

Joint External Evaluation

THE HEALTH SECTOR IN TANZANIA, 1999-2006



Joint External Evaluation of the Health Sector in Tanzania, 1999-2006

COWI



GOSS GILROY INC.

Management Consultants
Conseillers en gestion

EPOS
Health Consultants

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Preface

In 1999, the health sector in Tanzania entered into a sector-wide approach. This resulted in agreement on a joint monitoring and evaluation system replacing individual and separate review and evaluation activities in order to reduce transaction costs, to gain comprehensiveness and validity of lessons learned and thus to achieve greater credibility and broader ownership of results.

Tanzania's Joint Annual Health Sector Review is an excellent tool to measure the progress and achievements in the sector. However, in 2004 several members of OECD's Development Assistance Committee proposed that a joint external evaluation of the health sector as a whole should supplement the reviews. In April 2006 – at the 7th Joint Annual Review – the Ministry of Health and Social Welfare pointed out that input from an external evaluation would need to be coordinated with the national health sector planning process to feed into the Third Health Sector Strategic Plan covering 2008-15. For that to succeed the draft evaluation report should be ready by August 2007.

During the following months the Terms of Reference for the external evaluation were developed in close consultation with stakeholders in Tanzania. After an international competitive bidding process a consortium of COWI, Denmark; Goss Gilroy, Canada; and EPOS, Germany was selected to carry out the joint external evaluation study. Six development partners: Belgium, Canada, Denmark, Germany, the Netherlands and Switzerland have been the major funders of the direct cost of the study. The management of the evaluation was conducted by a management group comprising of Denmark, Germany and Tanzania.

The evaluation was launched on December 7, 2006 in Dar es Salaam under the lead of the Ministry of Finance. The Ministry of Finance also chaired the Inception Workshop on March 20, 2007 as well as the workshop following the completion of the field studies on June 14, 2007. At both workshops there was a broad representation of stakeholders with whom the evaluation team interacted.

Eight government agencies, more than 20 development partners, many non-government organisations, faith-based organisations, civil society organisations as well as the private sector were engaged in the joint evaluation exercise. In addition, more than 300 community members took part in focus group discussions during the evaluation.

The draft evaluation report was delivered on schedule on August 24, 2007 and all stakeholders were invited to comment in writing. This resulted in comments from a wide range of stakeholders. The draft report was then presented and discussed at Tanzania's 8th Joint Annual Health Sector Review after which it was finalized.

The Steering Committee wishes to express its gratitude to all who have been involved in the joint external evaluation exercise and who have shown willingness to make substantial sacrifices in the midst of their own very hectic working days in order to supply the essential information to the evaluation team.

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- Annex 2: References
- Annex 3: Documents Reviewed
- Annex 4: Key Informant Interviews
- Annex 5: Financial Flow Model
- Annex 6: CAST Focus Group Tool
- Annex 7: District Case Studies

Acknowledgements by the Evaluation Team

The evaluation team would like to express its appreciation for all those whose work and cooperation contributed to our ability to carry out this evaluation. From a governance and guidance point of view, the members of the Evaluation Management Group helped to keep the work on-track and to ensure that the evaluation provided high quality products to the Steering Committee and the Sub-Committee of the Steering Committee, so that decisions could be made in a timely way and the evaluation could proceed as expected and required.

In Tanzania, the evaluation team received important assistance and needed cooperation from both the Government of Tanzania and the representatives of Development Partners. In particular the staff of the Health Sector Reform Secretariat of the Ministry of Health and Social Welfare were indispensable in providing information and in arranging access as well as in assisting the evaluation team with logistical arrangements for data collection work in the field. Similarly, the Secretariat of the Development Partners Group for Health and the members of the coordinating Troika provided critical support to the evaluation. The Dar es Salaam office of the Aga Khan Development Network also provided strong support to the evaluation, especially in organizing and carrying out important workshops and consultations.

