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List of acronyms and abbreviations

4CCP	4 Corners Cultural Project
ALMC	Arusha Lutheran Medical Centre
CAT	Core Administration Team
CCT	Christian Council of Tanzania
CMT	Core Management Team
COSTECH	Commission for Science and Technology
CSSC	Christian Social Services Commission
CTC	Care and treatment Centre
DMO	District Medical Officer
ELCT	Evangelical Lutheran Church of Tanzania
HIHS	Haydom Institute of Health Sciences
HLH	Haydom Lutheran Hospital
HLRH	Haydom Lutheran Referral Hospital
KMH	Kibanga Mission Hospital
MD	Medical Doctor
MDG	Millennium Development Goals
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NACTE	National Council for Technical Education
NGO	Non-Governmental Organisation
NIMR	National Institute for Medical Research
NRRH	Nkinga Regional Referral Hospital
NSSF	National Social Security Fund
OPD	Out-Patient Department
PSPF	Public Service Pension Fund
QIT	Quality Improvement Team
RCH	Reproductive and Child Health
RMO	Regional Medical Officer
RNE	Royal Norwegian Embassy
SDG	Sustainable Development Goals
SFRH	St. Francis Referral Hospital
SGRH	St. Gasper Referral Hospital
TB	Tuberculosis

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We are very thankful to the key officials consulted at the Diocese of Mbulu, the Christian Social Services Commission (CSSC) and the Royal Norwegian Embassy in Tanzania. Their perspectives and opinions were very useful in validating and enriching information collected from HLH and NCA.

We owe much to the coordinating team which was able to organize consultation meetings with key stakeholders on a short notice. In such regard, we are thankful to Mr Edmund Matotay from NCA Tanzania and Mr. Charles D. Laiser at HLH. We are also thankful to Dr. Emanuel Q. Nuwas for ensuring that we are always served with what we wanted including providing us with the information we wanted.

Executive summary

Haydom Lutheran Hospital (HLH) opened in 1955. HLH is owned by the Evangelical Lutheran Church of Tanzania (ELCT), Mbulu Synod, but for decades, HLH has relied primarily on financial support from the Norwegian government through the Ministry of Foreign Affairs. The support was until 2014 channeled through the Royal Norwegian Embassy (RNE) in Dar es Salaam. From 2015, the management of the fund was transferred to Norwegian Church Aid (NCA). The total grant from Norad under the current four-year agreement is NOK 56 million. The four-year program managed by NCA has focused on supporting HLH to gradually sustain itself through expanding its revenue base, with the aim of reducing HLH's dependency on a single donor (Norad) while maintaining the quality of services. HLH has committed to reducing overall budget dependence on Norwegian government grants from 47% in 2014 to 22% by 2018.

The Grant Agreement document stipulated that a program evaluation should be held no later than 1 June 2018. This program evaluation was commissioned by NCA. The objectives of the evaluation were to assess progress and deviations in relation to the main purpose of the main Grant Agreement (QZA-0178 TAN 15/0009); and to assess the role of NCA in supporting HLH, especially on the deliverables defined in the Sub-Project Agreement.

Quality of services

HLH has been able to maintain the quality of its services. It has a very solid reputation in the population and among government officials for offering services of a superior quality as compared to other hospitals in the region and beyond. Important steps to further improve the quality has been taken which have resulted in an advancement from level two to level four in the SafeCare accreditation system. Based on the SafeCare criteria, HLH is among the best performing Faith-based Hospitals and better than all government owned Regional Referral Hospitals. The hospital has continued to strengthen its Quality Improvement Team (QIT). The hospital is missing a proper performance indicator framework. Death rates and length of stay has been quite stable over the last years. A small increase in death rates from 2016 to 2017 can be due to external factors but also increased fees and other internal factors. The hospital continued to retain their qualified staff despite of challenges due to the decline in Norwegian support and uncertainty about government support.

The hospital has retained its original principles of serving the poor but has introduced some measures to compensate for reduced funding, including increased user fees in. The utilization of services does not seem to have been much affected but for a number of services the number of clients went down from 2016 to 2017. The management claims that this is due to improvements in surrounding health facilities, but it may also result at least in part from the increased fees and introduction of a pre-pay system.

Financial sustainability

The hospital has not been able to reach the goal of reducing the donor dependency on Norad to 22% by 2018. Over the last five years the dependency has been halved from approximately 60% to approximately 30% which is a commendable achievement. It has, however, come at the cost of large deficits for a number of consecutive years, reduced capital funds, and inability to invest in maintenance and renovation of the infrastructures. The situation is now very critical. To keep up the quality of the services and the ability to serve an equal number of clients the hospital will continue to rely on support from Norad and other external donors if they can be found. It is clear, however, that there are few donors – if any - who are willing to provide flexible core funding. The possibility of scaling up income generating activities is being considered, but it will take years before they can yield any profit. Anyhow, local business in a place such as Haydom is not likely to generate enough profit to become a substantial source of income. A further reduction of this donor dependency seems mainly to be in the hands of the government.

Institutionalization

The program period has been a phase of transition in several ways. In addition to reduced funding, the position of hospital director has successfully been transferred from a Norwegian to a local Tanzanian. In terms of institutionalization this a significant development as it strengthens local ownership. The management has been strengthened through various training activities organized by NCA and CSSC, supportive supervision by NCA, and the engagement of an advisor to the MMD by the Friends of Haydom. The various initiatives are appreciated and have allegedly resulted in better routines, a better distribution of responsibilities, and a better understanding of the roles and responsibilities of the management. There may be a need for a more continuous support from a person or an organization with specific competence in hospital management and priority setting in resource poor settings.

The Board has received training organized by NCA that allegedly have improved the member's understanding of the Board's role and focus. However, there is a need to reconsider the Board's composition in order to ensure sufficient capacity for strategic decision-making and defining long-term priorities and visions, and to respond more effectively to the needs of the management.

Advocacy

HLH's strategy for advocacy is laid out in project document and expanded and incorporated in annual work plans. HLH has been involved in a substantial number of advocacy activities. Visits of and meetings with key officials seem to have left a number of promises for improvement of the hospital such as increasing the number of health professionals, increasing the availability of medicines and supplies, and electrical supply to the hospital water source and water project. HLH has undeniably succeeded in building a stronger awareness of its existence and plight at

regional and national government level and HLH has been more successful than other hospitals in getting staff on government payrolls. Still, most of the promises are yet to be implemented.

Innovation

HLH has made a number of innovations. In collaboration with Laerdal Global Health, it has contributed to the development of a fetal heart monitor named Moyo, and a neonatal resuscitation bag mask. In terms of good and promising practices, HLH has many lessons to share in terms of offering medical services of quality that are timely, efficient and provided with respect for the patient. Some notable efforts have been made to share these lessons through training offered to facilities and hospitals in the district and the regions, receiving visiting doctors and nurses both from Tanzania and other countries, and through presentations in conferences.

The delivery of NCA

In collaboration with Diakonhjemmet Hospital in Oslo, NCA has provided training in leadership, governance, clinical pathways, team work and conflict management. In addition, NCA has given continuous supervision and mentoring and been an active partner in discussions with the management. Compared to the previous agreement, where HLH received support directly from the RNE, the partners agree that this is a much better setup. The support from NCA is much appreciated and has reportedly resulted in a number of improvements in budget control, fund raising activities, etc. However, NCA should consider involving a partner with more specific competence in medical and health management, which can adapt and contextualize the training and supervision to a hospital operating in a resource poor setting.

NCA has contributed to advocacy through facilitation of HLH networks and relations with a range of actors in Norway and the RNE, building relationships with the members of parliaments, and involvement in various strategic donor cultivation meetings and by engaging in dialogue with the hospital owner (ELCT Mbulu Diocese) on governance issues. They also do advocacy through the Interfaith Standing Committee and CSSC. For a faith-based hospital, NCA's position and network among religious institutions and organizations do seem to be a considerable asset. NCA has not been successful so far in identifying other donors that can contribute substantially to the hospital's budget, which must be understood in the light of the fact there are few actors internationally who provide support for running costs for hospitals. The main achievement in this area appears to be the improvement of proposals and routines for resource mobilization.

In terms of replication, NCA has through its network invited groups of midwives from South Sudan, Sudan and Ethiopia to come to HLH to learn from the way the hospital works, and they are reported to have been very impressed. NCA has also facilitated training provided by HLH on saving mothers and babies during delivery. Otherwise, NCA's contribution to innovation and replication seems to be modest.

Main recommendations

For NCA and Norad, the main recommendation is to continue funding the hospital at a level that should be *at least* as the same level as for the last year of the current agreement. It needs to be kept at this level for at least two years before further reductions to allow the materialization of alternative funding to fill the gap. A further reduction will force the hospital to cut expenses that are likely to seriously compromise the range and the quality of the services.

There is a critical need to develop a more concrete plan for how to further reduce dependency on Norwegian funds on a longer term based on an analysis of the hospital's functions, sources of income and national and international funding trends for the health sector. Efforts must continue to identify alternative funding sources, including donors who can sponsor equipment and infrastructure investments.

Other key recommendations

- The hospital should introduce performance indicators that will enable management to monitor performances and outcomes continuously.
- HLH and NCA should involve a partner with competency in health sector and hospital management in resource poor settings, including expertise in priority setting.
- NCA should continue capacitation of the management and the Board in collaboration with CSSC or any other relevant partners with required capacity.
- The composition and ToR of the Board need to change for the Board to become more effective, act more strategically, provide timely and relevant guidance to the management, and contribute actively to advocacy and resource mobilization. It should have fewer members and members with more relevant competence, better connections and networks and meet more frequently to be better informed.
- Income generating projects should be turned into separate and independent entities with their own qualified management. Expansion and modernization of the guest houses and a different use of land for farming should be considered.

Conclusion

HLH has reduced the dependency on Norwegian funding from 60% to 30% over a period of four to five years while maintaining the quality and the range of the services. Even if this has come at the cost of budget deficits and lacking investments in infrastructures and equipment, it is a major achievement. The four years period of support was understandably not enough to enable the Tanzanian governance team of the hospital to settle and create a foundation capable of maintaining the quality delivery of services and improve further while at the same time reducing substantially the dependency of Norwegian support. Improvements in the financial control systems and management routines and higher level of quality accreditation, are testimony to a positive development laying a solid foundation for further progress.

