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Opportunities and Challenges of Implementing Service Agreement under Public-Private-Partnership Between the Government and Faith Based Organizations in Ilala Municipality, Dar es Salaam, Tanzania

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Abstract

Background
Access to essential health services is an important aspect of development. Due to population increase and technological advancement, governments could no longer cater for the services needed. One of the solutions was to involve the private sector through Public Private Partnerships (PPPs) in the provision of the services. In 2007 Tanzania made a generic Service Agreement (SA) to govern PPPs in health sector. However, since its establishment, less is known on opportunities and challenges of its implementation in the provision of health services in Tanzania.

Main Objective
To assess the opportunities and challenges of implementing SA in Tanzania using a case study of Cardinal Rugambwa Mission Hospital (CRMH) and the Ilala Municipality in Dar es Salaam.

Methods
A case study design using qualitative method of data collection was used. Data were collected by using an in-depth interview guide. Purposive sampling was used to select participants. The sample size was 23 participants based on the principle of saturation level of the information collected. Data were analyzed using a thematic analysis approach.

Results
The opportunities of implementing SA in CRMH, Ilala Municipality include: the existence of guidelines and policies, Patients receiving some health services free of charges, availability of some services at reduced prices, presence of SA review meetings, good coordination, availability of supervision, training and mentorship opportunities, presence of political support, trust of the hospital by suppliers and trust between government and the hospital. The identified challenges in implementing SA include: - partial fulfillment of financial commitment, inadequacy deployment of Human Resources for Health (HRH) to CRMH by government, lack of transport for supervision and donor dependency.

Conclusion
There are a number of available opportunities for partnering between the private sector and the government in the delivery of health services. However, for the PPP to achieve its desired objective of improving access to health services particularly to most vulnerable population such as women and children, there is a need for the two parties (private and public) to address the identified challenges such as partial fulfillment of financial commitment and inadequate deployment of HRH from the government to the private health facility as per SA.

Keywords: *Public Private Partnership, Implementation, Service Agreement, Tanzania.*

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Background

Access to essential health services is an important aspect of development (1). Governments around the world have increased the use of Private sector in a new form commonly known as the Public private partnerships (PPPs) in improving services provision and accessibility (1–3). Reasons for practicing PPP varies ranging from rising expenditures for constructing, maintaining and operating public assets, and deficit of government budgets, opting for seeking innovation through private sector and better risk sharing and management (1,3–5).

The private sector plays an ever-growing and diversified role in the delivery of public services around the world. The level of private involvement in its various forms is now vast (1,5–7). According to the most recent statistics, the private non-for-profit sector is the second biggest provider of health care after the public sector in the world. It constitutes an indispensable addition of 40% to the care provided by the public sector, particularly in rural areas. For profit private health service providers are mainly found in urban areas and while it is on a growing scale, still it has remained small (8).

The public sector has been the main actor in the development process of most countries in Africa and beyond until the mid-1980s. This was due to monopoly policy of state economy in most countries especially those that embraced centrally planned economic policies, like Tanzania (8). The introduction of Structural Adjustment Programme in 1980s, which was designed as an economic revival strategy and advocated for private sector involvement and decentralization of powers to local governments, contributed to establishment of PPP in Tanzania (9).

In Tanzania, despite the fact the private sector existed, the government has been the main provider of health services even before Tanzania became independent. This model of service provision was known as ‘Tanzanian model’ where by religious freedom was maintained (8,10). The main private health providers were religious organizations, traditional healers and birth attendants (10,11). Following the winds of change in social, political and economic reforms, the role of the public sector in the development process has substantially changed in many countries. Its role remained mainly that of a facilitator for the private sector-led economic development and growth. The role of the private sector in bringing about sustainable development in most economies has increasingly been recognized and acknowledged (1,8,12). One proposed approach to improve coverage and quality of health care for all citizens was to enter into contract with private organizations to deliver specific services that are pre-defined by health authorities (1,2,10,13,14).

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Public Private Partnership in the Health and Social Welfare Sector can take a variety of forms with differing degrees of public and private sector responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as defined in a contract or agreement (10–12,15–19). The private health sector was deemed better to support the government in implementing different projects due to its efficiency, accountability, quality of service and wide coverage nature (3,12). However, on various occasions there were reported weak collaboration**,** coordination and cooperation in health services delivery between public and non-government providers including FBOs and private service providers (15).

The Government of Tanzania started to strengthen the collaboration between public, private and civil society by setting a comprehensive policy, legal and institutional frameworks at all levels (16,17,20). In 2007 the government together with various stakeholders developed a national Service Agreement template, which was designed as a contractual tool to facilitate the implementation of public private partnership projects and collaboration. It defines how PPP projects will be well implemented and governed (16). The demand for the Service Agreement (SA) emerged from both the government and the Private sectors (6,13). On the government side, there was desire to increase accessibility of healthcare services particularly in rural and hard-to-reach areas with no public health facilities. On private sector a motive was on financial capital and human capital.