The evaluation team also acknowledges the support and cooperation of health sector staff at regional and council level, including members of Regional and Council Health Management Teams and the staff of hospitals and primary health facilities who tolerated lengthy interruptions to their working days and provided a rich body of evaluation information for the use of the team. The staff of research agencies, non-government organizations, faith-based organizations and private service providers also shared valuable insights and made themselves available whenever asked.

Finally, it is most important to acknowledge the contribution of the many community members, men and women, users and non-users of the health facilities visited by the evaluation, especially those who took part in focus group discussions. They provided the evaluation with an important reality check and helped to put all other forms of evaluation data in context. If the evaluation is to be judged a success it will be for contributing to better health services for these and other community members in the future.

As always, while all these groups and individuals have contributed to the evaluation, any errors or omissions remain the responsibility of the evaluation team.

Abbreviations

<i>ASS</i>	Assistant Administrative Secretary
<i>ACT</i>	Artemisinin-based Combination Therapy
<i>AHSA</i>	Annual Health Statistical Abstract
<i>AMDD</i>	Averting Maternal Death and Disability
<i>AMO</i>	Assistant Medical Officer
<i>ANC</i>	Antenatal Clinic
<i>APHFTA</i>	Association of Private Health Facilities in Tanzania
<i>ART</i>	Anti-Retroviral Therapy
<i>ARV</i>	Anti-Retroviral Drugs
<i>BFC</i>	Basket Financing Committee
<i>BMC</i>	Bugando Medical Centre
<i>CAST</i>	Change Assessment Scoring Tool
<i>CCHP</i>	Comprehensive Council Health Plan
<i>CDC</i>	Centres for Disease Control
<i>CHF</i>	Community Health Funds
<i>CHMT</i>	Council Health Management Team
<i>CHSB</i>	Council Health Service Board
<i>CO</i>	Clinical Officer
<i>CSO</i>	Civil Society Organisation
<i>CSSC</i>	Christian Social Services Commission (Tanzania)
<i>Danida</i>	Danish International Development Assistance
<i>DbyD</i>	Decentralization by Devolution
<i>DED</i>	District Executive Director
<i>DHS</i>	Demographic and Health Survey
<i>DMO</i>	District Medical Officer
<i>DP</i>	Development Partner
<i>DPG</i>	Health Development Partner Group – Health
<i>DPT</i>	Diphtheria, Tetanus and Polio Vaccine
<i>DRF</i>	Drug Revolving Fund
<i>EHIP</i>	Essential Health Interventions Package
<i>EPI</i>	Expanded Programme of Immunisation
<i>FBO</i>	Faith-Based Organization
<i>FY</i>	Fiscal Year
<i>GBS</i>	General Budget Support
<i>GFATM</i>	Global Fund for AIDS, Tuberculosis and Malaria
<i>GHI</i>	Global Health Initiatives
<i>GoT</i>	Government of Tanzania
<i>HBF</i>	Health Basket Fund
<i>HF</i>	Health Facility
<i>HIRS</i>	Health Information and Research Section
<i>HIV/AIDS</i>	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
<i>HMIS</i>	Health Management Information System
<i>HR</i>	Human Resources
<i>HRH</i>	Human Resources for Health
<i>HSF</i>	Health Services Fund
<i>HSR</i>	Health Sector Reform