Introduction

Haydom Lutheran Hospital (HLH) opened in 1955 at the request of the Government of Tanzania. It was located in a poor, remote rural area of northern Tanzania, 300 km from Arusha, the nearest urban center. HLH is situated in the south-west corner of the Mbulu District, which is part of Manyara region. The initial capacity was 50 beds, and the hospital also offered primary health care. In 1963, the administration of the hospital was handed over to the local church, the Evangelical Lutheran Church of Tanzania (ELCT) Mbulu Synod. HLH became part of the Tanzanian central health plan in 1967. In 1983, EZE Germany funded an extension of the hospital facilities, including a laboratory and a pediatric ward.

Together with nine other faith-based hospitals, HLH became a referral hospital at regional level in 2010. The hospital's immediate catchment area is home to about one million people, while the secondary catchment area includes about three million people. The hospital provides services to patients referred from four regions (Manyara, Arusha, Singida and Simuyu).

Today, HLH has a total of 420 beds. The range of services have expanded over time and currently the hospital offers major clinical service like internal medicine, pediatrics, maternal and gynecology services, surgical service, diagnostics (radiology and laboratory), dental and eye services for both inpatients and outpatients, mental health and addiction treatment. Since 1972, the hospital has also been involved in outreach services and currently there are 26 outreach clinics. 21 are accessed by car and five by aircraft. There is also an Out-Patient Department for primary and specialized care at HLH. In terms of staffing, the total number of staff reached 612 in 2017.

HLH is more than a hospital as it runs several other projects such as agriculture and water projects and development projects such as 4 Corners Cultural Project (4CCP) and vocational training. It has a large workshop which serves the community in servicing infrastructure around the villages and particularly in improving roads. The hospital also encompasses Haydom Institute of Health Sciences (HIHS), which is training nurses and clinical and laboratory technicians and has full accreditation from National Council for Technical Education (NACTE). Furthermore, there is the Haydom Global Health Research Centre that is recognized by the National Institute for Medical Research (NIMR) and the Commission for Science and Technology (COSTECH) and partakes in several major research programs in the fields of mother and child health and tuberculosis.

The owner of HLH, ELCT Mbulu Diocese, owns one hospital, three health centres and one dispensary in Manyara and Arusha region.[1] The hospital's director is elected by the Diocese but reports to a board composed of 13-15 members with a variety of backgrounds and competencies. The chair of the board is the assistant Bishop of Mbulu Diocese.

[1] Nationally, ELCT owns 23 hospitals and more than 140 health centres and dispensaries.

For decades, HLH has relied primarily on financial support from the Norwegian government grant through the Ministry of Foreign Affairs. The support was until 2015 channeled through the Royal Norwegian Embassy (RNE) in Dar es Salaam. In 2011, the RNE funded 61% of the hospital's budget. The 2010-2014 agreement with RNE comprised a block grant to HLH amounting to NOK 88.6 million, including a NOK 13.6 million grant related to MDGs 4 and 5 (Maternal-Child Health).

From 2015, the management of the fund was transferred to NCA. The total grant from Norad under the current four-year agreement is NOK 56 million broken down as follows:

Table 1: Annual grant

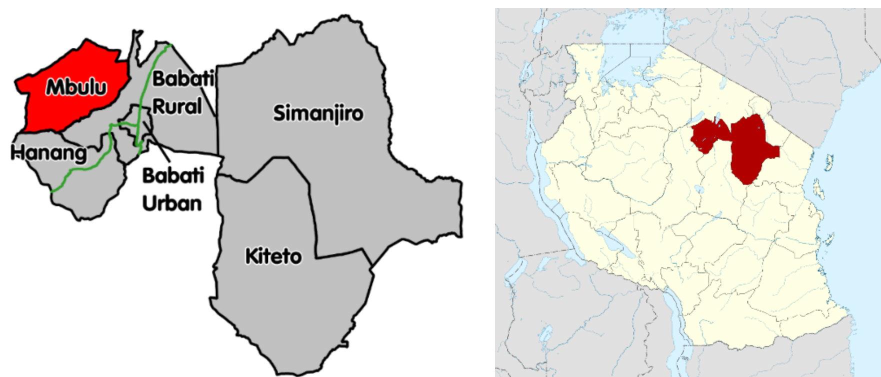
Year	Total Grant (NOK)
2015	16,953,000
2016	14,950,000
2017	13,243,000
2018	10,854,000
Total	**56,000,000**

This means that there has been a 36% reduction of the annual grant from 2015 to 2018. For the year 2016, NCA provided extra funding amounting to NOK 850,000 to help covering a deficit. NCA also gave NOK 200,000 in support of capacity building in 2015 and an additional NOK 600,000 yearly for the period 2016-2018.

The program has focused on supporting HLH to gradually sustain itself through expanding its revenue base, with the aim of reducing HLH's dependency on a single donor (GoN) while maintaining the quality of services. Under the overall project, HLH has committed to reducing overall budget dependence on Norwegian government grants from 47% in 2014 to 22% by 2018.

In the Grant Agreement document, it was stipulated that a program evaluation should be held no later than 1 June 2018. This program evaluation was commissioned by NCA. The objectives of this evaluation were to assess progress and deviations in relation to the main purpose of the main Grant Agreement (QZA-0178 TAN 15/0009); and to assess the role of NCA in supporting HLH, especially on the deliverables defined in the Sub-Project Agreement.

Figure 1: Map of Manyara region and its location in Tanzania



Progress on key outcomes demonstrated by HLH

The grant aimed at achieving the following outcomes (table 2).

TABLE 2: Expected Outcomes

Outcome Area	Expected results
Quality of service	Access to quality of services maintained and made directly measurable
Financial sustainability	Dependency on Norwegian public grant more than halved within the project period;
Institutionalization	Effective management of all available resources is embedded in the institution
Advocacy	Stakeholders are positively influenced to support HLH specifically and diaconal health facilities more broadly
Replicability	HLH innovations documented and shared for potential replicability

Quality of services

The quality of services has remained a key priority for HLH. The HLH Strategic Plan 2015 - 2019 provides a strong indication of the commitment of the hospital to maintain and strive further to improve the quality of the services. Observably, the hospital cleanliness and patient care is impressive. Patients are given attention and immediate response once they are in need. One of the admitted patients from Shinyanga Region, where both Bugando Zonal Hospital and several other referral hospitals are located, said that the quality of services provided at HLH is superior to several other hospitals in the country. A similar account was given by another admitted patient from the district headquarter, where the district hospital is located and there is easy access to

Arusha town where there is both a zonal hospital and a regional referral hospital. This is a good indication that the hospital is highly trusted and reputable for the quality of services it provides. Ex-pat visiting doctors and students serving at the hospital confirmed that the medical services have a high standard.

The quality of services is demonstrated by the attainment of level 4 SafeCare accreditation[2] in 2017. The hospital has advanced from level 2 in 2015, which is a promising progress toward the attainment of the highest level (level 5) (HLH Full year Narrative Report to NCA 2017). The key indicators for accreditation include: leadership process and accountability; educated, component and capable staff; safe environment for staff and patients; clinical care of patients and; improvement of quality and safety. Based on the SafeCare criteria, HLH is among the best performing Faith-based Hospitals and better than all government owned Regional Referral Hospitals (MOHCDGEC, Report on the Assessment of 13 Not-for-Profit/ Faith-based Hospitals, 2018).

The quality aspects were further substantiated with the District Medical Officer (DMO) and the Regional Medical Officer (RMO), who have acknowledged that HLH hospital provides better quality health services than all other hospital in the region. The RMO asserted that "HLH has qualified staff and advanced equipments, and we see that services are still improving".

High service quality at HLH has partly been achieved through the introduction of rigorous mechanisms to facilitate and control the quality of service delivery. As indicated in the strategic plan, the hospital has introduced daily, weekly, monthly, quarterly and annual monitoring and evaluation of organizational functions at all levels. This goes hand in hand with effective operationalisation of staff performance and appraisal systems. In view of the hospital technical management advisor, the hospital now produces quality reports that are easy to follow and understand for generating effective short and long-term actions for quality improvement of hospital services.

The hospital has continued to strengthen its Quality Improvement Team (QIT). The hospital has set a target for the QIT based on the baseline survey conducted in 2015 to ensure that 99 percent of clinical histories are taken correctly.

In terms of outcomes, the hospital operates with death rates and stay days as the main quality indicators (tables 3 and 4).

[2] SafeCare is part of the Pharm Access Foundation and has developed standards for different categories of healthcare providers in resource-restricted settings. SafeCare awards healthcare facilities with *Certificates of Improvement* reflecting the quality level, ranging from 1 (modest quality) to 5 (high quality). See: http://www.safe-care.org/

TABLE 3: Death rates at HLH

Outcomes	2015	2016	2017
Hospital death rate	5.98%	6.25%	8.58%
Maternal death *(per 100.000)*	240	206	227
Neonatal mortality rate	27.31%	13.37%	24.72%
Under 5 years mortality rate	12.49%	7.87%	14.36%
Above 5 years mortality rate	4.93%	5.97%	7.44%

TABLE 4: Average stay days per ward

Average Stay Days per ward	2015	2016	2017
Maternity Ward	2.34	3.21	3.13
Lena Ward	8.21	7.09	7.24
Old Ward	12.24	8.55	7.37
TB Ward	17.86	11.36	14.06
Surgical 1	7.7	8.22	8.75
Surgical 2	17.48	17.36	16.36
ICU	3.16	2.74	2.95

These figures indicate a rather stable performance but are difficult to interpret as they may depend to a large extent on external factors. The trend of increasing death rates from 2016 to 2017 is a worrying issue. It may be due to a change in the composition of the customers with a larger number coming with severe conditions. Staff claim that a larger part of complicated cases are being referred from other hospitals and clinics. But it may also be caused by patients delaying seeking care because of increased fees. More seriously, it could also result from overloads of patients, underperforming staff, equipment failures and erroneous use of medicine. However, this remains pure speculation. The anecdotal information obtained by the evaluation team does not allow to analyze the numbers further and merits further attention.

