other donors and had to defend the approach. The criticism was softened by the fact that CIDA was also contributing heavily to general budget support, while the earmarked MST programme was pitched as a dedicated effort to advance PPP implementation.

Meanwhile, MST carried out advocacy with the many layers of government to be affected by the partnership, especially those under the central level. This type of advocacy was focused on clarifying objectives of the PPP design and trying to build support for the initiative. Early on, central level voices were often required to persuade regional and district government stakeholders of anything. As one MST staff member said, "PPP advocacy with government was hard even though we weren't really asking for government money!"

## Public sector motivations for entering the contract with MST

At the onset, the programme offered the Ministry of Health an opportunity to increase service delivery at public facilities and thereby contribute to its duty of extending health coverage to the Tanzanian population. The new PPP approach in Phase II did not proffer any particular financial reward or incentive linked to public management of the MST contract, with the exception of occasional per diems to attend planning meetings.

At the district level, LGAs were not required to partner with MST to receive and purchase services. However, the programme was positioned to help LGAs meet the health coverage indicators (such as under-5 immunization rates) which were already in place to measure district performance. Accepting to participate meant that they could improve indicators compared to other districts. Nevertheless, if a district was disinterested in the arrangement, the PMO-RALG could direct MST to approach another rural district in its place. Like the MoH, LGAs were not offered any direct financial benefits for programme administration or contract management. The rationale was that CIDA was already supporting MoH and LGA administration through its general budget support.

## Final milestones to signing – 2005 to 2008

Following initial positive agreements and a kick-off partners' inception workshop, formal Service Agreement contracts were not actually signed between MST and the LGAs until a few years after the programme started.

According to interviewees, implementation of the PPP seemed blocked with misunderstandings. MST made its own mistakes during this time. While lacking signed contracts, MST was keen to avoid breaks in service supply. MST therefore commenced service delivery under the assumption that activities would be reimbursed by the LGAs. When MST presented its claims, some LGAs refused to pay and these issues could not be resolved locally. MSI London had to front the funding gaps.

MST realised that the partners' inception held during the 2005 programme launch had been taken too lightly and that challenges urgently needed ironing out. A re-clarification workshop was held in 2008 which brought together more than 100 people over 3 days from each of the 13 LGAs, PMO-RALG, MoH, MoFEA, CIDA, MSI and MST. The workshop aimed to address relationships and misunderstandings, and the programme Steering Committee was restructured as a result. It was also a chance to identify 'problem' LGAs that were slowest to adopt the PPP principle. A small delegation of CIDA, MoH and MST representatives then visited all identified problem districts as immediate follow-up to the workshop.

After this extensive clarification exercise, MST's outstanding invoices were cleared and the last of 13 Service Agreement contracts were signed in early 2008. From this point onwards, the contracting model began to function albeit very slowly. Even with contracts in place it took the rest of 2008 for financial flows to build adequate momentum (see challenges).

## 4.2 Contract details

### Contract type

The MST and the LGA Service Agreements were best described as cost-based, single-tiered contracts. In other words, these contracts were not expressly output- or performance-based and did not permit further sub-contracting to third parties. According to Tanzanian decentralisation, MST signed a contract with each of the 13 programme district LGAs which was equal to roughly 10 percent of the LGAs in the country. Contracts covered outreach service delivery in public facilities (or contracted-in services) as well as in centres (contracted-out services), although the former contributed the larger part of the overall programme.

### Service package determinants

The integrated service package was pre-determined based on MST and CIDA prior arrangements in Phase I and originally responded to wider national health priorities.

### Bidding process

MST was pre-selected by CIDA for this programme and there was no competitive bidding process.

### Funding flows

CIDA's financial support for the programme was divided into two parts: direct programme management funding to MST (47 percent of the total programme budget) and indirect funding channelled through the Ministry of Finance and Economic Affairs (22 percent). Remaining contributions from MSI and LGA sources are presented in Table 2.

CIDA's indirect funding should be understood as the component that permitted MST and LGA contracting. It covered immediate running costs of service delivery such as medical consumables, fuel and per diems. On its release to the Ministry of Finance, this funding was earmarked to reach the 13 LGAs for the express purpose of MST services financing (see right side of Figure 2B). A total of roughly 1,275,000 USD of services were purchased through Service Agreement contracting over the programme period. Meanwhile, MST programme staff salaries and other overheads were always directly funded (see left side of Figure 2B).