Due to decentralization by devolution policy, the implementation and management of SA has been left to be practiced by Local Government Authorities. The SA in Health services is administered by the Council Health Management Teams (CHMTs) on behalf of the District Executive Director. CHMT through Council Health Services Board (CHSB) identifies the private Health facilities to partner with and assess their capacities. The Private Health Facility administrator held talks with government (CHMT representatives) on the Local Government Authorities (LGAs) intention to enter into contract, agree on the terms and requirements of SA. Then CHMTs with advice from District Legal Officer contextualize the generic SA to fit their health services' needs. Then the SA for the provision of health services is ready for the signing process. The District Executive director, Council Chairperson and chairperson of Council Health Services Board sign the SA on the side of government and private facilities administrators on the side of Private side (10). SA is a formal contract established between the government and non-state provider that stipulates the roles and responsibilities of all parties involved in the contract, the types of health care services to be provided, how the contract will be financed, accountability and performance monitoring mechanisms with focus

on public health priorities (10,11,21,22). The most preferred areas that are included in the SA as public health priorities include the provision of health services for children under five, pregnant women, elderly and public goods (Immunization, Malaria, HIV/TB) (15).

On various occasions it was reported that the implementation of SA faces several challenges including inadequate fulfillment of roles and responsibilities by government and private partners as per SA. For instance, monitoring of the contractual relationship was not properly done and supervisions has remained erratic (10,11).

The 2017/18 SA between Ilala Municipal Council and Cardinal Rugambwa Mission Hospital consists of two major components that were assessed in this study. The first component is about the roles of the CRMH whereby the hospital is assigned the task of providing the maternal and child health services free of charge and some at reduced prices as per national guidelines (antenatal care, delivery and postnatal care services; and Prevention of Mother to Child Transmission of HIV (PMTCT)). The second component of the SA is about the roles of the Ilala Municipal council in which the municipal has been assigned several tasks, namely: conducting quarterly supportive supervision to the CRMH, sending quarterly 10% of the total Health Basket Fund received to the CRMH, conducting one SA review meeting annually as part of monitoring and evaluation, and deployment of seven health workers to CRMH that is three nurses, two laboratory technicians and two clinicians.

To our level of knowledge, there is no systematic study that that has been conducted to assess the opportunities and challenges of implementing SA in various areas of Tanzania including Ilala municipality. This study was an attempt to fill this gap.

Methodology

Study area

The study was conducted in CRMH in Ilala Municipality which is one among the five councils in Dar es Salaam region. The study setting was purposively selected because is one of the few municipalities in Tanzania where SA is implemented. It is located at the business center and official places. The Municipality hosts around 1,220,611 people (23) who spent their night in the council and more than 4,000,000 people during day time (business time). This large population needs health services and other services as well.

The local government cannot provide all the services needed on its own, hence needs to involve the Private sector. Therefore, the Municipal Council has to enter into SA with the Mission Hospital to support in the provision of health services. The hospital was selected because it is found in Ukonga ward with population of 80,034 people (23) but there is no

nearby public hospital and it takes three (3) hours to the nearest hospital (Amana Regional Referral Hospital).

Study design

A case study approach was employed in this study whereby the Service Agreement between Ilala Municipal council and RMH was regarded as a case for this study for exploring in detail and getting deeper understanding about the implementation of SA. Case study design was found adequate to this study because opportunities and challenges facing the implementation of SA are not linear and some are embedded in social, political and economic factors (24).

Sample size and sampling procedures

A total of 23 respondents were involved in this study including 6 District health managers, 2 Council Health Service Board (CHSB) members, 5 Hospital Management Team members and 3 health workers from the hospital. On patients' population, we interviewed a total of 7 patients who were interviewed after receiving health services and the information saturation was reached at the 7th respondent.

All study participants were purposively selected because they are knowledgeable and experienced people in the implementation of SA (24). The Council Health Service Board members, Hospital Management Team members and District Health managers were purposively selected for Key Informant interview (KII) due to the roles they play in implementation of SA. We also used convenient sampling to select patients receiving health services at the hospital during data collection days due to ease accessibility (25). The participants were obtained after they had received health service.

Data collection methods

In exploring opportunities and challenges of the implementation of SA, we used in-depth interviews with key informants including Council Health Service Board members, Hospital Management Team members, District Health managers and a few patients. Interview guide was developed to guide collection of primary data. The questions included in the interview guides were framed around two themes originating from the study objectives. First was on opportunities of implementing SA and second was on the challenges of implementing SA.

Data analysis

A thematic analysis approach was used in analyzing the data. The analysis was carried out in three stages as recommended by Virginia Braun and Victoria Clarke (26):- first, the line-by-

line coding of field notes and transcripts; second, the in-depth examination and interpretation of the resultant codes and their categorization into descriptive and analytical themes; and third, the development of an overarching theme.

Results

Characteristics of the respondents

The study interviewed 23 Respondents who were categorized into three categories; the first category included eight (8) district health managers; the second category included eight (8) facility health care workers the last group included seven (7) patients.

The majorities (74%) of respondents were female and 83 % of respondents' ages were above 40 years and 17% were below 40 years. The level of education of respondents varied between patients who had mostly primary and secondary education levels while the district Health managers and hospital care workers had college or university education level.