As indicated above, the hospital scores well in the SafeCare accreditation system. Yet, the hospital is missing a proper performance indicator framework. The SafeCare standards focus on infrastructure, systems and defined responsibilities but do not assess the outcomes. For instance, some of the missing indicators (such as infection rate, bed occupancy rate etc.) in the SafeCare assessment makes it difficult to establish impact of the systems improvement on the quality of services. A cost effectiveness analysis conducted by a consultant in February this year also highlighted the lack of performance measures. In Appendix 1, we provide an example of an extensive indicator framework that should be considered implemented fully or partially. HLH

states that a tool for a patient satisfaction survey was developed in 2017 and will be implemented in 2018.

Human resources

The ability of the hospital to maintain and enhance quality provision of health services is attributed to a long-term investment in and strategy for human resource development. In the presence of the general lack of health personnel in the country (National Human Resources for Health strategic Plan 2014-2019), HLH demonstrates an exception on the availability and retention of qualified health professionals. As indicated in table 5, the hospital continued to retain their qualified staff despite the challenges due to the decline in Norad support and uncertainty about government support. HLH is remotely located and it is a challenge to ensure sufficient supplies of highly qualified medical personnel like specialists, who are in high demand in urban health facilities. Yet, the availability of qualified staff is far better than for many other regional referral hospitals in the country. The strategy of recruiting local people and support them to get further training and specialisation elsewhere in Tanzania and abroad, has started to really pay off.

Currently, the hospital provides specialized services with seven specialists that include two General Surgeons, two Pediatricians, two Physicians and one Ophthalmologist (table 5). The hospital also receives super specialist from abroad and from Mohimbili National Hospital.

TABLE 5: Status of staff availability at HLH compared to the national standards for regional hospitals and to other related Faith-based Hospitals

SN	Cadre	Required		SFRH	NRRH	SGRH	KMH	HLRH	ALMC[3]
		Min	Max						
1	Specialist	21	24	12	6	4	0	7	15
2	Medical Officer	29	30	16	5	11	2	14	16
3	Assistant Medical Officers	22	23	10	4	1	3	7	4
4	Dental Surgeon	2	3	0	1	0	0	0	2
5	Clinical Officers			9	0	5	6	10	0
6	Assistant Dental Officer	3	4	1	0	0	0	0	0
7	Dental Therapist	2	4	1	0	1	0	2	1
8	Anesthesiologist	1	3	0	0	0	0	0	0

[3] ALMC - Arusha Lutheran Medical Center; HLRH - Haydom Lutheran Regional Hospital; NRRH - Nkinga Regional Referral Hospital; KMH - Kabanga Mission Hospital; SFRH - St. Francis Referral Hospital; SGRH - St. Gasper Referral Hospital.

9	Obstetrics & Gynecology	3	1	0	2	1	0	2	2
10	Occupational Therapist	1		0	0	0	0	0	0
11	Ophthalmologist	1	1	0	0	0	0	0	1
12	Optometrist	2	3	1	0	0	0	0	0
13	Paediatrician	1	2	0	1	1	0	1	2
14	Nursing Officer	30	37	2	1	3	0	19	1
15	Assistant Nursing Officer	77	131	63	36	45	0	173	30
16	Nurse	91	137	46	20	35	40	15	8
17	Health Laboratory Scientist	1	1	1	1	0	0	2	1
18	Health Laboratory Technologist	8	10	9	9	3	1	4	3
19	Assistant Health Laboratory Technologist	6	10	4	7	1	5	6	5
20	Dental Laboratory Technologist	2	4	0	0	0	1	0	0
21	Radiologist	1	1	0	0	0	0	0	0
22	Radiographer	1	4	3	3	0	0	3	5
23	Assistant Radiographer	2	3	0	0	1	1		0
24	Bio Medical Engineer	1	1	0	1	0	0	0	0
25	Bio Medical Technologist	1	2	1	1	0	0	0	0
26	Pharmacist	1	4	1	1			1	

Compared to the national standards, HLH still needs more specialists and medical officers. However, it is particularly when it comes to the numbers of nurses that there is a large gap. Whereas the national standard is 91, HLH has only 19 nurses. This seems to be compensated to some extent by a higher number of Assistant Nursing Officers (173 as compared to 77 according to the standard) but raises questions about the quality of the nursing services. In fact, an expat doctor said he thinks the doctors perform well but that there is more room for improvement in nursing services. Again, this calls for more developed performance measures.

HLH has more than hundred health personnel paid by the government through Public Private Partnership arrangements. This is the highest number when compared to many other Faith-based Hospital in the Country as will be indicated elsewhere in this report.

A strategic choice to recruit and develop staff from within the Haydom catchment area was based on an assumption that they are less likely to seek work elsewhere. As indicated in the HLH strategic plan 2015-2019 and substantiated by hospital management officials, the experience is that staff born in the surrounding Haydom area and supported by HLH to achieve further

education "have remained loyal even when they could find a job in one of the major cities of Tanzania or abroad".

Stagnant salary levels and few or no possibilities for promotion due to the economic situation will be a challenge for the motivation and morale of the staff. Due to the economic situation, 114 staff members were retrenched in April 2018 after lengthy considerations and consultations with the staff including the health workers' union (Tanzania Union of Government and Health Employees - TUGHE). Staff members who had to leave were mostly unqualified staff. Some of the staff members we met signaled fatigue and worries that the retrenchment of more than 100 colleagues will increase their work load to an unsupportable level. However, since the retrenchment was realized just before this evaluation found place, it was too early to assess any real effect on the quality of services or the work load.

The management reports a number of mutual benefits of the relation to the Institute for health science and their research program. On a longer term, the reduction in support to the hospital resulting in fewer staff may affect also the research activities by reducing the capacity of the staff to contribute to research activities. Also, the hospital will be less able to recruit those finishing their education.

To be a good employer for health professionals, the hospital has made a commitment to continue providing opportunities for advancement of staff; a good working environment with medical equipment, supplies and a well working electronic data management system; involvement of all staff in hospital decision making processes; clear definition of roles, and transparency in financial management.

Utilization of services

The hospital has continued to respect its diaconal foundation and to keep its original principles of serving the poor but has introduced some changes to help the hospital survive. The main changes are the introduction of pre-pay as opposed to post pay for the services for elective surgery and some diagnostic investigations and raised patient fees. As indicated in table 6, the use of services has remained by and large steady in the program period but with a decline in the utilization of most services from 2016 to 2017.

TABLE 6: Utilization of hospital services (number of patients)

Type of services	2015	2016	2017
Inpatients	12,992	14,020	12,635
Outpatients	77,747	105,044	103,173
Operating Theatre	5,111	5,776	4,693
Laboratory	336,773	360,577	293,062
RCH Mothers	35,162	28,140	26,723
RCH Children	92,284	91,154	84,070
Maternity ward	5,255	5,532	5,274
Lena Ward	2,000	2,223	2,130
Old Ward	1,919	2,357	2,089
TB Ward	504	653	762
Surgical 1 Ward	1,675	1,676	1,271
Surgical 2 Ward	788	673	871
ICU	822	882	796

The decline in the number of patients in many services can be associated with a combination of factors. While the management claims that this is due to improvements in surrounding health facilities including the district hospitals, it may also result from the increased fees (table 7) and the introduction of pre-pay at HLH.

TABLE 7: Fees before and after change of fee levels in 2016

OPD Consultation Charges 2016/2017		
Consultation and registration	**Old Fees 2014/2016**	**New Fees 2016/2017**
New registration	500	1,000
Consultation fees - CO's	2,000	3,000
Consultation fees - AMO's	2,000	3,000
Consultation fees - MD's	2,000	3,000
Consultation fees - Specialist	N/A	10,000

Both internal stakeholders and community members interviewed during this evaluation pointed out that community members in the HLH catchments area are very poor and that any increase of user fees is likely to have an effect on service utilization. Only a few percent of the population has a health insurance. This may cause people to go for traditional medicine or dispensaries,

which often delay them from receiving the right treatment in time, and which may contradict with the diaconal principle of helping the rural poor community. The population's ability to pay for services depends on external factors such as the weather and the success of harvest. In this regard a more detailed assessment of causes and effects of changes in utilization of services need to be done to support hospital decisions.

Infrastructure and equipment

The MOHCDGEC Report on the Assessment of 13 Not-for-Profit/ Faith-based Hospitals 2018 acknowledges the importance of infrastructure and equipment as key components in the delivery of services and observes that HLH's infrastructure and equipment are in good shape and well maintained. Nevertheless, HLH infrastructure and much of the equipment are too old and increasingly inadequate to commensurate with new demands of the time. In some cases, the spaces available are not according to the standards. We observed that some inpatients were placed in the corridor because of the limited space in the ward. A matter of great concern is that the hospital CT diagnostic machine is out of service and cannot be repaired because it is too old to get spare parts.

The hospital is planning to develop a blueprint of a new hospital building as approved by the Board in 2017. This will be a step towards mobilizing resources for the construction of the building-which will help the hospital to create a conducive working environment and enable to acquire the status as a zonal hospital. In view of the HLH management and consulted government officials, the acquisition of a zonal hospital status will provide HLH more opportunities for support from the government and other stakeholders and hence greater ability to provide more quality health services, as well as reduce further the dependency on support from the GoN.