### Payment procedures

Starting in 2008, payments were extended in advance based on a three-month work plan of MST activities in each LGA jurisdiction. These payments relied on the plan's forecast execution budget and therefore no per-service costing exercise was done. At the end of the 3-month period, MST retired the advance by submitting evidence and justification of expenses (fuel, per diems, medical supplies and so forth). A second advance could not be requested until the first was retired. Advances generally took about one month to process although rogue cases took up to a year. MST was required to send an acknowledgement letter to the LGA upon receipt of the advance. The programme originally planned for costs to be reimbursed rather than advanced; however, owing to early experiences, MST felt exposed to risk and cash flow constraints when working on reimbursements. CIDA and the PMO-RALG therefore agreed to arrange payments using the advance-and-retire approach.

### Contract performance monitoring

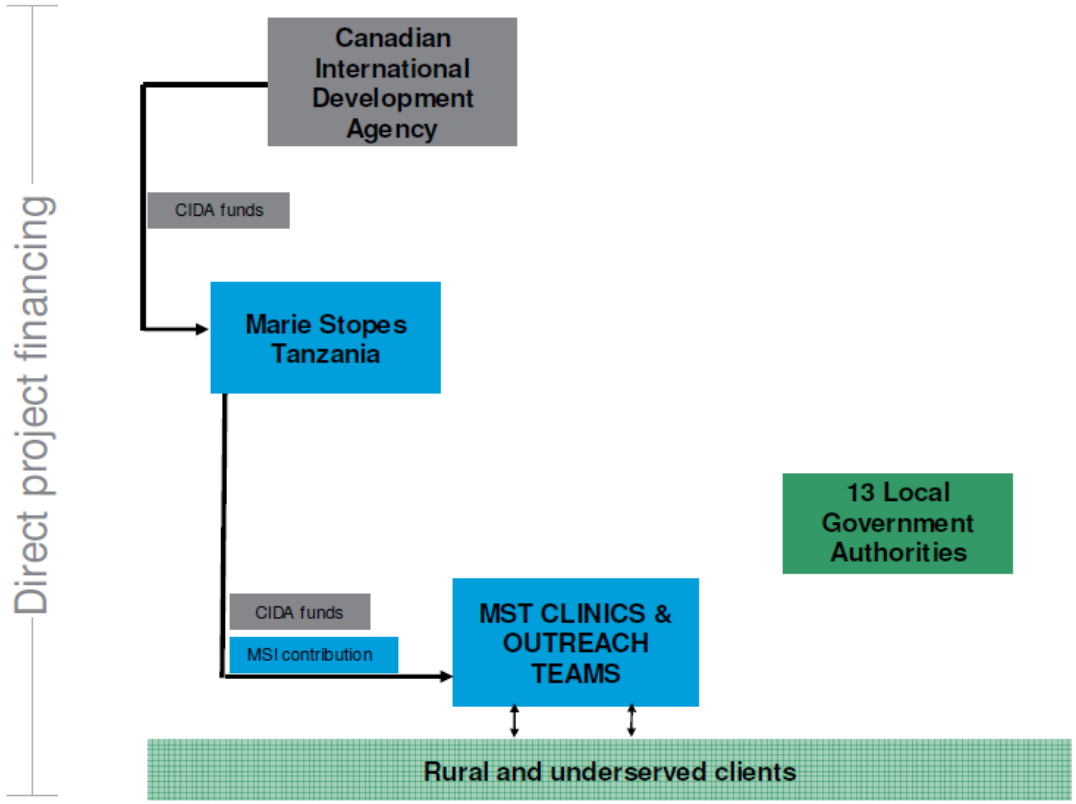
The programme built on existing monitoring systems for private health providers by assigning the District RCH Coordinator to be monitor for each contract. The Coordinator frequently attended outreach events in person and accompanied MST staff on joint supervision visits. However, contracts did not indicate specific performance requirements to be verified. At a minimum, MST had to dispatch the outreach teams 18 days per month or else seek LGA approval. Outputs were reported in regular service statistics but were not linked to payments. Interviewees suggested that quality and output indicators were perhaps unnecessary since MST's reputation was well established from Phase I. Also, most services were delivered in public facilities where the District RCH Coordinator could be easily informed about inaccurate service statistics reports or quality shortcomings. On the other hand, the lack of regular monitoring at MST centres activities perhaps contributed to the LGAs' greater suspicion of services delivered through this channel.