The results are presented in two main themes, the first theme is on the opportunities of implementing SA, which has eight sub themes, namely: presence of policies and guidelines for implementing SA, patients receiving services at reduced cost and some at free cost, presence of supportive supervision and workers' involvement in trainings and mentorship, presence of SA review meetings, good PPP coordination, political support, trust of the hospital to suppliers and trust between the parties implementing SA. The second theme is on the challenges of implementing SA which has four sub-themes namely inadequate deployment of Human Resource for Health (HRH) by government to the hospital, inadequate fulfillment of government financial commitment to support to the hospital, lack of transport for conducting supportive supervision and donor dependency as summarized in Table 1**.**

Table 1: Summary of codes, subthemes and themes of the study

Codes	Subthemes	Themes
No cost, free services, free of charge reduced cost, reduced price, relief cost, covers cost, less costly, affordable cost/price	Patients receive some health services free of charges	Opportunities of Implementing SA
	Patients receive some health services at reduced prices	
Existence/presence of guidelines, guidance, Acts, policies, regulations, directives, rules	Existence of guideline and policies on SA	
Existence/ presence of supervision, supportive supervision, workers involvement, involvement in	Presence of supportive supervision	

the trainings, getting mentorship, accessing training, accessing mentorship, peer coaching	Workers' involvement in trainings and mentorship	
Presence/existence of review meetings, Service agreement, evaluation meetings, appraisal meetings	Service Agreement review meetings	
Trust, suppliers, hospital, trust of hospital, trust of suppliers, trust of each other	Trust of hospital to suppliers	
	Trust between parties	
Existence/ presence, well organized, good coordination, good coordinator, availability of good coordination	Presence of good coordination	
Local political support, political party, Councilor, support, working together, political leaders	Existence of political support	
Inadequate deployment, inadequate human resources for health, inadequate health workers to the hospital, not employed	Inadequate deployment of Human Resources for Health to the hospital by the government	Challenges of implementing Service Agreement
Inadequate fulfillment, not sending, not implementing financial commitments, inadequate funding	Inadequate fulfillment of the government financial commitment to support the hospital	
Lack of transport, lack of means of transport, lack of fuel, lack of vehicles, inadequate vehicles, inadequate transport, supervision transport, missing transport	Lack of transport for conducting supportive supervision	
Depends on donors, donors' support, outsides' support, external support, externally funded and donor funded, not our own funds, inadequate internal funding, stakeholders' support.	Donor dependency	

The opportunities of implementing Service Agreement in the hospital

Patients receive some health services free of charge

Interviewed patients and health workers at the hospital reported that there are a number of health services that are currently provided free of charges. These include: weighing of children, assessment of children, provision of health education, vaccination services, Ant malaria (SP) also known as IPT, drugs for deworming, Ferrous and Folic Acid (FEFO), HIV

test, opening of Cards and pregnancy assessment. All these services are provided at the Reproductive Child Health (RCH) clinic as one respondent said,

> *"… I came here when I was pregnant, a number of services were provided free. These included: health education, assessments of pregnancy, deworming drugs and many other services" (IDINo.04).*

Patients receive some health services at reduced prices

Interviewed patients and health workers at the hospital reported that there are number of health services that are currently provided at reduced prices. These include: test for hemoglobin and delivery services. For instance, delivery services are provided at reduced price of Tanzania's' Shilling 50,000/= equivalent to 25 USD instead of 100,000/= equivalent to 50 USD per one normal delivery. Cesarean section costs 100,000/= equivalent to 50 USD instead of 200000/= equivalent to 100 USD per delivery. HB is charged at reduced price of 2000/= equivalent to 0.8 USD instead of 4000/= equivalent to 1.6 USD per test. One of the respondents reported,

> *"During delivery I could not deliver normally so I undergone Hemoglobin check-up for 2000/= and then after that I delivered by cesarean section which costed only 100,000/= instead of 200,000/= and it was cheap compared to other private facilities for the same services I got here" (IDI No.03).*

Existence of guidelines and policies on SA

The interviewed study participants reported that the implementation of SA is possible because it is enabled and facilitated by national policies and guidelines. For instance, they mentioned that the presence of SA implementation policies and guidelines clearly state all the procedures for implementing SA at council levels. One respondent said,

> *"We are able to implement Service Agreement without any obstacle because it is directed by national guidelines and policies and not from me as Municipal Medical Officer; if it could be my directives, then we could have failed" (KI No. 15).*

Moreover, the interviewed members of the hospital management team and health workers reported that the partners who implement SA are also obliged to observe government guidelines that provides directives on how various health services including Reproductive and Child Health (RCH) services should be provided:

> *"We have government guideline related to provision of RCH services here. It guides us in how particular services need to be provided. We must and we are obliged to follow it as per SA" (KI No.02).*

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Health workers' involvement in trainings

Training is one way of making sure that services are provided at the required standards. Health care services do undergo changes in line with technological advancement and recommendations from research. Interviewed members of the hospital management team reported that after starting to implement SA the staff from the hospital are included in training and given updates of services provision by the CHMTs. Such trainings aim at ensuring that services are provided by skilled and updated health care workers. This was not the case before service agreement. This was remarked by one of the interviewed HMT members:

> *"We have seen Service Agreement to be beneficial to us because now days as the hospital leaders and workers are included in the trainings and given updates on changes regarding health services provision. This helps to motivate workers and improves the quality of services provided as agreed in the Contract" (KI No. 11).*