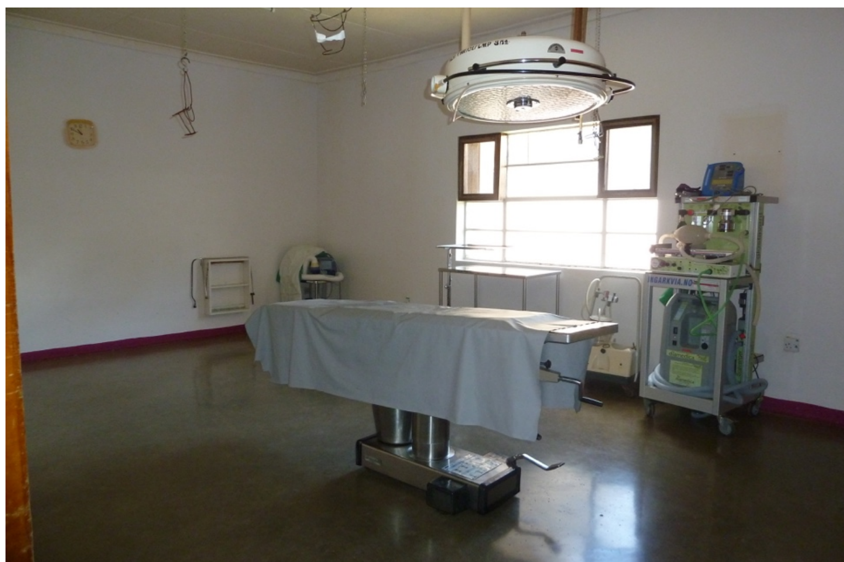


Photo: HLH operating theatre

In sum, the available information indicates that HLH has been able to maintain the quality of its services and in at least some aspects even improve it as demonstrated by the higher SafeCare rating. There are, however, a number of important challenges that need to be addressed in a short, medium and long term: old infrastructures and lack of adequate spaces, outdated or broken equipment, stagnant salaries and increasing work load for the staff are among the factors that can affect the quality of health services. Some worrying numbers merits further analysis, including a decrease in the number of patients and increased death rates from 2016 to 2017.

Financial sustainability

According to the project document, the dependence on funding from the Norwegian government decreased from around 60% to less than 50% in 2014. The sub-project HLH-NCA agreement 2015-2018 provides the intention to further reduce single donor dependency from 47% in 2014 to 22% by 2018. The main sources of revenue for running the hospital can be categorized into four main groups: Norwegian grant through NCA, User fees, Government Support and other incomes (table 8).

TABLE 8: Sources of revenue for 2015, 2016 and 2017

Name of the source	% Contribution to the Budget in 2015	% Contribution to the Budget in 2016	% Contribution to the Budget in 2017
User Fee (Medical service Income)	23.36%	27.86%	32.50%
Farm income	2.14%	1.66%	1.82%
Guest House income	2.39%	2.44%	2.03%
Machines Hiring income	2.14%	2.04%	2.07%
Fund Raising Income	1.61%	0.33%	1.13%
Friends of Haydom - Norway	0.96%	1.25%	0.24%
Research Overhead for HLH	0.93%	0.79%	1.37%
Mulbadaw Farm contribution	1.28%	0.00%	0.00%
Staff Canteen	1.29%	1.48%	0.00%
Inkind Donations/gifts	0.13%	0.16%	1.72%
Other non-medical services	1.14%	1.48%	2.53%
PEPFAR Income (Aids Relief)	0.55%	0.21%	0.00%
Financial (Exchange gain, Interests)	6.35%	4.11%	4.94%
NORAD/NCA Grant Contribution	38.72%	38.03%	30.61%
GoT Support	17.02%	18.17%	19.04%
Total	**100.00%**	**100.00%**	**100.00%**

In 2015, Norwegian Grant through NCA supported the HLH total budget by 38.72% (Tsh. 3,929,850,000/=). And the Tanzania government support increased to 17% (Tsh. 1,727,064,000/=) as compared to 14% (Tsh. 1,212,712,000/=) which was received in 2014. The increase of government support enabled the hospital to offset some of the deficit that otherwise would have been caused by the reduced Norad support.

In 2016, the decrease of support from Norad was significantly felt because other expected sources of budget support did not yield as were expected (table 9). The HLH narrative report for 2016 indicates that the hospital had to adjust its plan to offset the deficit of about 800 Million Tanzanian Shillings. The deficit resulted from a combination of shrinking of Norwegian grants and less government support than expected. Some of the consequences were no increase in salaries, very little spending in maintenance of infrastructure, no recruitment of new staff and much reliance on seconded or remunerated staff by the government. The report further states that the hospital was able to save 1.5% on medicines and medical supplies and 4.5% on salaries, allowances and wages. According to NCA Full year Narrative Report 2016, the cutting down of activities and efficient financial utilization and management, enabled the hospital reduce expenditures by 8%. Without these savings the deficit would have been 8% rather than 1,2%. As of the second half of 2016, several fund proposals were expected to be submitted but this work was delayed when the fundraiser resigned from his job from October 2016.

In 2017, the total HLH revenue was 11,358,937,000 TZS including 275,683,000 TZS taken from the capital fund. The sub-total NORAD-NCA contribution was 3,392,446,000 TZS. According to the finance department the contributions from budget sources in 2017 were: Government 19%; Patients 32.5%; NCA 30.6%; other sources 13.4%. According to the financial statement, 2017 the net deficit due to less budget funding was Tsh. 622,664,000/=.

TABLE 9: Sources of funding, planned and actual amounts and percentages

Sources of Fund	2015		2016		2017	
	Planned (Tsh "000")	Actual (Tsh "000")	Planned (Tsh "000")	Actual (Tsh "000")	Planned (Tsh "000")	Actual (Tsh "000")
Norad Fund	4,255,272	3,929,850	4,010,339	3,897,412	3,394,506	3,392,446
	40%	38.72%	34.23%	38.03%	29.35%	30.61%
Government Support	1,703,311	1,727,064	2,378,500	1,861,479	2,140,000	2,110,368
	16%	17.02%	20.30%	18.17%	18.50%	19.04%
Other Sources	4,766,487	4,493,026	5,328,249	4,488,393	6,030,931	5,580,440
	44%	44.27%	45.47%	43.80%	52.15%	50.35%
Total	**10,725,070**	**10,149,940**	**11,717,088**	**10,247,284**	**11,565,437**	**11,083,254**

As discussed above, a measure introduced during the second half of 2016 was an increase in patient fees. From 2016 to 2017, the total income from patients increased from 2.9 Billion to 3.6 Billion TZS (see Table below) and increase of 26%. The patient income as a percentage of total income was 28% in 2016, compared to the 23% in 2015. This increase in the share of total income of 5% was 2 percent points higher than the defined target. According to respondents from the finance departments, user fee contribution to the hospital budget is projected to rise to 4.1 Billion in 2018. It should be noted that the people living in the hospital's catchment area are mainly small-scale farmers who are very sensitive to changes in costs such as increased fees. Table 10 shows specific increases and overall contribution of patient's fee to the hospital budget between 2016 and 2017.

TABLE 10: Percentage contribution of patients' fee to the hospital budget between 2016 and 2017

Category of patient revenue	2017 Amount (TZS)	Percentage	2016 Amount (TZS)	Percentage
Cash patients	2,262,337,600	62.8%	1,910,104,612	66.9%
NHIF	898,766,950	25.0%	561,610,652	19.7%
NSSF	12,127,500	0.3%	15,487,500	0.5%
iCHF	92,230,099	5.3%	97,118,933	3.4%
Poor patient fund	38,993,470	1.1%	19,382,125	0.7%
Ambulance income	79,053,506	2.2%	109,756,160	3.8%
Patients paying in installments	118,616,198	3.3%	141,015,475	4.9%
Total	**3,602,125,323**	**100%**	**2,854,475,457**	**100%**

An overall analysis of the budget and expenditure indicates that the accumulated deficit for the 2015-2017 period should be approximately 1.492 billion TZS. Consequently, such deficit forced the hospital to cut down planned activities by 24% in 2017 (Full year Narrative Report to NCA, 2017). According to the HLH director some of the activities that were not implemented did not have an effect on the quality of services provided. It is, however, not clear which activities were cut and how they were selected.

The accumulated deficit after the two first months of 2018 was 411,145,047 TZS (budgeted deficit 93,5 million). The total expenditure was 56 million lower than budget, indicating that efforts have been made to reduce spending but that much remains to be done to have a budget in balance. So far, in 2018, 1 billion TZS has been borrowed from the hospital's reserve account to compensate the liquidity situation of the hospital. The remaining reserve is 1 billion TZS and may

have to be used later this year. The first phase of retrenchment of 112 staff appears to provide some relief to the growing budget deficit. It is estimated that with this first phase that was implemented by the end of March 2018, the hospital will save about 200 Million TZS; this amount is expected to rise up to 400 million Tanzania shillings, when the second phase is implemented in 2019.

The evaluation team has not been able to assess the cost levels of the various departments. However, we do think there is a need to reconsider which services the hospital should provide given the difficult financial situation. One may argue that services that are outside the core activities for a regional level hospital should be financially sustainable on its own. This would mean to increase substantially the user fees to a level where they cover all related costs. This could be the case for example for the department for mental health. The quality of the services would need to be of a quality that will attract patients with ability to pay from the whole of Tanzania and even from abroad. It can then also be a resource center that can assist other hospitals in developing similar services. In talks with the evaluation team, ideas about developing more exclusive services for patients with ability to pay for them, i.e. private rooms with a higher standard, has been discussed. Apparently, there is a market for this and Haydom's solid reputation can make it possible to attract customers from far away. It would require, however, important investments to renovate and expand the aging infrastructure.

Given the economic situation the hospital is confronted with a fundamental question whether to continue relying heavily on an external donor to be able to provide services at prices that are acceptable for the local population or to raise user fees to reduce dependency. In order to develop plans and strategies for which services to offer and develop, priority setting expertise should be involved. As has been reported in studies, hospitals and regional health authorities must set priorities in the face of resource constraints. Little has been reported from the perspective of Board members and senior managers about what criteria, processes and parameters of success they would use to set priorities fairly.

Income generating activities

As can be seen in table 8 above, income generating activities such as farming, renting out machinery and guest houses contribute to a very small degree to the budget with little variation from year to year. It should be noted that the farm is a very unreliable source since much depends on the weather that has been unfavorable the last three years. Particularly the main crop which is maize have suffered from insufficient rain.

A process has been started to consider how to increase revenue from available sources. The development of these potential sources is still at an infant stage and it will most likely take years before they can contribute to the budget. Some are likely to face serious challenges in the future if deliberate effort is not made to improve the quality, the promotion and the branding of the products. However, being situated in a small town in a rural area that do not attract many

tourists, local business activities are not very likely to generate an income that can contribute substantially to cover running costs.