### Auditing

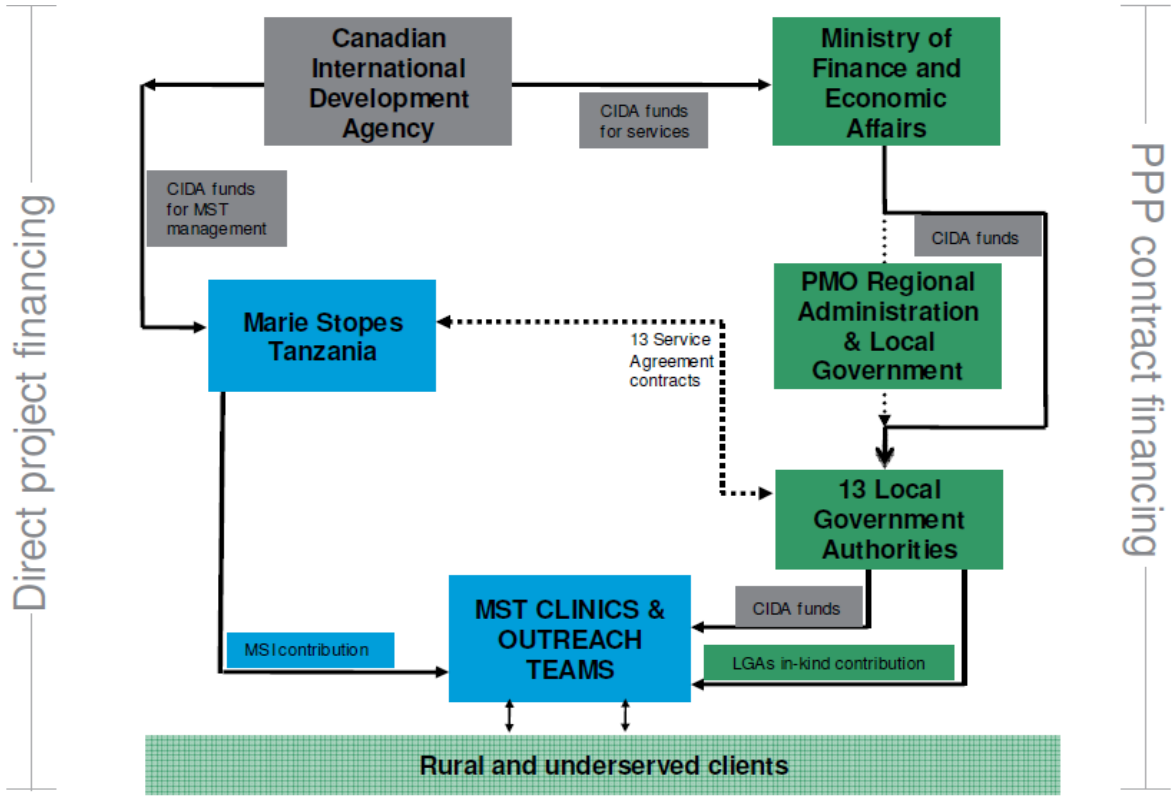
Contracting through LGAs made the District Executive Director ultimately accountable for any misappropriated funds. This meant that LGAs were very concerned with attaining all required financial information from MST so that PMO-RALG would find them financially compliant in contract management during the LGAs' own audits. LGAs also conducted random audits of MST centre operations once or twice to

**Figure 2: Funding flow changes between Phase I and Phase II: Adding the PPP component**

**A: Phase 1 direct project funding**




**B: Phase 2 PPP funding**




Adapted from R.G. Mutakyahwa, 2008

verify the reported volumes of consumed medical supplies. No other MST audits were conducted to verify what was submitted to the LGAs.

### Other means of programme funding

MST, MSI and the LGAs contributed a further 31 percent of total financial resources to this programme (see Table 2). With the exception of immunization and VCT, MST centres also charged a consultation fee to recover some service-related overheads as the centres received limited LGA in-kind financing. However, charging any type of fee proved confusing to government authorities who felt that the contract advances should be used to provide completely free services.

**Table 2. Financial sources for the MST integrated services programme, 2005-2011**

| | |
|---|---|
| Direct management funding to MST from CIDA | 47% |
| LGA contract payments originating from CIDA | 22% |
| MST/MSI contribution | 22% |
| LGA in-kind contribution (estimated) | 9% |
| Total 5-year programme | 5,800,000 USD |

*Source*: CIDA end-programme financial report, May 31st 2011

In-kind financing was important to the outreach component of the programme. Outreach teams benefited from the occasional use of government vehicles, public sector staff secondments and medical supplies. However, one interviewee pointed out that this was not prescribed and in-kind financing was variable over time. Table 2 presents the best estimate of this total in-kind contribution although this was difficult to quantify.