ABBREVIATIONS

<i>HSRS</i>	Health Sector Reform Secretariat
<i>HSSP</i>	Health Sector Strategic Plan
<i>IFMS</i>	Integrated Financial Management System
<i>IMCI</i>	Integrated Management of Childhood Illnesses
<i>IMF</i>	International Monetary Fund
<i>IMR</i>	Infant Mortality Rate
<i>ITN</i>	Insecticide Treated Nets
<i>JAHSR</i>	Joint Annual Health Sector Review
<i>KCMC</i>	Kilimanjaro Christian Medical Centre
<i>LGA</i>	Local Government Authority
<i>LGCDG</i>	Local Government Capital Development Grant
<i>LIC</i>	Low Income Country
<i>LLIN</i>	Long Lasting Insecticidal Net
<i>MDA</i>	Ministries, Departments and Agencies
<i>MDG</i>	Millennium Development Goal
<i>MEMS</i>	Mission for Essential Medical Supplies
<i>M&E</i>	Monitoring and Evaluation
<i>MKUKUTA</i>	National Strategy for Growth and Reduction of Poverty (in Swahili)
<i>MMR</i>	Maternal Mortality Rate
<i>MOF</i>	Ministry of Finance
<i>MOH</i>	Ministry of Health
<i>MOHSW</i>	Ministry of Health and Social Welfare
<i>MSD</i>	Medical Stores Department
<i>MTEF</i>	Medium Term Expenditure Framework
<i>NACP</i>	National Aids Control Program
<i>NGO</i>	Non-governmental Organisation
<i>NHIF</i>	National Health Insurance Fund
<i>NSGRP</i>	National Strategy for Growth and Reduction of Poverty
<i>NMSF</i>	National Multi-Sectoral Strategic Framework (HIV/AIDS)
<i>OC</i>	Other Charges
<i>OECD/DAC</i>	Development Assistance Committee of the Organization for Economic Cooperation and Development
<i>PBF</i>	Performance Based Funding
<i>PE</i>	Personal Emoluments
<i>PEPFAR</i>	President's Emergency Plan for AIDS Relief
<i>PER</i>	Public Expenditure Review
<i>PHF</i>	Primary Health Facility
<i>PHN</i>	Public Health Nurse
<i>PLWHA</i>	People Living with HIV/AIDS
<i>PMO-RALG</i>	Prime Minister's Office – Regional Administration and Local Government
<i>PMTCT</i>	Preventing Mother to Child Transmission
<i>PO-PSM</i>	President's Office-Public Service Management
<i>POW</i>	Programme of Work 1999-2002
<i>PPP</i>	Public Private Partnership
<i>PPRA</i>	Public Procurement Regulatory Authority
<i>PRBS</i>	Poverty Reduction Budget Support
<i>PRS</i>	Poverty Reduction Strategy
<i>PRSP</i>	Poverty Reduction Strategy Paper
<i>RAF</i>	Resource Allocation Formula

<i>RHMT</i>	Regional Health Management Team
<i>RMO</i>	Regional Medical Officer
<i>STI</i>	Sexually Transmitted Infection
<i>SWAP</i>	Sector-Wide Approach
<i>TA</i>	Technical Assistance
<i>TACAIDS</i>	Tanzania Commission for AIDS (Prime Minister's Office)
<i>TEHIP</i>	Tanzania Essential Health Initiative Project
<i>TFDA</i>	Tanzania Food and Drug Authority
<i>TFNC</i>	Tanzania Food and Nutrition Centre
<i>THIS</i>	Tanzania HIV Indicator Survey
<i>TIKA</i>	Tiba Kwa Kadi (urban expansion of the CHF)
<i>TMAP</i>	Tanzania Multi-Sectoral AIDS Programme
<i>ToR</i>	Terms of Reference
<i>TRCH</i>	Tanzania Reproductive Child Health Survey
<i>TSPA</i>	Tanzania Service Provision Survey (2006)
<i>TSH</i>	Tanzanian Shilling
<i>U5MR</i>	Under Five Mortality Rate
<i>UNICEF</i>	United Nations Children's Fund
<i>USD</i>	United States Dollar
<i>VA</i>	Voluntary Agency
<i>VCT</i>	Voluntary Counselling and Testing
<i>WHO</i>	World Health Organization
<i>ZTC</i>	Zonal Training Centres

Glossary of Terms

The definitions below are from the World Health Organization (WHO) Statistical Information System (WHOSIS) www.who.int/whosis/en/index.html

Life Expectancy

Average number of years that a newborn is expected to live if current mortality rates continue to apply.

Neonatal Mortality:

Number of deaths during the first 28 completed days of life per 1000 live births in a given year or period.

IMR: Infant Mortality Rate

Infant mortality rate is the probability of a child born in a specific year or period dying before reaching the age of one, if subject to age-specific mortality rates of that period. It is expressed as a rate per 1000 live births.