The potential for income generating activities was examined in detail by the Cost effectiveness report from February 2018. Here we would like to add a few minor points. It is important that any income generating project is organized as a separate unit with its own management. These activities should not distract or require any investment of time for the hospital management who anyway is not qualified to be business managers. Currently the development projects do not seem to represent a heavy load on hospital resources but still they may at times be a distraction requiring too much attention that takes the focus away from the teams' core responsibilities. Expanding the income generating activities will require to set up a separate mechanism like creating a business unit specifically designated to manage income generating programs.

When it comes to the farm land, which we understand is a sensitive topic for the community, one may consider using the land for production of consumer goods that would make sense for an institution promoting health. This could be bee keeping for healthy organic honey; nuts, herbs and spices with known health benefits; and lotions and other types of products for hygiene and body care. Such products could be branded to contribute to the promotion of the hospital and its services.

The effort to improve hospital revenue will involve setting aside some fund for investments to help improve income generating activities like the guest house. As Haydom town is growing, it is likely to attract potential investors in hotels and guest houses, but the hospital is well placed to be in front by expanding the number of beds and also offer accommodation of a higher quality. On a longer term this may contribute more to the hospital budget that it does today. There is confidence among internal stakeholders that if the available sources are strengthened (which in their views means increasing and extending support from NCA for some more years), the hospital may be able to generate more sources of fund.

In conclusion, the hospital has not been able to reach the goal of reducing the donor dependency on Norad/NCA to 22% by 2018. Over the last four to five years the dependency has been halved from approximately 60% to approximately 30% which is a commendable achievement. It has come at a cost of important deficits for a number of consecutive years, reduced capital funds and an inability to invest in maintenance and renovation of the infrastructures. All stakeholders are well aware that the situation is very critical. To keep up the quality of the services and the ability to serve an equal number of customers, the hospital will continue to rely on support from Norad and other external donors if they can be found. For the moment, a further reduction of this donor dependency seems mainly to be in the hands of the government.

Institutionalisation

The program period has been a phase of transition in several ways. In addition to reduced funding, the position of hospital director has successfully been transferred from a Norwegian to a local Tanzanian. In terms of institutionalization this a significant development as it strengthens local ownership and makes it clearer that HLH is neither owned nor managed by a Norwegian organisation. According to several sources, the new director was in a short span of time able to build up a true *team* of managers who previously suffered from a lack of direction. The positive achievement on hospital systems strengthening, despite all the unresolved issues and challenges, are largely attributed to the good leadership off the MMD. He is also acknowledged for his efforts to integrate the hospital more fully into the Tanzanian Health system. It should be noted that it took the owner of the hospital more than one and a half year to instate the current director after the previous (Norwegian) director retired, during which time he served as an Acting Director without a full mandate to start implementing the large changes required to meet the goals of the four-year plan.

The management has been strengthened through various training activities organized by NCA and CSSC, supportive supervision by NCA, and from the summer of 2017 the engagement of an advisor to the MMD by the Friends of Haydom. The Board has received training organized by NCA (see next chapter).

In 2016 training was facilitated by CSSC on General management, Leadership and Human Resource management, Safety and Quality and Financial Management. All senior and middle management including all heads and in-charges from all departments, units and wards participated. Training was conducted in two sessions (May and September). Similarly, in 2017, all senior and middle management participated in training facilitated by CSSC on General management, Leadership and Human Resource management, Safety and Quality and Financial Management. Moreover, middle level management training that is organized by NCA in collaboration with HLH was conducted in December 2017 that covered areas such as change management, customer care and relationship, human behavior at work and team building.

For the last six months, the MMD has been assisted by a Norwegian advisor recruited by the Friends of Haydom. The advisor has a business background and has no institutional links to the health sector or institutions providing leadership training. However, he has contributed to improvement of reporting routines and meeting efficiency. He has also assisted the management in getting a better overview and control of the financial situation through monthly economic reports. There has also been an improvement in quality and timeliness of reporting from departments. Thus, the health management capacity is used more effectively. He has stressed the need to improve time management through more efficient and less frequent meetings and the introduction of electronic meeting calendars that will prevent conflicting meetings and unforeseen cancellations.

An important change has been to make Heads of Departments more responsible and to enable them to make more autonomous decisions. This has led to more involvement of the lower cadres and other staff in decision making, planning and budgeting. Creating and empowering a middle layer of management is important to provide more room for the top management to focus on the more strategic aspects of the organization but it may be too early to see the full rewards of this strategy.

However, it is reasonable to believe that any outsider with a non-medical background may have a challenging task in motivating and supporting management team members to lead the process of change that the hospital requires. When such a person questions the basis for decisions and asks for more information and changes in procedures there is a chance it will be conceived as criticism from a person with little insight in the subject matter.

NCA contributed to bringing experts in hospital management from Diakonhjemmet in Oslo, which has been appreciated, but there is still a need for a more continuous support from a person or an organization with specific competence in hospital management and priority setting in resource poor settings.[4] Neither NCA nor the director's adviser sit with this competency. NCA's intention was that the consultant from Diakonhjemmet should have a more continued mentor function but this turned out to be more difficult than foreseen.

The management of the hospital is involved in managing projects besides health such as agriculture, guest house, machines repair and hiring, and water projects. This gives HLH special characteristics that need special attention. Though, the arrangement has worked for some-time, the new demands for improving quality and self-sustainability can seem overwhelming for a management team with limited skills on revenue generating activities (business) and fundraising. Separation of the two with proper linkages and terms seems to be viable at this juncture. Under the management of Diocese of Mbulu and Boards, it is likely to enable each management team to be more focused on fulfilling specific demands more effectively and efficiently. After all, each team will have more time to work for the designated role.

The Board has received training that allegedly have improved the member's understanding of the Board's role and focus. However, the Board meetings has reportedly been dominated by crisis management and discussions of minor issues as well as issues that are not under the Board's mandate. It is also reported that out of the 13-15 Board members, only the minority is normally taking an active part in the discussions.

[4] An example of an organization with such a competence is the Clinton Health Access Initiative (CHAI) that Norway has collaborated with in Tanzania, Ethiopia and Nigeria. CHAI contributed to the establishment of a Master program for hospital management in Ethiopia. See: Kebede, S., Mantopoulos, J., Ramanadhan, S., Cherlin, E., Gebeyehu, M., Lawson, R., & Bradley, E. H. (2012). Educating leaders in hospital management: a pre-post study in Ethiopian hospitals. Global public health, 7(2), 164-174.

There has reportedly been an improvement of the Board's composition in the sense that the members now have more varied backgrounds as compared to earlier when it was mainly local people without relevant experiences. However, there is a need to reconsider the Board's composition in order to have a group of people that is qualified to guide strategically an institution such as a hospital. The Board ought to be capable to think more strategically and on a longer term in relation to the difficult economic situation and to respond more effectively to the needs of the management. One may consider bringing in for example a health economist, an IT expert and a legal expert. Board members should also be able to take a more active part in advocacy and resource mobilization through their networks. Particularly given the ambition to become a zonal hospital, the hospital management must be able to use the Board more effectively.

We highlight and support three of the recommendations of the Cost Effectiveness Analysis report:

1) The Board need to have a mix of professionals such as economics and finance/accounting/audit.
2) Need to meet more frequently – two times a year meeting is not effective of the oversight of the HLH activities.
3) The Board should be looking at the sustainability of the hospital - for the past 3 years there is no substantial investment.

It is suggested that the Board should meet at least four times per year and to reduce the number of members. An argument against more frequent meetings has been the cost dimension. With fewer members (6-8) it will be less costly to cover transport and accommodation.

The diocese of Mbulu plays a key role in overseeing and supporting the management in running the hospital. The chairman of the HLH board is the Deputy Bishop who provides an important link between the hospital management and the Diocese. According to the Bishop, apart from having access to the report of the Board, the hospital management is visiting the Diocese headquarter from time to time to inform about important updates and share the hospital challenges. On their side, the Diocese management visits the hospital to see the challenges and discuss how to address them. In January of every year there is "Haydom Day" where all churches within Dioceses conduct a special collection to support HLH.

The Diocese management facilitates also linkages between HLH and top government officials and structures**.** In view of the Bishop sometime the Diocese Management conducts meetings with top level officials (e.g. Ministers, deputy ministers, permanent secretaries, directors, etc) to discuss the hospital issues. In some issues, the Diocese uses the CSSC which is the umbrella for all faith-based organizations to represent HLH in policy issues and other important matters that require government attention. It also conducts meeting with key officials at the region (e.g.

regional commissioners and Regional Secretariat) and district officials. The interaction between the government and Diocese on hospital issues are guided by the Memorandum of Understanding (MOU). The outcome of such interaction has contributed to more specialists and other practitioners being seconded from the government to HLH. According to the Bishop, the Diocese management remains committed to continue strengthening the relationship between the government and HLH for more support.

Advocacy

The narrative reports for 2015, 2016 and 2017 show that the hospital has been involved with a substantial number of advocacy activities. The reports indicate officials visit of key officials from governments of Tanzania and Norway and participation in forums to advocate about HLH. According to the 2017 narrative report:

> The advocacy efforts have been continuously enhanced towards GoT to increase its support through various meetings and forums at the hospital and outside the hospital. These efforts were collaboratively done with our partners NCA, CSSC, ELCT and Government. The fundraising functions enhanced, donor mapping and cultivations done by submitting various concept notes and proposals whereby some have stated to materialize especially on quality improvement projects. (p.4)

HLH has initiated, attended and conducted several meetings with policy makers and decision makers from district, region and ministry level including Minister for Health and his deputy, members of parliament of Manyara regions and also nearby regions including Singida. This has led to finalization of MoU that is awaiting signature. The meetings has been done in collaborations with partners like CSSC, NCA, ELCT Health Department and Government Officials.