Supportive supervision and mentorships

Majority of interviewed District Health managers, members of the Hospital Management team and health care workers mentioned supportive supervision as an opportunity of implementing SA. Supportive supervision refers to a friendly and more supportive way that provides a room for learning whereby supervisor and supervisee assumes the same role of teaching and learning from each other on performing work in a right way as required. This was also evidenced by researchers from the hospital visitors' book whereby more than 17 Supportive Supervisions were recorded in the past twelve months. Five supportive supervisions were conducted in each quarter (first, second and third) of financial year 2018/2019. Only two supportive supervisions were conducted in the fourth quarter of financial year 2018/2019. Furthermore, respondents reported that Supportive supervisions and mentorships give opportunity for improving the quality of services provided. One of the respondents said:

> *"We are conducting supportive supervision quarterly, which is integrated supervision and not specific for SA. Most of the time it includes different departments such as RCH, Quality improvement, Laboratory services, Pharmacy, HIV and checking for HRH. It is very comprehensive which also includes the services agreed in SA"* (*KI No. 16*).

Service Agreement review meetings

Majority of the interviewed respondents reported that SA implementation is also monitored by the SA review meetings which are done once per year between district government officials and the Hospital management. The review meetings are used as a platform for both parties to monitor and evaluate the progress of the implementation of SA activities as well as discussing

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the challenges and solutions of implementing SA. It was reported that SA review meetings give parties an opportunity to report the progress as well as challenges of implementing SA. For example, one respondent had this to say:

> *"We call Cardinal Rugambwa Management members for review meetings every year and we also have long review meeting when the contract ends whereby, we as government party, we give feedback and informs them on some changes if any in the contract and they also get opportunity to give their opinions" (KI No. 19).*

Trust of the hospital to suppliers

The interviewed study participants reported that the Mission hospital is trusted by suppliers of various drugs and other medical supplies because it is owned by the religious organization. Given such trust, the hospital can take equipment, drugs or medical supplies and promise to pay later. Such arrangement contributes to smooth running of the hospital activities including provision of services as agreed in the SA. The findings show that the hospital is run by religious congregation which put it at advantageous position to be trusted by suppliers. One of the respondents said,

> *"We are church people, and we are trusted outside (suppliers) there even if we have not received Health Basket Fund for that quarter then we just ask them to supply us with commodities worth even over 30 million and we promise them to pay when we get fund from the Council…And when I get money, I pay them on time. This helps us in providing services as agreed in Service Agreement when funds have delayed" (KI No.09).*

Trust between parties in SA

The interviewed district health managers reported that they trust the data and reports from the hospital and also the hospital trusts the government through Municipal Council Medical Office. They claimed that this type of trust is good for having productive partnership as elaborated by one of the respondents below:

> "*Now we trust them, and they trust us, and we trust even the reports they are submitting to us. This is now very strong even they dare to report the bad things happening such as maternal deaths. For instance, last year the hospital reported two maternal deaths which was not the case before, that is because we told them that they will not be penalized when maternal deaths happen but when it happens, we need to organize a joint meeting to find out the causes and put measures of ensuring that it does not happen again" (KI No. 18).*

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Presence of good coordination

The interviewed study participants reported that the Municipal Council Medical Office has appointed a responsible person to coordinate all Private Health facilities in the council and is responsible for all matters related to SA as well as PPP in general. This was mentioned to be an opportunity in implementing SA in the council. One of the respondents expressed the following:

> *"The act of having PPP coordinator is also a factor which has helped us (the municipal council) and the Hospital to implement well the SA because he acts also as a channel of communication among the two parties and other development partners who have interest in SA. When we miss transport for supportive supervision, he goes to APFHA and we are given a car to conduct supervision. He actually coordinates well everything related SA in the Council…" (KI No. 18).*

Existence of Political support

The majority of the interviewed Municipal Health Managers, Council Health Services Board and members of the Hospital Management Team acknowledged that they get full political support in the implementation of SA. This was seen as a major opportunity because politicians such as councilors have an influential power in making decision regarding any project or activity, which is being implemented at Local Government Authorities level. In this aspect, one respondent had the following remarks:

> *"The councilor of Ukonga area is very supportive in SA issues while holding talks with the Local Government officials for signing this SA and he has been supporting its implementation and actually he is a member of Hospital Governing Board. He is marketing and advocating our services to the public out there. He always asks about our services and if we face any challenge, he is there to support us. For me I think he has remarkable contribution in successfully implementation of SA in Ilala" (KI No 11).*

The challenges facing the implementation of SA in the hospital

Inadequate deployment of health workers to the hospital by the government

The interviewed respondents acknowledged that as part of the SA, the government agreed to deploy seven staff including three nurses, two laboratory technicians and two clinicians so as to increase the number of services provided by the hospital as well as improving the quality of services. However, by the time of undertaking this study, the government deployed only three staff including two laboratory technicians and one clinician. When commenting on the deployment of health workers, one respondent said:

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> *"We agreed that the government will deploy seven health care workers to the hospital in these three years of implementing SA including two laboratory technicians, three nurses, two clinicians, however, till now which is the end of third year we have received only one clinician and two laboratory technicians"* (*KI No.11).*

Inadequate fulfillment of the government's financial commitment to support the hospital