U5MR: Under Five Mortality Rate

Under-five mortality rate is the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period, also expressed as a rate per 1000 live births.

MMR: Maternal Mortality Ratio

Number of maternal deaths per 100,000 live births during a specified time period, usually one year. A maternal death is the death of a woman while pregnant or within 42 days after termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Immunization Coverage Among One-year-olds:

Measles immunization coverage is the percentage of one-year-olds who have received at least one dose of measles containing vaccine in a given year.

DTP3 immunization coverage is the percentage of one-year-olds who have received three doses of, the combined diphtheria and tetanus toxoid and pertussis vaccine in a given year.

HepB3 immunization coverage is the percentage of one-year-olds who have received three doses of Hepatitis B3 vaccine in a given year.

Antenatal Care Coverage

Percentage of women who used antenatal care provided by skilled health personnel for reasons related to pregnancy at least once during pregnancy, as a percentage of live births in a given time period.

Births Attended by Skilled Health Personnel

Percentage of live births attended by skilled health personnel in a given period of time. A

skilled birth attendant is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. Traditional birth attendants, trained or not, are excluded from the category of skilled attendant at delivery.

Children aged less than five years sleeping under insecticide-treated bed nets (ITN)

Percentage of children under five years of age in malaria endemic areas who slept under an ITN the previous night, ITN being defined as a mosquito net that has been treated within 12 months or is a long-lasting insecticidal net (LLIN).

HIV/AIDS Prevalence Rate

Percentage of adults 15 to 49 who are HIV infected.

For surveillance purposes, **HIV infection** is diagnosed through HIV testing, according to the HIV surveillance testing strategies recommended by the WHO/UNAIDS HIV/AIDS/STI surveillance working group.

Antiretroviral Therapy Coverage Among People with Advanced HIV Infections

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy according to nationally approved treatment protocol (or WHO/Joint UN Programme on HIV and AIDS standards) among the estimated number of people with advanced HIV infection.

Chronic/Acute Malnutrition

Percentage of underweight (weight-for-age less than negative two standard deviations of the WHO Child Growth Standards median) among children aged less than five years.

Percentage of **stunting** (height-for-age less than negative two standard deviations of the WHO Child Growth Standards median) among children aged less than five years.

Severe underweight and stunting are defined as less than negative three standard deviations of the weight-for-age and height-for-age WHO Child Growth Standards median, respectively.

Children 6-59 Months Who Received Vitamin A Supplementation

Proportion of children aged 6-59 months who received a high-dose vitamin A supplement within the last six months.

Executive Summary

During the 1990s, the health sector in Tanzania faced a period of stagnation. Local health services were characterized by severe shortages of essential drugs, equipment and supplies and deteriorating infrastructure and were plagued by poor management, lack of supervision and lack of staff motivation. The sector also faced stagnating or deteriorating hospital care. There was little cooperation in health service delivery between the public sector, faith-based organizations, and private service providers. Health services were severely under-funded, with public health sector spending at USD 3.46 per capita. There was also little coordination of support to the health sector by Development Partners.

The Government of Tanzania and Development Partners responded to this situation together in a process beginning with a joint planning mission convened by the Government in mid-decade. By 1999, this process resulted in the first major health sector strategic plan, the Health Sector Program of Work (POW) and an agreement that support to the health sector would take place in the framework of a Sector Wide Approach (SWAP). The POW and subsequent Health Sector Strategic Plan 2 (HSSP2) articulated a process of health sector reform aimed at addressing the recognizable deficiencies in the sector and achieving specific goals and targets in health as set out in the Millennium Development Goals (MDGs) and the National Strategy for Growth and Reduction of Poverty (NSGRP)/MKUKUTA).