According to MOH Report on assessment of faith-based hospitals, HLH was the best performing institution among regional hospitals as working closely with Government and it also managed to receive more resources form Government due to advocacy done by the hospital. The visits of key officials that were initiated by hospital management following meetings with those officials, are a sign of recognition. The meetings and visits seem to have left a number of promises for improvement of the hospital such as increasing health professionals, increasing medicine and supplies, electrical supply to the hospital water source and water project just to mention a few. HLH has undeniably succeeded in building a stronger awareness of its existence and plight at regional and national government level and HLH has been more successful than other hospitals in getting staff on government payrolls. Still, most of the promises are yet to be implemented.

Replicability

HLH has a number of innovations. On the technology side, they have in collaboration with Laerdal Global Health contributed to the development of a fetal heart monitor named Moyo. The monitor, which can be bought for USD 198, eases the work of the birth attendant without interrupting current routines by its ease of use and speed at detecting the fetal heart rate. It is now used and being introduced in a number of hospitals in Tanzania and Norway. HLH and Laerdal have also tested an Upright Resuscitator with PEEP (a self-inflating, manual and reusable bag-mask intended for newborns and infants who require respiratory support).

In 2016, the 12 steps method for adults' addiction treatment and Care 2X[5] was shared with visitors from two hospitals (Sengerema and Mvumi) who wanted to learn about Care 2X. In 2017, Nkinga Hospital in Tabora, Sengerema from Mwanza and Mvumi from Dodoma, and Baptist hospital from Kigoma all came to learn on various issues that include substance/alcohol abuse, mental health steps for adults and Care 2X.

In terms of good and promising practices, HLH has many lessons to share in terms of offering medical services of quality that are timely, efficient and provided with respect for the patient. As noted above, the hospital is widely recognized for offering better quality than found elsewhere. Some notable efforts have been made to share these lessons through training offered to facilities and hospitals in the district and the regions, receiving visiting doctors and nurses both from Tanzania and other countries, and through presentations in conferences with other health service deliverers. HLH has in its work plans every year a plan for replications by allowing and supporting their staff to attend the national and regional scientific forums and conferences where they present and also share innovations. Staff members have also contributed to publications in national and international journals. It is possible that even more can be done but a balance is needed to not affect the service delivery. Effective representation of HLH in the relevant ministerial structures and various health policy dialogues is likely to facilitate replication and policy influence.

[5] CARE 2x is an Integrated Hospital Information System including Surgery, Nursing, Outpatient, Wards, Labs, Pharmacy, Security, Admission, Schedulers, Repair, Communication and more. The Outpatient department of HLH is fully computerized and entirely "paperless" and in 2017 the hospital took further steps to integrate the system into the inpatient clinical routines more firmly.

The delivery of NCA

NCA was asked to take on the responsibility of fund manager by RNE who later transferred the contractual responsibility to Norad. According to the sub-project agreement, the NCA value-added to be brought to the project will be most relevant in these key focus areas:

a) Capacity Development in Diaconal Hospital Management, Leadership and Governance, as well as in strengthening the Internal Control Function.
b) Fundraising to reduce single donor dependency;
c) Replication of HLH health innovations,
d) Advocacy for faith-based hospitals as relevant and sustainable actors within the Tanzania health system, and to ensure the right to health for all citizens.

At the outset, NCA stressed that their area of competency was not health systems or hospital management but fund management and organizational capacity building. In fact, NCA has a health portfolio mostly supporting community-based activities but no experience with hospital or health service support. Accordingly, NCA's focus has been to strengthen the fund raising, financial systems and the management functions.

Capacity Development

In 2016, HLH management, in collaboration with NCA, organized two sessions of leadership training for 20 trainees in May and 17 trainees in October. A third session was given in March 2018 and the last one will be held in October this year. The training has been facilitated by staff from Diakonhjemmet Hospital in Oslo and a consultant who previously was the director of the same hospital. The training covered leadership, governance, clinical pathway, team work, change management and conflict management. The training was also attended by the CSSC trainers who are responsible for the training of the hospital's middle management in order to make sure that all trainings are interconnected.

In 2017 one session of management training was conducted by the consultants on managerial issues to senior and middle management team where 80% of the management team attended the trainings. Two sessions of training on change management was given to Owner, Board members and senior management by the consultant from Diakonhjemmet.

Members of the administration team express satisfaction with the training received. They claim it has been relevant and useful. Staff point out that the training has "opened the eyes" of the management and has helped it identify its weaknesses. The NCA is reportedly "on the back" of the management to ensure follow up and implementation of agreed steps to take.

However, the satisfaction seems to be even higher with the more continuous support offered by NCA. The way NCA has offered supportive mentoring and supervision through meetings and

discussions is highly appreciated. According to NCA, the mentorship and coaching has led to important improvements. One of them is the introduction of job descriptions.

CSSC agrees with NCA that the financial management and control systems have improved. According to staff in the Finance department, there is an improved understanding in the management, including at department level, for budget control, billing and spending. Before the medical management had a more limited focus on service delivery.

In some aspects, the outcome of the training may take time to materialize. The added value of the partnership is likely to increase with time as the staff will become able to use the skills and apply what they have learned.

The contributions of NCA, CSSC and the director's advisor seem to be complementary in the sense that they focus on different aspects and different parts of the management. CSSC focus on mid-level management and ensure that the staff is on board. It is not always clear to whom the various improvements can be attributed.

However, NCA should consider involving a partner with more specific competence in medical and health management, which can adapt and contextualize training and supervision to a hospital operating in a resource poor setting. There is a need for more continuous support of this kind than what has been possible for Diakonhjemmet to deliver. The need for competent and specialized support and guidance is exacerbated by the lack of sufficient competence to adequately deal with the problems facing HLH on the side of owner.

Strengthening of Hospital Governance

As pointed out in the previous section, NCA has contributed to strengthening the management. In addition, they have organized training sessions for the Board. The consultants only met the chair of the Board and one Board member and have limited information about to what the degree the Board members found the training useful. Various persons met claim that the Board now has a better understanding of its role and responsibilities. However, as pointed out above, a further professionalization of the Board will most likely require recomposing of the Board. As a faith-based organization NCA should be in a good position to discuss this issue with the Diocese and the owner.

Fundraising

In the 2016 narrative report it is stated that "The NCA and HLH have developed fundraising functions and employed fundraisers at HLH, NCA Dar es Salaam and NCA Norway are working together to realize a new donor to fund". NCA has not been successful so far in identifying other donors that can contribute substantially to the hospital's budget. It is clear, however, that there is a very limited range of actors internationally who may be interested in providing support for

running costs whereas there are more who may contribute in terms of equipment and infrastructure investments and support for research.[6] Possible donors include individuals and organizations in Norway and USA who are known to support health and research institutions, but again, substantial funding for running costs is not very likely to materialize. The Lutheran Hospital in Arusha has received support from a number of Lutheran Churches in the USA and this source may be worth exploring although there is little reason to expect large and long-term contributions.[7]

The main achievement under this area appears to be the improvement of proposals and routines for resource mobilization. NCA has thoroughly supported several single projects application to various donors

Replication

NCA has through its Global Reproductive Health program currently implemented in six African countries invited groups of midwives from South Sudan, Sudan and Ethiopia to come to HLH to be trained in maternal and newborn health in collaboration with trainers from Laerdal Global Health in Stavanger (using the mannequins Mama Natalie and Neo Natalie[8] developed by Laerdal). Otherwise, NCA's contribution seems to be modest.

In 2016, HLH participated in a joint NCA meeting in Nairobi on GBV and reproductive health where around 11 countries participated in a one-week long training. Practices on saving mothers and baby during delivery through simulation by using MamaNatalie and Neonatalie were shared. HLH staff received training in Gender Based Violence referral guidelines and got an introduction to clinical management of rape at Nairobi Women's Hospital.

Advocacy

As noted in the previous chapter, HLH is involved with many advocacy initiatives. For instance, the hospital management, Board, and CSSC in collaboration with NCA, had around 10 high level meetings in 2016 with Government of Tanzania and other key partners. NCA has as a policy not to engage directly in advocacy, but rather to engage and build the capacity of partners to engage in advocacy in their contexts. In the case of HLH, the Interfaith Standing Committee – representing all major faith communities in the country – is the main partner. Still NCA has initiated or been involved with a number of activities. NCA has contributed to advocacy through facilitation of HLH networks and relations with a range of actors in Norway and the RNE, building relationships with the members of parliaments, and involvement in various strategic

[6] For instance, Bill and Melinda Gates Foundation has supported a research project.
[7] Some information about the support to Arusha Lutheran Hospital is found here: https://www.trinitylc.org/page/show/231078-mission-tanzania.
[8] MamaNatalie is a birthing simulator produced by Laerdal Global Health that makes it easy to simulate very compelling simulations of normal to more complex birthing scenarios. MamaNatalie comes with NeoNatalie newborn simulator.

donor cultivation meetings and by engaging in dialogue with the hospital owner (ELCT Mbulu Diocese) on governance issues. NCA has not been in a position to influence national and local health policies and priorities for effective delivery of improved quality and access to health services in resource-poor areas of Tanzania. However, for a faith-based hospital such as HLH, NCA's position and network among religious institutions and organizations do seem to be a considerable asset.

In summary, the partnership with NCA is much appreciated by the management at HLH. Their contribution to the improvement of financial control and the better understanding of the management and the Board's roles and responsibility is noteworthy. As compared to the previous period when the funding came directly from RNE, NCA has been able to be much more present and involved in continuous supervision and mentoring. According to NCA, a considerable effort has been made to deliver and it has meant stretching the organizations resources. The lack of success so far in mobilizing alternative funding may to some extent be due to NCA's lack of experience and network from the health sector but is first of all an indication of a difficult funding environment for organizations and institutions who need flexible core support.

The relevance of the grant

The grant has been very relevant in helping HLH to implement its own Five-Year Strategic Plan (2015-2019). The major part of project documents were drawn from the hospital strategic five year plan. Without this grant, HLH would have been forced to put an end to a major part of the services offered. The flexibility of the funding arrangement has allowed HLH to spend the money on the activities the hospital finds is most important to uphold the services and implement its plans.

HLH strategy, government policies and external factors

The HLH strategy is fully in line with Tanzanian health authorities' priorities in terms of expanding the access to quality health services for poor, rural and marginalized populations. The government has acknowledged the relevance of the hospital by seconding a number of specialist doctors to the hospital and by putting an important number of other staff on the payroll of the district.