According to SA between the Council and the hospital, it was agreed the government has to send to CRMH 10% of total Council Health Basket Fund received for each quarter. However, the exact amount was not agreed due to its fluctuation tendency. The interviewed members of the Hospital Management Team reported that delay of funds caused many problems such as lack of smooth continuation of services because sometime the hospital delay in procuring medical supplies, delaying in paying salaries of workers and inadequate funds for administrative costs. One of the respondents said,

> *"The Health Basket Fund from the government is headache in the sense that it is not coming on time and quarterly as agreed …we are supposed to get ten percent of the total Council Health Basket Fund, but we do not know the exact amount since we do not know the total amount of basket funds for the council"* (*KI No.12).*

Lack of Transport for conducting supportive supervision

The interviewed study participants reported that the Municipal Council Medical Office has a big problem of transportation, and this has affected the implementation of SA as the District Health Managers fail to go for supervision to the hospital. The health department has a few vehicles which are not enough to carry out regular supportive supervision of all health facilities including the hospital. One of the respondents had the following remarks,

> *"As I have said earlier on, we have failed to go for supportive supervision because we have no transport for such visits as you know we have few vehicles and there are many ad hocks (emergencies) in this municipality. All these emergencies need transportation, and you cannot control them" (KI No. 18).*

Donor dependency

The interviewed study participants especially at district level reported that the Municipal Council Medical Office depends on resources from Association of Private Health Facilities in Tanzania (APHFTA) and development partners through Basket Fund for the implementation of SA. APHFTA is an association that nurture the private health facilities in Tanzania including

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signing service agreement and its implementation. Basket Fund is the main source of funds pooled from different development partners through the government channels and the fund is sent to LGAs for supporting health interventions in the council. The guidelines direct 10-15% of the total Basket fund received by a council to be used in those voluntary agency facilities operating under SA. The development partners support the LGAs by providing them with transportation, training and funds for the implementation of SA. If such support decreases and many development partners withdraw as is the case now or ceases to exist, then the implementation of SA will also stop. In support of this finding, one the respondents said,

> *"We understand that these funds are not ours we are just given by donors. We need to use them well, but we would like to acknowledge the support given by APHFTA. Without this association maybe we could not have SA in Ilala. They were the first to convince us and to talk to the Municipal Council on collaborating and signing SA. Even now they call us together and provide training in SA. If we have challenges related to implementation of SA, we feel that APHFTA 's office is our home"* (*KI NO. 01).*

Discussion

This paper aimed at understanding the opportunities and challenges for the implementation of Service Agreement between local government authorities and Mission hospital in Ilala Municipality, Dar es Salaam, Tanzania. Understanding the opportunities and challenges for the implementation of Service Agreement is important because it will help the policy makers and parties involved in Public Private Partnership to effectively utilize the identified opportunities as well as looking for solutions to address the identified challenges and ultimately implement sustainable SA.

From the study findings, it was found that there are a number of available opportunities for the implementation of SA. In one hand, the implementation of SA has created opportunity for vulnerable population such as women and children to access some of the health services free of charge while on the other hand, patients receive services at reduced prices as per SA. The evidence from this study has shown that the presence of guidelines in every point of service and prices posted on walls or notes boards is an indication that the hospital is providing services as agreed in SA.

This was similarly reported in a study done on Public and private maternal health service capacity and patient flows in southern Tanzania (22). This study reported that among six Faith Based hospitals, only two hospitals which operated under SA were not charging pregnant women when providing health services to them as agreed in the SA and the remaining four

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health facilities were charging pregnant women as they had not entered into SA with the government. This was different to the results reported by an evaluation study on SA conducted in China whereby barefoot doctors charged for services did not provide health services as agreed. Other studies done in Sub Saharan Africa reported that Faith Based Hospitals charged for the service supposed to be provided free due to constant delays in reimbursements from Government (10,11,27,28).

Supportive supervisions, trainings and mentorship

The study findings revealed that SA has provided an opportunity for health workers from the private health facility to access regular training, supervision and mentorship programs from the LGAs in general and Council Health Management Team in particular. This study found that Supportive supervision is regarded as a platform whereby the supervisors and supervisees are at the same level and are able to learn from each other. Supervision is regarded as a facilitating agent for effective provision of the health services and not for doing an inspection for the mistakes. Supervision was seen as an opportunity that could help to improve the implementation of SA since supportive supervision can be used to address challenges facing the implementation of the agreement; however, the supervisions were not conducted quarterly as planned due to inadequate means of transport and delays of money. However, the hospital can use the opportunity of being frequently supervised and mentored to improve the workers' capacities, hence improves the total quality of services provided. Similar findings were reported by other studies including a study on Contracting-out primary health care services in Tanzania towards UHC (18) and Boulenger who did a study in Sub Saharan Africa on contracting between FBOs and the Public Sector in Africa (11). Supervision of SA was identified to be weak, sometimes done by unskilled personnel and not done quaterly as planned. This was also reported in another study done in China on evaluation and mechanism for outcomes exploration of providing public health care in contract service in Rural China whereby the provincial governements were not conducting supervision as agreed (12).