The POW and HSSP2 identified priority areas of strategic intervention. These included:

- Strengthening district health services;
- Transforming the role of the central Ministry of Health and Social Welfare into a facilitative policy organization;
- Reforming and strengthening regional and national referral hospitals;
- Improving central support systems (including infrastructure, health management information systems, drug supplies, transport, and communications and information technology);
- Dealing more effectively with issues in human resources for health;
- Improving the level, appropriateness and sustainability of health care financing;
- Promoting public private partnership;
- Adopting and implementing a national strategy for combating HIV/AIDS as an explicit element of the HSSP 2; and,
- Improving Government and Development Partner relations to improve harmonisation and alignment of external and Tanzanian resources in a more effective partnership.

Evaluation Focus and Approach

The evaluation focused on four thematic areas:

1. The relevance of health sector strategic and implementation plans to achievement of the MDGs in health and to MKUKUTA health sector goals and targets, and the appropriateness and relevance of external support;

2. The extent of progress and achievements under each of the nine strategic priorities of the health sector reform process, as listed immediately above;
3. Achievements in improving access, service quality and health outcomes during the evaluation period; and,
4. Changes in partnership during the evaluation period, including the evolution of efforts at harmonization and alignment and the use of different aid modalities.

The evaluation was conducted from December 2006 to September 2007 by a team of eight international health and evaluation consultants, three of whom were nationals of Uganda and Malawi. The main methodologies used were an extensive document review, key informant interviews at national level, district self-assessments carried out by MOHSW staff in 16 districts in Tanzania, in-depth case studies in six districts (including discussions with community members) carried out by the evaluation team, an analysis of financial and other resource flows to the health sector at national, regional and council level, and a review of national health outcomes data. Finally, evaluation information from all the methodologies used was tested and triangulated to identify contradictions and strengthen the validity of findings and conclusions.

Relevance of Strategies, Plans, Programmes and External Support

Relevance of Health Sector Strategies, Plans and Programmes

Assessed in total, health sector strategies, priorities, plans, budgets and programmes have been relevant to achieving the MDGs and health sector goals and targets throughout the evaluation period. Strategic planning documents have been coherent and the priorities they identify can be directly linked to constraints identified during the evaluation at the central, regional and council levels. In particular, the district case studies and reviews of regional operations carried out by the external evaluation team confirm the requirement to strengthen health services provided by Local Government Authorities in the context of decentralization.

On the other hand, it is important to note that sector plans, programmes and activities have not been as clearly directed to achieving goals relating to maternal mortality and requiring improvements in safe delivery services and family planning as they have to other goals and targets. This will be an important area for increased emphasis and more concrete action during Health Sector Strategic Plan 3. Similarly, the relative lack of progress related to strategic priorities in hospital reform and public private partnership identified by the evaluation suggests that programmatic follow through in these areas has been lacking in comparison to others.

Finally, the strategic priorities identified for the sector during the evaluation period have not been explicitly linked to verifiable targets or an integrated monitoring and evaluation system.

Relevance of External Support

The organization of much of the external support to the sector under a SWAP agreement has helped to ensure that most remains relevant to the needs of the health sector and the national priorities expressed in MKUKUTA and the MDGs. Contributions to the Health Basket Fund have played a particularly important role in enabling one of the central strategies of health sector reform: strengthening council health services.

Global Health Initiatives and very large bilateral programmes with a multi-country scope also make a contribution to meeting national goals and targets, especially in relation to HIV/AIDS, malaria and tuberculosis. On the other hand, they remain largely outside the SWAP process, sometimes divert human and financial resources from other priorities, and, in the case of HIV/AIDS programming, have sometimes distorted local priorities and created inequities in the assignment and pay of health sector staff (often through incentive pay for health workers engaged in Voluntary Counselling and Testing services).

Achievements Under Health Sector Strategic Plans

Strengthening Council Health Services

The evaluation period has seen significant progress in decentralizing planning, budgeting and management of health services to local level. Important institutional bodies are in place and functioning including the Council Health Management Teams, Primary Health Facility Committees and Hospital Management Committees. Councils are engaged in the Comprehensive Council Health Plan (CCHP) process in a meaningful way. The budgetary aspects of the CCHP have been strengthened over time and the introduction and support of a comprehensive health services planning tool throughout mainland Tanzania is a notable accomplishment.