For three years, there have been consultations with the MoHCDGEC to establish a Memorandum of Understanding between the Government and the country's ten faith-based referral hospitals at regional level. That this has not come to a conclusion makes it unclear what these hospitals can expect in terms of financial support from the government.

Limitations

This was a rapid evaluation and the time was too short to examine in depth some important aspects of the management of the hospital. A hospital the size of HLH is a complex organization

and to evaluate its many parts and elements is a demanding task. Even though available information indicates that the hospital delivers services of a relatively high standard, we have not done a systematic assessment of the quality of the various departments. Other aspects that we did not examine closely are human resources management, the collaboration with the research and training units, cost-effectiveness, management of equipment and supplies, and the composition of the service package. This would require much more time and also more specialized competency.

As according to the terms of reference, the evaluation team has not assessed the achievements of the training institution or the research unit. They have an important role in terms of providing staff and creating a conducive work environment and career opportunities. The co-existence apparently benefits the three mutually. There may be, however, cost and human resources implications that ought to be assessed more thoroughly. Also, we did not examine in depth issues related to the HLH farm and the various development projects.

Another factor that we did not explore is the role of Friends of Haydom whose many valuable contributions do not always seem to be aligned with the hospital's priorities. Contributions should be integrated in the budget and be approved and coordinated by the management that is best placed to know what the needs are and how contributions can be of greatest value.

Manyara Regional Referral Hospital, Mbulu District Hospital and Primary health facilities within HLH catchment area have much influence on utilization of services at HLH. An assessment of these nearby health facilities is important for future planning of HLH but was beyond the scope of this evaluation.

Recommendations

Main recommendations

For NCA and Norad, the main recommendation is to continue funding the hospital at a level that should be *at least* as the same level as for the last year of the current agreement. It needs to be kept at this level for at least two years before further reductions to allow the materialization of alternative funding to fill the gap. A further reduction will force the hospital to cut expenses that are likely to seriously affect the range and the quality of the services.

There is a critical need to develop a more concrete plan for how to further reduce dependency on Norwegian funds based on an analysis of the hospital's functions, sources of income and national and international funding trends for the health sector. Efforts must continue to identify alternative funding sources, including donors who can sponsor equipment and infrastructure investments.

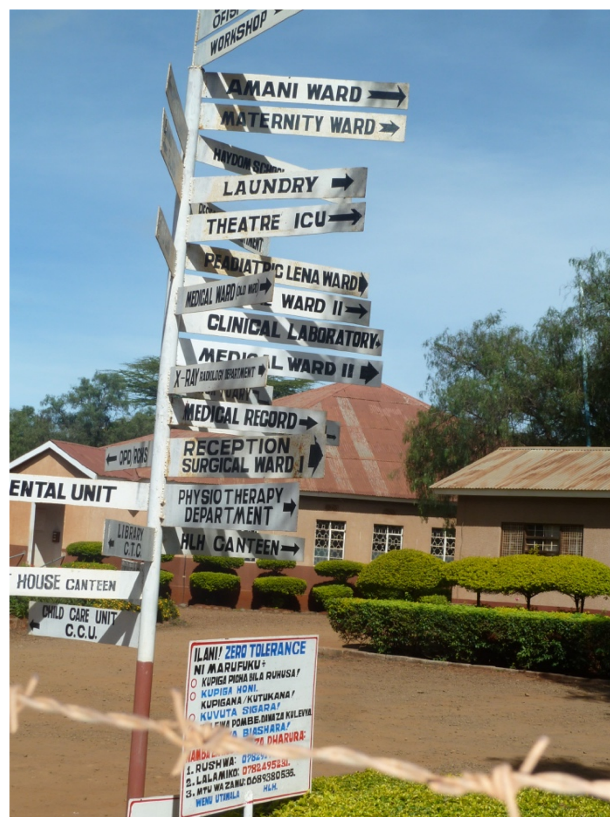
Other key recommendations

- The hospital should introduce performance indicators that will enable management to monitor performances and outcomes continuously.
- HLH and NCA should involve a partner with competency in health sector and hospital management in resource poor settings, including expertise in priority setting.
- NCA should continue capacitation of the management and the Board in collaboration with CSSC or any other relevant partners with required capacity.
- The composition and ToR of the Board need to change for the Board to become more effective, act more strategically, provide timely and relevant guidance to the management, and contribute actively to advocacy and resource mobilization. It should have fewer members and members with more relevant competence, better connections and networks and meet more frequently to be better informed.
- Income generating projects should be turned into separate and independent entities with their own qualified management. Expansion and modernization of the guest houses and a different use of land for farming should be considered.

Conclusion

HLH has reduced the dependency on Norwegian funding from around 50% to around 30% during the program period while maintaining the quality and the range of the services. Even if this has come at the cost of budget deficits and lacking investments in infrastructures and equipment, it is a major achievement. Improvements in the financial control systems and management routines and higher level of quality accreditation, are testimony to a positive development laying a solid foundation for further progress.

Special attention is needed to enable HLH to cope with demand of the time while building a strong foundation for the resources base. The new strategy requires a long-term support to help the hospital change the mindset on single donor support and develop a strong network that would enable them to stand on their own. A smooth transition from Norwegian to Tanzanian leadership and management of the hospital requires a long-term investment to build a foundation for self-governance of the hospital. The four years period of support was understandably not enough to enable the Tanzanian management team of the hospital to settle and create a foundation capable of maintaining the quality delivery of services and improve further while at the same time reducing substantially the dependency of Norwegian support.



Appendix

Appendix 1: Example of Performance Indicator Framework

BSC perspectives	Indicators		Indicators	
Finance (F)	F1	Ratio of total revenue to total costs	F6	Current cost per bed
	F2	% Deductions of hospital	F7	the ratio of capital expenditures to current costs
	F3	Average hospitalization expenditures	F8	the cost of drugs and materials
	F4	Average outpatient expenditures	F9	%Personnel costs of total costs
	F5	Average expenditures per bed per day	F10	Total fixed cost for per Bed occupancy
Internal Process (P)	P1	average Length of stay	P15	Wrong-site surgery
	P2	Bed Turnover Interval	P16	Leaving a foreign object during surgery
	P3	Bed occupancy	P17	Medication errors
	P4	bed turnover	P18	wrong in the type of blood group
	P5	Mortality rate	P19	Patient falls rate
	P6	Cancelled operations	P20	Hospital accidents prevalence rate
	P7	% Repeated surgeries	P21	Sentinel event rate
	P8	Discharge with Personal satisfaction	P22	Needlesticks and sharps injury
	P9	Hospital infection rate	P23	the legal complaint from a hospital
	P10	Clinical errors	P24	Doctors on-call at night
	P11	Readmission rate	P25	Waiting time for admission operation room
	P12	% Occupational accidents	P26	Mean Length of stay in emergency department
	P13	Pressure Ulcers rate	P27	Emergency Room (ER) waiting time
	P14	Medical errors	P28	Waiting time from triage to see doctor
Learning and Growth (G)	G1	Staff satisfaction rate	G6	the amount of the electronic medical record
	G2	Staff turnover	G7	number of days of sick leave to total employees ratio
	G3	Training expenditures per capita	G8	Employee absenteeism rate
	G4	key Jobs Contains substitute	G9	Rate of employee sick-leave
	G5	Average hours of Internet use		
Customer (C)	C1	The facilities for families and visitors	C4	Other Stakeholders satisfaction
	C2	Patients satisfaction percentage	C5	Social satisfaction
	C3	Rate of Patient complaints		

Source: Rahimi, H., Kavosi, Z., Shojaei, P., & Kharazmi, E. (2016). Key performance indicators in hospital based on balanced scorecard model. *Journal of Health Management and Informatics*, *4*(1), 17-24.

Appendix 2: Persons consulted

	Name of Participants	Position
1	Gweneth Berge	Country Director, NCA Tanzania
2	Theonata Mushi	Grant Manager, NCA Tanzania
3	Edmund Matotay	Senior Program Officer, NCA Tanzania
4	Kari Øyen	Regional Director, NCA Oslo
5	Haldis Karstad	Senior Adviser health, NCA Oslo
6	Britt Hilde Kjolas	Counsellor, Aid Administratio, RNE
7	Trygve Bendiksby	Head of Cooperation/ Deputy Head of Mission, RNE
8	Godlisten Lyimo	Program Manager Competent Centre. CSSC
9	Dr Josephine Balati	Director of Health Services, CSSC
10	Dr. Emanuel Q. Nuwass	Managing Medical Director, HLH
11	Timothy D. Burra	Head of Finance, HLH
12	Charles D. Laiser	Head of Fund Raising Unit, HLH
13	Emanuel Fabiano	Ass. Head of Finance, HLH
14	Clementina Dakay	Ass. Health Secretary, HLH
15	Sigbjørn Langvik	Management Advisor, HLH
16	Emmanuel Mighay	Quality Assurance officer, HLH
17	Elibariki Gabriel	Internal Audit Officer, HLH
18	Joseph Ndukusi	Hospital- Health Secretary, HLH
19	Dr Isaack Malleyeck	Doctor of Orthopaedic, HLH
20	Andrea Naman	Nurse Senior, In-charge of Outpatients Department, HLH
21	Dr. Museveni N. Justine	Acting Research Manager, HLH
22	William A. Mollam	Head of Department Pharmacy, HLH
23	Anania D. Tippe	Head of Department- clinical Laboratory, HLH
24	Dr. Igogo J. Alexander	Head of Surgical department, HLH
25	Dr. Yuda Munyaw	Head of Department for Obstetrics and Gynaecology, HLH