This study found that the existence of guidelines and policies help to describe the procedures and ways that implementers of any plan need to follow in order to achieve certain results or outcomes of interest. This study found that the existence of guidelines and policies on the implementation of SA is an opportunity for provision of guidance and direction by the government on how to implement, monitor and evaluate the progress of SA. These results are different from a study done by Boulenger in Sub-Saharan Africa on contracting between FBOs and the Public Sector in Africa (3). It was reported that guidelines about SA and service provision in general were not found in Health facilities, which were implementing SA. This was

noted to affect mostly the peripherial facilities. Similarly Maluka reported that there was lack of guidelines and monitoring systems related to SA implementation in some of the health facilities in Tanzania (18), which indicate that even in Tanzania not all LGAs that have distributed the guidelines and policies to the health facilities that implement SA so as to guide them on how the SA should be implemented, monitored and evaluated. `

Gaining political support during the implementation of SA was seen as an important opportunity for facilitating effective implementation of PPP. In this study the political influence was first seen at the stage of discussing and approving the municipal council Health Plans including the implementation of SA and the Health Basket Fund as main source of financing SA in the local governments. The Councilors, who are decision makers at the local authority's level were also advocating and promoting the use of the Hospital in the provision of health services since they have seen the benefits of SA. The same results were reported by a study on Contracting Out Non-State Providers to Provide Primary Healthcare Services in Tanzania: Perceptions of Stakeholders (13). The study reported that there was political will of leaders to implement SA, however, they were not capacitated in implementing and monitoring it. Another study done on Health contracting experiences in Sub-Saharan Africa reported that the relations with the administrative authorities were cooler: there was a certain mistrust of "politics" due to a tendency of some individuals belonging to the administrative authorities to protect their own interests, particularly financial interests (29).

In this study the existence of good planning and coordination mechanisms was also reported as an important factor facilitating the implementation of SA. The study found that the appointment of PPP focal person to coordinate all issues related to Private Health facilities, the presence of Hospital plan submitted to Municipal Medical Officer and the presence of special committee to supervise all private health facilities together have contributed to good implementation of SA in the Council. This implies that good coordination in PPP issues in a council provides an opportunity for successful implementation of SA. This was in agreement with the World Bank; PPP Reference guide on successful PPP Projects which documented that for any PPP project to be successful, good planning and coordination system is important (14).

Trust has been reported as an important factor facilitating the implementation of SA. For instance, the hospital has been well trusted by people to the extent that they can supply commodities or services expecting to be paid, later on. In this study, the hospital was seen to be trusted by suppliers of medical commodities even if the Health Basket Fund was delayed.

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This was one of the factors which made hospital to be able to provide services by having sufficient drugs and other medical supplies as agreed in SA. The same finding was reported by a study done in India (30) whereby the private practitioners were not ready to enter into SA with Indian Government as it could reduce the reputations and trust of their facilities, which indicates that trust is an important factor for the implementation of SA. Another study done in East and Southern Africa reported that in the relationship between Public and Private sectors the Church health services are much trusted by people due of community involvement, using a word of God in curing people (charity) and frequent contact with people while using signs of God's presence (28).

In addition, the trust that was built over time between key SA implementing parties was reported as one of the facilitating factors for the implementation of SA. Thus, trust has been a fundamental foundation for productive relationships during the implementation of SA. Similarly, the patients have also built trust in the hospital, and they regularly visit this facility to access health services. The results of this study are different from the results reported by a study done in China (12) which found that the patients mistrust the bare foot doctors who signed SA with Local provincial governments and preferred to go to higher government hospitals. Other two studies done in India (7,28) also reported mistrust between parties whereby government accused private for submitting forged data and being profit oriented, which resulted to private providers to withdraw from the Contracts. Other studies done in Sub Saharan Africa also reported mistrust between parties to affect negatively the implementation of SA (10,11). The reports submitted by another party could not be trusted by the other party and whatever is done by the other party is not trusted by the other partner. This situation posed difficulties in the implementation of SA between government and Private parties.

This study also reported a number of challenges facing the implementation of SA. Inadequate deployment of health workers from the government to the hospital was one of the barriers towards effective implementation of SA. It was noted that during the implementation of SA, the government through LGAs made a commitment to deploy health workers to the hospital so as to improve quality and number of services. However, the study found that the government has not fulfilled this commitment as agreed. For instance, the study findings revealed that the government deployed only three health care workers out of seven health care workers as agreed for the three years of implementation of SA. That is from government financial year 2015/16 to financial year 2018/19.

Similar findings were reported in a study done in Southern Regions-Tanzania; whereby HRH was found to affect both government and private health sectors (22). Other studies done in

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Sub-Saharan Africa on difficult relationships between government and Faith Based Organizations (27,29) reported similar results indicating that sharing of HRH is one of the difficult things in relationship between Government and Faith based organizations.

Inadequate fulfillment of the government's financial commitment has been reported as a challenge for achieving objectives of SA. The study found that funds are coming late or not coming at all for the whole quarter and when they come, they need to be used and finished before the end of the quarter. This situation partly affects the capacity of the hospital to provide health services as agreed. This was similarly reported in other studies done in Sub Saharan Countries (11,13,18,22,27,29) whereby government was unable to send funds on time as agreed on SA. This was also reported by a study on SA conducted in China whereby provincial government did not send money to barefoot doctors as agreed (12), thus affecting the effective implementation of SA as originally planned.