However, the CCHP planning process is complex and resource intensive and has yet to become participatory beyond the boundaries of the Council Health Management Team. In order for planning process to become more participatory, Council Health Services Boards and Hospital Governing Committees would need to be strengthened through training and capacity building and to be further empowered to carry out their mandates. The quality of CCHPs remains uneven and council health staff view the CCHP as a cumbersome but essential budgeting tool.

At council level, supervision of health facilities by the Council Health Management Team has shifted to a supportive model and has been strengthened by training and the use of guidelines. It also encompasses health facilities operated by the public sector, faith-based organizations and private service providers, but it focuses mostly on non-clinical aspects of facilities. As a result, supportive supervision of primary health facilities requires continued strengthening.

There is little or no evidence of improvements in the operation of the referral system. The problems in the referral system noted throughout the evaluation period have not been effectively addressed and the resulting bypassing of primary health facilities contributes to serious overcrowding, especially at regional hospitals.

Finally, there is also an opportunity to increase collaboration between the health sector and, for example, activities in water and sanitation, education, hygiene and nutrition in an effort to improve health outcomes at local level.

The Changing Role of the Ministry of Health and Social Welfare

MOHSW has been largely successful in transitioning from its role as the operator of most health facilities in Tanzania to a policy and technical support role during the evaluation period. It has responded partly through the development, circulation and monitoring of an extensive set of operational guidelines assessed by the evaluation as being of high quality. At council level, health service managers and other key stakeholders are

largely positive in their view of this new role of MOHSW. At the same time, the sheer volume of major and minor reforms in health service planning, management and implementation as promoted and supported by the Ministry has tended to overwhelm the capacities of health service managers in the regions and districts.

MOHSW and the Prime Ministers Office-Regional and Local Government continue to experience difficulties in aligning their organizational cultures and structures, policies and processes. The most striking example of this has been the persistent problem of their different attitudes to the role of the Regional Medical Officer and the size and funding of the Regional Health Management Team. One result has been chronic under-funding of the latter so that they are largely unable to carry out their role of supportive supervision to Council Health Management Teams in their jurisdiction.

Hospital Reform

Despite some improvements in the availability of drugs, provision of equipment and in-service training for hospital staff, hospital reform has not progressed at the same pace as other aspects of health sector reform. There is little evidence of progress in improving the governance structure or management practices at hospital level and, while budgets for regional hospitals have increased, they remain under-funded and continue to experience severe shortages of qualified staff, medical supplies and essential drugs. They also suffer ongoing serious problems with utilities including running water and electricity.

Central Support Services

Infrastructure: Despite construction and rehabilitation activities during the evaluation period, there are still substantial capital investment requirements. In addition, the lack of running water, electricity and communication equipment has negative consequences for the quality of care and staff housing in remote areas could potentially help in dealing with the human resource crisis.

Drug Supply: The supply of drugs, equipment and other medical supplies provided by the Medical Stores Department has improved over the evaluation period, but shortages and delays in delivery are still common. First the Indent and now the Integrated Logistics System have been an improvement over the kit system for ordering drugs, but order processing remains overly centralised. More competition would increase efficiency and ensure better availability of drugs at facilities. Finally, fixed allocations of drugs and other supplies for health facilities at a given level, unrelated to utilisation are not efficient.

Health Management Information Systems: The quality of the Annual Health Statistical Reports has improved and the inclusion of faith-based organizations and private sector providers in the system results in more complete data. At the same time, the reliability of data is still problematic. Data analysis, information use and feedback to lower levels remain insufficient and lack of capacity at all levels is a major constraint to improving the situation.

Transport: The difficulty and expense of public transport has negative consequences for access to care and contributes to maternal mortality. There is also no evidence of improvement in the organization and management of ambulance services during the evaluation period.

Monitoring and Evaluation: An overall framework for monitoring and evaluation is lacking and the roles and inter-relationships between the Health Management

Information System, Sentinel Surveillance Surveys, National Census Data, and specific studies is not clear.