MSI funds supported the programme through usual internal financing mechanisms for outreach activities (CHOICE funding). Furthermore, MSI backstopped MST by fronting cash when LGA payments were unusually delayed. This phenomenon was particularly burdensome on MSI during the early years.

## 4.3 Contract management requirements

### MST dedicated human resources

Interviewees reported that the government contracting approach absorbed substantially more management time during implementation than would a typical programme. However, some argued that much time lost was due to inadequate planning and communication while the model itself was perhaps less to blame.

One accountant was responsible for tracking the 13 district financial agreements (each one assigned with a separate MSI donor code) and consolidating 13 LGA financial reports each quarter, as well as fulfilling CIDA financial reporting requirements for MST's directly funded portion. The role required the accountant to uphold personal relations through regular travel to districts. The accountant also held other MST responsibilities and, in retrospect, MST staff suggested that the accountant should have been dedicated full-time to the programme.

The programme manager was meanwhile tasked with ensuring that 13 budgeted work plans were submitted to the respective LGAs to request advances each quarter.

### Formal and informal partnership management

The programme originally established a Steering Committee comprising MSI London, MST, CIDA representatives, a PMO-RALG representative, a MoH representative, and five Regional Ministry of Health medical officers. The Committee Terms of Reference were to review the programme deliverables and work plans every 6 months and provide any recommendations.

The 2008 re-clarification workshop highlighted that the Steering Committee structure was inadequate considering the relative importance of some affected government stakeholders. In response, new Committee members were drawn from the Ministry of Finance, additional departments of the PMO-RALG as well as the LGAs themselves. Strong membership of the PMO-RALG was especially critical in establishing the Committee's authority as the agency directly managed the LGAs. The PMO-RALG therefore carried real weight compared to the Central or Regional level MoH and was best positioned to unblock LGA contract

issues as needed. The Assistant Director for Sector Development was particularly dedicated to the idea of making PPP work on the ground and became an important influencer in support of the programme.

CIDA also held great leverage over government partners as it was simultaneously contributing to the national government's general budget support. This meant that any missing funds or delayed payments from LGAs risked being immediately deducted from budget support contributions where high-level government authorities would take notice.

Alongside the programme manager, MST's executive team members including the Country Director were regularly engaged in these stakeholder meetings and also conducted ad hoc district visits to keep up the essential relations that facilitated the partnership. While MST sought to identify one dedicated contact person at each level of government, turnover in Tanzania's public sector posed a great challenge to the continuum of relationships. This situation dictated that MST constantly provide programme orientations especially for district public officials. While time consuming, it was a step that could not be skipped. As one interviewee explained, "Personal relations were very important to keeping things smooth. You had to know the people." Outreach team leaders and centre managers also played an important role in partnership management so that issues could be locally managed as much as possible.

## 4.4 Contracting advantages

"This programme built our capacity to see how PPP with the government really works."

- MST staff member

### Perceived benefits to MST

The programme achieved a relatively high-profile status in Tanzania owing to both service delivery results and the PPP design. Staff noted that MST's reputation benefited from the close affiliation with government authorities who could appreciate the contribution of a private organisation to Tanzanian national health goals. MST emerged as a key implementation partner to government and was made part of the health stakeholders' PPP task force.

MST staff admitted that contracting gave them valuable exposure to government systems beyond what they had ever experienced. As one interviewee said, "We usually dealt with the Reproductive Health Unit in the MoH, you know, just sharing plans and informing them of our activities. But this was working with the entire system – it really was engagement." Another explained, "LGA relationships were harder but they were genuine. We weren't just dropping by and paying face to partnership." Despite the dramatic challenges prior to 2008, the MST staff interviewees pointed out that day-to-day contract management was eventually ironed out such that MST and LGAs could fully handle it themselves.

MST staff reported that they continue to notice the improved quality of its relationships. The staff feel that this type of initiative represents the most sustainable way of working for the future.

### Perceived benefits to CIDA

CIDA was already satisfied with the programme's achievement of measurable outputs in the rural districts during both Phase I and II. The agency felt strongly that MST's service delivery model effectively bridged critical public sector supply-side gaps for the immediate benefit of the population. After all, Phase II alone succeeded in delivering integrated services to 600,000 people living in underserved areas.