26	Ruth E. Mneney	Assistant Matron, HLH
27	Rehema D. Maramar	Assistant Reproductive and Child health In-charge, HLH
28	Jackson Tarmo	Finance Officer
29	Samson Andrew	Finance Officer
30	Dr. Paschal Mdoe	Deputy Hospital Director and Head of Research Unit, HLH
31	Theodotha Malisa	HLH Matron, HLH
32	Nicolaus Nsanganselu	Bishop, Diocese of Mbulu
33	Mr. John Nade	Deputy Bishop, Diocese of Mbulu, and Chairman of HLH Board
34	Batholomeo Magangi	Principal, Haydom Training Institute
35	Dr. Damas Kayera	Regional Medical Officer, Manyara Region
36	Joseph D. Fwoma	District Medical Officer, Mbulu District
37	Mr. Makani Emanueli	Patient from Shinyanga Region
38	Paskali Paulo John	Patient from Mbulu
39	Monika Zakaria	Health attendant, HLH, at Endagulda Village Outreach
40	Maria Anania Gitige	Nurse, HLH, at Endagulda Village (Outreach)
41	Michael Q. Sulle	Leader of TUGHE at HLH, Tanzania Union of Government and Health Employees (TUGHE)
42	Michael Panga	Community Representative, Haydom Town
43	Morten Skjørshammer	Consultant, Diakonhjemmet Hospital
44	Gunstein Instefjord	HLH Board member, representing Friends of Haydom
45	Jonas Rosenstok	Former head of fund raising, external relations and IT, HLH

Appendix 3: Terms of Reference

Evaluation of Agreement between Norwegian Church Aid and Norad for Financial Support to Haydom Lutheran Hospital (QZA-0178 TAN 15/0009)

1. BACKGROUND

Throughout the years, Haydom Lutheran Hospital (HLH) has received significant funding from the Government of Norway (GoN). From 2022 to 2014, the Royal Norwegian Embassy in Tanzania (RNE) has grant-managed GoN funds that amount to NOK 188 million. The 2010-2014 agreement with RNE comprised a block grant to HLH amounting to NOK 88.6 million, including NOK 13.6 million support to MDG 4 and 5 (Matneral-Child Health). Through these funds, the GoN has contributed to improved access to affordable health services in a marginalized area of Tanzania. In addition, a key component of the support was to reduce single donor dependency of GoN funding. Despite demonstrated progress from HLH, it was decided that it was necessary to provide a steady but responsible decrease in the amount of GoN funding to help the hospital reach the goal of long-term sustainability, while maintaining quality health services. The current grant, demonstrates the commitment of the GoN to help lay the foundation for this sustainability. Key features in the current grant are the shift of grant management from RNE to Norwegian Church Aid and, within the role of grant manager, the definition of a Sub-Project aimed at building HLH capacity in diaconal hospital management, fundraising, replication of HLH innovations and advocacy.

The above Grant Agreement has stipulated that a program evaluation shall be held not later than 1 June 2018. The agreement covers the period from 1 January 2015 – 31 December 2018. There are three key documents regulating deliverables - both of NCA as Grant Manager and of HLH as Grant Recipient.

- **NCA-Norad Grant Agreement -** stipulates that there are the grant manager/recipient responsibilities
- **The Memorandum of Understanding between NCA and HLH** formalizes that there are partnership commitments between the two organisations.
- **The Sub-Project Agreement** stipulates that there are specific NCA capacity building deliverables to HLH.

2. SCOPE OF THE EVALUATION:

2.1 The main focus of the evaluation will be to assess progress and deviations in relation to the main purpose of the main Grant Agreement (QZA-0178 TAN 15/0009). However, a main incentive for Norad/RNE in choosing NCA as grant manager was the assumption that NCA could have a unique added value for HLH, beyond the formalities of grant management. A secondary priority is therefore to assess the role of NCA in supporting HLH, especially on the deliverables defined in the Sub-Project Agreement.

The Grant Agreement states that HLH shall use the funding for the following main purpose/achievement of the following 5 outcomes:

a. ***Quality of service:*** *Access to quality of services maintained and made directly measurable*;
b. ***Financial sustainability***: *Dependency on Norwegian public grant more than halved within the project period;*
c. ***Institutionalisation***: *Effective management of all available resources is embedded in the institution;*
d. ***Advocacy:*** *Stakeholders are positively influenced to support HLH specifically and diaconal health facilities more broadly;*
e. ***Replicability:*** *HLH innovations documented and shared for potential replicability;*

It is assumed that achievements on these 5 outcome areas shall contribute to realization of main goals and objectives of the HLH 5-Year Strategic Plan.

2.2 The NCA - HLH Sub-Agreement defines how NCA value-added will be used to expand HLH capacity, specifies NCA competencies to be shared, and provides a resource framework for delivering on the focus areas for support. These focus areas are defined as NCA commitments in the MoU between NCA and HLH:

a. *Value-based Leadership Development*
b. *Facilitate capacity building for effective management of human and financial resources, including strengthening internal control functions;*
c. *Fundraising – Assist HLH to institutionalize fundraising*
d. *Give HLH access to NCA arenas for sharing health innovations for replication*
e. *Support policy advocacy for enabling environment for improved quality and access to health services in resource-poor/rural areas.*
f. *Strengthen HLH networks and cooperation with relevant resource partners in Dar es Salaam.*

3. MAIN EVALUATION QUESTIONS:

The evaluation will focus on the key questions:

a. To what extent has HLH demonstrated progress on the five key outcome areas, as specified in the Grant Agreement? Particular attention should be given to achievements and deviations as they relate to quality health service delivery and increased financial sustainability through reduced dependency on Norwegian public grants.
b. To what extent has NCA successfully delivered on the main focus areas for support as specified in the MoU/Sub-Project Agreement? What are the key achievements and deviations? NCAs added value?
c. To what extent has the NCA - NORAD Grant been relevant in helping HLH to implement its own Five-Year Strategic Plan (2015-2019)?
d. To what extent are HLH strategies for achieving longterm sustainability and quality health care in line with Tanzanian health authorities' priorities and plans? To what extent are assumptions about sustainability from increased government funding realistic, given actual implementation of national health policies? Assess the cost level compared to other healthcare institutions that are natural to compare with.
e. To what extent have HLH-NCA been able to influence national and local health policies and priorities for effective delivery of improved quality and access to health services in resource-poor areas of Tanzania? (e.g. MoUs and service agreements for government support of health personnel and provision of drugs)
f. To what extent have external factors assisted or impeded progress towards the key outcome areas of the Grant Agreement? (e.g. due to emerging political and/or health sector policy developments)

4. METHODOLOGY

The evaluation team are expected to use the following methodologies in carrying out the evaluation:

a) Review and analysis of key documents, including:
  - NCA – Norad Grant Agreement,
  - HLH Strategic Plan, 2015-2019,
  - HLH-NCA Memorandum of Understanding (2015-2019),
  - Sub-Project HLH-NCA Agreement 2015-2018,
  - Annual narrative and financial plans and reports,
  - Key documents on National, Regional and District Health Policies, Plans and Budgets, with particular focus on Service Agreements with faith-based hospitals,

new guidelines on hospital staff qualifications, policies on patient income and emerging policy on universal national health insurance.
- Other background documents identified to be relevant, e.g. regarding key developments in the Tanzanian Health Sector and the role and challenges of faith-based hospitals.

b) Face to face interview and focus group discussions with key stakeholder groups, including:
- Management and staff of HLH;
- Governing Board of HLH, including the hospital owner- ELCT Mbulu Diocese.
- HLH Auditors
- Relevant national, regional and district level health officials
- Technical support partners for capacity Christian Social Services Commission (CSSC) in Dar es Salaam and Diakonhjemmet Hospital in Oslo.
- Relevant staff and leadership from NCA in Oslo and Dar es Salaam,
- Relevant staff and leadership from RNE in Dar es Salaam,
- Relevant stakeholders in Norad.

c) Validation and feedback meetings with relevant stakeholders on preliminary findings and recommendations.

5. EVALUATION TEAM - ROLES AND RESPONSIBILITIES

The evaluation team will be comprised of two people as follows;
- Team Leader: An international consultant with competence on health systems and hospital management, African health systems, and expertise/experience in assessing value for money issues in health institutions. Evaluation methodology with a minimum five (5) year experience and knowledge about Norwegian development cooperation.
- Member: A Tanzanian consultant with expertise on the Tanzanian health systems and current policy developments, knowledge on FBOs health service delivery, evaluation expertise with a minimum of five (5) years practical experience.

The main role and responsibilities of the team include:
- Conducting a desk review for relevant project documents and agreements, including relevant local and national health plans
- Conducting a literature review on health project evaluations;
- Producing a draft evaluation report, including recommendations for improvements
- Incorporating feedback from key stakeholders and producing the final report.
- Presenting the report to HLH/NCA/Norad/RNE.

6. TIMEFRAME

11 December 2017	Approval of TOR by Norad (The Grant Recipient shall develop a draft TOR to be approved by the second party/Norad – ref Grant Agreement pt 6)
31 January 2018	Recruitment and contracting of evaluation team
Feb- March 2018	Desk review, interviews and focus group discussions in Oslo and Tanzania. Report writing.
15 March 2018	The draft report shared with Partners for factual verification and corrections
30 March 2018	Finalized Evaluation Report

7. BUDGET

NOK 300.000

Expenses related to the implementation of the Program Review shall be covered within the Program Budget (See Grant Agreement, pt. 6)

Haydom Lutheran Hospital (HLH) opened in 1955. HLH is owned by the Evangelical Lutheran Church of Tanzania (ELCT), Mbulu Synod, but for decades, HLH has relied primarily on financial support from the Norwegian government through the Ministry of Foreign Affairs. The support was until 2014 channeled through the Royal Norwegian Embassy (RNE) in Dar es Salaam. From 2015, the management of the fund was transferred to Norwegian Church Aid (NCA). The total grant from Norad under the current four-year agreement is NOK 56 million. The four-year program managed by NCA has focused on supporting HLH to gradually sustain itself through expanding its revenue base, with the aim of reducing HLH's dependency on a single donor (Norad) while maintaining the quality of services. HLH has committed to reducing overall budget dependence on Norwegian government grants from 47% in 2014 to 22% by 2018.

The Grant Agreement document stipulated that a program evaluation should be held no later than 1 June 2018. This program evaluation was commissioned by NCA. The objectives of the evaluation were to assess progress and deviations in relation to the main purpose of the main Grant Agreement (QZA-0178 TAN 15/0009); and to assess the role of NCA in supporting HLH, especially on the deliverables defined in the Sub-Project Agreement.

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