Transportation has been reported to be one of the things for smooth implementation of most of the health interventions. However, unreliable means of transport led to the failure of Municipal Health managers to conduct regular supervision to the hospital as planned in the supervision matrix, thus failure to regularly track the status of implementation of SA. Similar findings were reported in other studies done in Sub Saharan Countries (11,13,18,22,27,29) which showed that irregular flow of funds results to unavailability of fuel hence lack of transportation, which in turn affects implementation of SA due to government's partial fulfillment of financial commitment for conducting regular monitoring of the implementation of SA. This study has also revealed that the implementation of SA has been over dependent on donors. The support of APHFTA and development partners was a pivot in successful implementation of SA. The support was in terms of training, providing platforms for discussions about SA and transportation for supportive supervision. The implication of donor dependency is that the implementation of SA in the Council cannot be possible if the donors decide to withdraw their support. This endangers the sustainability of SA as a strategy for improving health service delivery. Other studies done in Sub Saharan Africa reported similar finding (11,18,22) whereby introduction and the implementation of SA were seen to be presided by development partners such as GIZ in Tanzania. This affected implementation of SA because when some partners withdraw, it reduces the amount of support and sometimes delays the disbursement of funds.

Conclusion

In summary, this study aimed at evaluating the opportunities and challenges of the implementation of SA between Ilala Municipal Council and the Mission hospital in Dar es

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Salaam, Tanzania. The study revealed that there are several opportunities following the implementation of SA, which include among others; Community members' access to affordable health services, supportive supervisions from the LGAs to the hospital, health workers of hospital are now getting access to the training and mentorship opportunities offered by the LGAs and good coordination of SA implementation, which ensure joint review meetings between LGAs and the hospital. However, the findings have indicated a few challenges affecting effective implementation of SA. The failure of the government to disburse funds on time and to deploy health workers to the Mission hospital as agreed has hindered smooth implementation of SA. Furthermore, it was revealed that the implementation of SA mainly depends on Health Basket Fund, which is donor dependent, thus not sustainable source of financing SA. The findings of this study have some policy implications. The central government through Ministry of Health and President's Office Regional Administration and Local Government should find additional, reliable and sustainable sources to fund the implementation of SAs as well as ensuring deployment of the service providers under SA is done as agreed. Furthermore, the government should ensure that reliable means of transport for the LGAs to conduct regular supervision visits on the implementation of SA are available.

Study limitations

A qualitative inquiry using key informant interviews is sometimes vulnerable to social desirability bias, resulting in some respondents particularly implementers of SA possibly over-reporting or underreporting the opportunities or challenges of implementation of SA. Bias was minimized through training research assistants to ensure neutrality and confidentiality as well as emphasizing that participant's responses would help in formulating strategies for sustainable implementation of SA in the country.

Ethical considerations

The study was approved by the Ethical Review Board of the Muhimbili University of Health and Allied Sciences (MUHAS). Permission to conduct the study was requested and granted by the office of Dar es Salaam Regional Administrative Secretary, the Ilala Municipal Executive Director through Municipal Medical Officer and the RMH authorities. Written consent was obtained from the participants before each interview. Participants were also informed that they could decline to be interviewed and those interviewed were free to end the interview at any point. Participants were not given any incentives to take part in the study. Confidentiality was observed throughout the study; no participant identifying information was

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recorded. Participants were informed about the objectives of the study and their participation was voluntary.

Authors' contributions

PL was involved in the planning of the study, data collection, analysis and interpretation, and preparation of the first draft of this manuscript. GF participated in the planning of the study, data collection and commented on the first and subsequent drafts of this manuscript. All authors read and approved the final manuscript.

List of abbreviations

CBOs	Community Based Organizations
CDH	Council Designated Hospital
CHMT	Council Health Management Team
CHSB	Council Health Services Board
FBOs	Faith Based Organizations
HIV	Human Immuno-Deficiency Virus
HMT	Hospital Management Team
LGAs	Local Government Authorities
M & E	Monitoring and Evaluation
MoH	Ministry of Health
NGOs	Non-Government Organizations
PPP	Public Private Partnership
SA	Service Agreement
TB	Tuberculosis
VA	Voluntary Agency
WHO	World Health Organization