Meanwhile, one former CIDA representative explained that the contracting design helped the agency to meet its government direct financing indicators while simultaneously improving PPP implementation on the ground. From CIDA's perspective, an important programme benefit was the improved capacity for sharing resources at the district level, leading to increased mutual understanding, transparency and trust between the government and the private sector. About two years into the programme, other donors reportedly began to complement CIDA on the approach despite having been initially critical of its earmarking. Bringing Service Agreements to life was recognised as a genuine achievement in Tanzania. The former CIDA representative also felt certain that CIDA would re-adopt the contracting model to couple other high value programmes with PPP capacity building in the future.

### Perceived benefits to Tanzanian Authorities

Reinforcing government's position as the health sector steward was one of the great strengths of this programme. In fact, the MoH's newly established PPP unit featured the MST contracting example in its debut June 2012 PPP newsletter, which testifies to the government's appreciation of the contracting approach (excerpt below).

"In the spirit of partnership Marie Stopes supported 13 councils to implement SA [Service Agreements]... Although a few challenges remain in the implementation of these partnerships, the benefits remain far greater: maternal, infant and under-five mortality rates have projected a declining trend where such agreements are in place."

- PPP-Health newsletter, June 2012 (MoHSW PPP unit)

Rural LGAs also benefited in several ways beyond increasing population access to services. The LGAs were able to experience PPP and apply contracting mechanisms first-hand. All 13 learned to successfully manage the Service Agreement with MST despite the initial challenges. Rather than merely being informed of the programme, they increased control over district activities and were in a strong position to push MST on results. Furthermore, LGAs benefited from increased cash flow to district coffers which facilitated some extra benefits and flexibility.

When asked if LGAs would prefer to avoid headaches by allowing MST to receive direct programme funding in a potential Phase III, all adamantly rejected the proposal. This sentiment stood in stark contrast to the disinterest LGAs had demonstrated in the early years of Phase II.

"Through the 2005-2011 public-private partnership contracting experience, government authorities learned to work with the private sector while the private sector was working in our public facilities."

– Honorable Minister of Health Dr. Mwinyi, London, July 2012 FP Summit side session

Two of the participating LGAs, Musoma and Kilolo, have since entered Service Agreements with other non-state actors for different types of services. Interviewees felt this would not have occurred without prior experience gained with the MST programme.

## 4.5 Contracting challenges

### Essential compromises

The contracting approach forced all parties to compromise their normal ways of operating. Contrary to typical levels of donor involvement, CIDA played a very active part of contract management throughout the duration of the programme. As one interviewee explained it, "Of course this programme led CIDA into a much more hands-on role that a typical funding arrangement, but I personally believe donors have a role to play in making PPP technically possible." All other stakeholders agreed that achieving this level of inter-sectoral working would not have been feasible without CIDA's willingness to be hands-on in the process.

At various points, MST felt that its service delivery efficiency was being compromised by government bureaucracy requirements and slow payments. Implementation was delayed such that two no-cost extensions were required to complete programme deliverables. This proved difficult for MST as it affected cash flow and stability for operations. The team poorly tolerated the perceived bureaucracy during the early years but their patience improved as they learned to better predict funding flow variations and otherwise manage the contracts as required. Handling government partnership was therefore an essential new skill set for MST. The team learned that working within government financial flows was not like the private sector where invoices are dropped off then paid. Referring to the earlier phases, one MST staff described that, "We weren't empathetic enough to the challenges faced by individuals working in government bureaucracy." Overtime, the team recognized the realities of public systems and began to work with the individuals rather than standing back and getting frustrated. They learned, for example, that senior public officials needed to be contacted by senior MST staff, and that senior MST staff could not only get involved when money wasn't flowing. They had to demonstrate regular involvement and acknowledge prompt payments as well.

Meanwhile actors within the public financing system were charged with more responsibility to administer the earmarked funds without any compensation to do so. The higher levels of the system, such as the Ministry of Finance, were especially tasked with looking after relatively tiny amounts of funding in comparison to their usual financial flows. In other words, the public financing system was asked to pay close attention to a small job for limited reward. This made it even more important for public officials to share the vision that the model was trying to achieve. One interviewee explained, "You had to appeal to them personally."

### Early challenges (pre-2008)

Interviewees pointed out that the initial challenges were largely due to the absence of clarity on PPP mechanisms resulting in insufficient stewardship by all parties. Challenges were greatly concentrated from 2005 to 2008 when the PPP approach was poorly understood. It literally took years to get the financial flows running due to weak communication and contract management skills. At the beginning, even many CIDA people were reportedly confused by the proposed model.