References

1. Bouti K, Borki R. Public-Private Partnerships In Health. Int J Med Surg [Internet]. 2015;2(1):1–2. Available from: http://www.mbmj.org/index.php/ijms/article/view/66
2. Dalton-jez O, Harvey-rioux S, Barrows PD, Mcdonald PI, Supapol PA. Public Private Partnerships in Canadian Healthcare: A Case Study of the Brampton Civic Hospital Prepared for the Oecd March 2011 Professor Atipol Supapol Table of Contents Executive Summary. Sch Business, York Univ. 2011;V12(1):1–177.
3. Boulenger D, Odisee H, Keugoung B, Criel B. Contracting Experience. 2009;(January).
4. Bolleyer N. Intergovernmental Cooperation. Intergov Coop [Internet]. 2009; Available from: http://www.dos.ny.gov
5. Greve J, Coelho VSRP. Evaluating the impact of contracting out basic health care services in the state of São Paulo, Brazil. Health Policy Plan. 2017;32(7):923–33.
6. Roehrich JK, Lewis MA, George G. Are public-private partnerships a healthy option? A systematic literature review. Soc Sci Med [Internet]. 2014;113:110–9. Available from: http://dx.doi.org/10.1016/j.socscimed.2014.03.037
7. Sonalini K. Public-Private Partnerships in the Health Sector. The case of a National Health Insurance Scheme in India. 2016;
8. Dr. Kenneth M.K. Bengesi, Dr. Patricia Mwesiga and MTM. Research Report on Assessment of Public Private Partnership (PPP) in Transportation Infrastructure in Tanzani 2016;
9. Ngowi H. Public-Private Partnership (PPPs) in the Management of Municipalities in Tanzania – Issues and Lessons of Experience. African J Public Adm Manag. 2006;17(2):29–31.
10. Kentikelenis A. Structural adjustment and health: A conceptual framework and evidence on pathways. Soc Sci Med [Internet]. 2017;187(2):296–305. Available from: http://dx.doi.org/10.1016/j.socscimed.2017.02.021
11. Boulenger.D, Barten.F C. Contracting between Faith-Based Health Care Organizations and the Public Sector in Africa. Rev Faith Int Aff [Internet]. 2014;V12(1):21–9. Available from: http://dx.doi.org/10.1080/15570274.2013.876730
12. Zhou H, Zhang S, Zhang W, Wang F, Zhong Y, Gu L, et al. Evaluation and mechanism for outcomes exploration of providing public health care in contract service in Rural China: A multiple-case study with complex adaptive systems design. BMC Public Health. 2015;15(199):1–12.
13. Maluka S. Contracting Out Non-State Providers to Provide Primary Healthcare Services

in Tanzania: Perceptions of Stakeholders. Int J Heal Policy Manag [Internet]. 2018;7(10):910–8. Available from: https://doi.org/10.15171/ijhpm.2018.46

14. International Bank for Reconstruction and Development / The World Bank, Asian Development Bank and I-ADB. Public-Private Partnerships: Reference Guide. 2014;V2:1–216. Available from: www.pppnetwork.info and www.ppiaf.org
15. Felsinger K, Miranda J, Skilling H, Booth K, Areneta E, Birken MA, et al. Public-Private Partnership Handbook Acknowledgments. 2008;100. Available from: https://www.adb.org/sites/default/files/institutional-document/31484/public-private-partnership.pdf
16. Raman K. What is a Public Private Partnership (PPP)? 2015;(November 2014).
17. World Bank Group. Main Types of PPP. 2009;1(March):12–21.
18. Maluka S, Chitama D, Dungumaro E, Masawe C, Rao K, Shroff Z. Contracting-out primary health care services in Tanzania towards UHC : how policy processes and context influence policy design and implementation. 2018;1–13.
19. MoHCDGEC. The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016 - 2020). 2016;1–142. Available from: www.moh.go.tz
20. Grout P a. Private Delivery of Public Services. Cent Mark Public Organ [Internet]. 2009; Available from: http://www.ssrn.com/abstract=694582
21. Rog DJ, Copeland AP, White KM, Fowler FJ, Cooper H, Yin RK, et al. Case Study Research: Design and Methods. Fourth Edi. Leornard Bickman, Peabody College, Vanderbilt University, Nashville Debra J. Rog W, editor. Califonia: SAGE Publications Inc; 2009. 1–57 p.
22. Tabatabai P, Henke S, Sušac K, Kisanga OME, Baumgarten I, Kynast-wolf G, et al. Public and private maternal health service capacity and patient flows in southern Tanzania : using a geographic information system to link hospital and national census data Public and private maternal health service capacity geographic information system . 2014;9716.
23. The United Republic of Tanzania. 2012 Population and Housing Census: Population Distribution by Administrative Areas. 2013.
24. Creswell JW. Qualitative Inquiry & Research Design: Choosing Among Five Approaches. 2nd Ed. Robinson LCSKGDSJ, editor. Vol. 114, Sage Publications. Califonia: SAGE Publications Inc; 2007. 179–186 p.
25. Kothari.C.R. Research Methodology: Methods and Techniques. 2nd revise. Japur,India:

New Age International Publishers; 1990. 1–414 p.

26. Braun V. Using thematic analysis in psychology,Qualitative Research in Psychology. J Chem Inf Model [Internet]. 2013;3(2):77–101. Available from: http://dx.doi.org/10.1191/1478088706qp063oa
27. Green A, Shaw J, Dimmock F, Conn C. A shared mission? Changing relationships between government and church health services in Africa. Int J Health Plann Manage. 2002;17(4):333–53.
28. Ganguly P, Jehan K, Costa A De, Mavalankar D, Smith H. Considerations of private sector obstetricians on participation in the state led " Chiranjeevi Yojana " scheme to promote institutional delivery in Gujarat , India : a qualitative study. . BMC Pregnancy Childbirth. 2014;14(352):1–13.
29. Boulenger D, Criel B. The difficult relationship between faith-based health care organisations and the public sector in sub-Saharan Africa. Stud Heal Serv Organ Policy [Internet]. 2012;V29(29):1–236. Available from: https://www.medicusmundi.org/.../2012/...in.../2012-itm-mmi-boek-final.pdf
30. Hellowell M. Are public – private partnerships the future of healthcare delivery in sub-Saharan Africa ? Lessons from Lesotho. BMJ Glob Heal. 2019;4(10):1–6.