> "There is a general lack of PPP models on the ground from which to learn, leading to limited experience in managing PPPs and Service Agreements in Tanzania"
>
> - CIDA presentation to USAID, 2010

MST received highly mixed messages early on from national, zonal, regional, and district levels of government about what would be required to formalise the partnership as they sought to move towards implementation. MST therefore struggled to isolate the essential government stakeholders. As MST had the habit of liaising with the MoH, they did not fully understand the fundamental role of the PMO-RALG as a means of engaging the LGAs. In fact, MST failed to sufficiently include the PMO-RALG during the 2005 programme inception and the first Steering Committee, which contributed to LGAs inaction and years of lag time before Service Agreements were finally signed.

Although the contracts signalled a major turning point for the programme, the Service Agreements left gaps in the roles and responsibilities, coordination structures and measures for conflict resolution at all levels of implementation. MST and LGAs alike stumbled for clarity on issues such as appropriate financial justification procedures. LGA bank accounts were also slow to open. Looking back on the ordeal, one MST interviewee advised other private sector implementers that when it comes to contracting: "Do your groundwork, don't just start delivering services!" Another emphasized that a partnership communications strategy should be in place from the outset, saying that MST planned for service delivery but not nearly enough for the PPP.

By August 2008, only one LGA had actually processed a payment to MST. At this point the MST programme manager and accountant concerted efforts to be much more involved with the LGA stakeholders to make the system work. By the end of the year, the money began flowing.

### Enduring challenges

Once financial flows were actually under control, MST interviewees felt that the biggest remaining challenge was constantly facing turnover of many government stakeholders. The programme manager said, "I was always repeating and re-explaining the approach to new people."

On a few isolated occasions money did go missing in public financing flows. In one case, the LGA used the money to cover other district expenses then didn't have it available in time for MST's advance requests. Actual fraud was detected in another case. When money went missing and couldn't be retrieved, CIDA deducted the same amounts from general budget support. This mechanism helped protect against further mismanagement as consequences were visible and internal pressure would follow.

Initially it was believed that using budgets and advance payments would be easier than costing all of MST services and asking for reimbursements. However, this approach proved to be more challenging than expected. The 8 outreach teams moved between the 13 districts but had to keep track of which district had paid for the medical supplies they carried. At the same time MST centres were viewed with suspicion when requesting funds for medical supplies as LGAs lacked assurance that funds would be appropriately used. In retrospect, some interviewees felt that a simple cost-per-service reimbursement might have reduced complexity.

# 5 Conclusions and programmatic lessons

Overall, both government officials and MST staff reported great appreciation of this programme and in particular of the contracting approach. It is interesting to note, however, that contracting was unlikely to take place without CIDA's strong support as an external donor. This case study serves to show how donors can help Marie Stopes International and national governments to pilot solutions that keep government at the centre of stewardship while reinforcing MSI's role as an implementing agent of priority sexual reproductive health services.

Having recounted their individual experiences with the PPP model, the interviewees for this case study concluded by sharing key programmatic lessons:

- Entering a government contract for the first time may require a steep learning curve. Partner inception cannot be under-prioritised. In the end, everyone involved must be able to speak confidently about the model and advocate its benefits.

- Contract management is an ongoing exercise requiring dedicated time and human resources. Activities span from financial procedure adherence to regular orientation with new stakeholders.

- Given the importance of partnership relations, a communication plan should be developed from the beginning that assigns responsibility of different stakeholder communications to each team member. Seniority of public officials should be appropriately matched.

- Decentralisation of government authority may add to the number of stakeholders involved and hence complexity of contracting. The structure must be understood (especially of less well-known influencing bodies beyond the health sector) and each layer appropriately mapped into a communications strategy. All those in direct line management of the immediate contractors must be programme champions.

- Government systems can be slow to produce payments. Risks may be mitigated by working on advances or by maintaining a programme bond to keep working through the delays. In the case of MST, risks were also mitigated through blended financing approaches (direct and indirect CIDA funding; MSI support).

- Contract stipulations should be as clear as possible as early as possible. This includes expected financial procedures, roles and responsibilities, and means of resolving conflicts.

- A cost-based contract may be more complicated to track and justify than an output-based contract. On the other hand, output-based models would require stronger monitoring of service delivery and a potential shift in government finance approaches (depending on the context).

- In the end, PPP with government authorities and integration with its systems can boost reputation in-country.

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