Human Resources for Health

By all estimates, Tanzania has faced a severe shortage of skilled health sector workers throughout the evaluation period and continues to do so, although this only became a priority policy and programme focus later in the period. Despite some improvements in quantity (small) and quality (more significant) of the workforce, severe staff shortages persist, particularly among the higher qualified cadres.

Government and private training institutions have increased their output in recent years and thereby increased the supply of newly trained health workers. There have also been improvements in in-service training for public health workers, most recently through strengthening Zonal Training Centres.

However, despite some very recent emergency hiring initiatives, efforts to recruit, deploy and retain public sector health workers, especially those assigned to remote or hardship posts, continue to be hampered by administrative problems, the absence of an effective incentive scheme and loss of professional staff to other jurisdictions. This impedes improvement in the quality of care in large parts of the country and contributes to inequities in access to services and, eventually, to avoidable morbidity and mortality.

Throughout the evaluation period, the nominal staffing requirements of each primary health facility have been based on the level (health centre or dispensary) rather than the actual workload of the facility. This has hampered the efficiency of service provision and has not contributed to improving health staff productivity.

Finally, recent improvements in pay and benefits for public sector health workers have had significantly negative effects for faith-based organizations and private service providers.

Health Care Financing

Public expenditures in the health sector increased substantially during the evaluation period, with both domestic and external sources of funds contributing to the rise, measured both as per-capita spending and as a share of national public spending. However, the increase was not as sustained in most recent years and still falls short of national and international targets.

With costs in the health sector escalating (in part as a reflection of the higher costs of improved malaria drugs and other treatment options) and health expenditures below target as a percentage of public spending, there is a need for Development Partners and the Government of Tanzania to increase the level of investment in health.

At the same time, the allocation of resources over the evaluation period has been characterized by a slight but steady decrease in the share allocated to Local Government Authorities, although their overall spending has risen significantly.

Because the financial data available did not allow the evaluation to identify the proportion of MOHSW (and national vertical programme) expenditures occurring at the local level, it is difficult to determine the trend in health expenditures at local level as a share of total spending. Nonetheless, it would be useful to establish a target for the share of on-budget resources to be allocated to Local Government Authority level.

Despite some problems, the evaluation period has been characterized by improvements in budget performance in the health sector. On-budget resources (both domestic and foreign) have been more predictable and achieved higher levels of budget execution than off-budget funds.

Finally, cost-sharing mechanisms implemented during the evaluation have had limited success in achieving their stated goals of raising additional resources for health, improving the quality of services and improving the operation of the referral system. On the other hand, there is some evidence they have strengthened ownership and involvement by local communities. Mechanisms put in place to ensure that those unable to pay can access services where fees are being charged have been largely ineffective.

Public Private Partnership

There is little evidence of progress to advance the strategy of public private partnership during the evaluation period, although there are some examples of good cooperation at council level. Concrete measures will be required to retain the interest and cooperation of faith-based organizations and private health service providers if this strategy is to be made effective.

Given the significant role that non-government service providers play in the sector, lack of action and progress on public private partnership could have serious consequences for the provision of health services in Tanzania.

HIV/AIDS

Including HIV/AIDS as a specific strategy in HSSP2 has contributed (along with other factors) to a more effective national response through increased resources, infrastructure improvements and improved coverage of testing and treatment.

At the same time, important constraints in HIV/AIDS programming remain. These include staff shortages, limited rural coverage, service bottlenecks, low participation by males, limited availability of services for prevention of mother to child transmission, continuing stigma for patients, and relatively weak home-based care and workplace programmes. In addition, the large increase in external funding for HIV/AIDS sometimes distorts priorities and draws staff away from, for example, maternal and child health services. Finally, prevention efforts require increased attention and priority in comparison to recently strengthened care and treatment programmes.

Health Service Quality, Access and Equity

The evaluation has identified evidence of improvements in service quality in the areas of an improved ability of health facilities to deal with malaria and HIV/AIDS, improved vitamin supplement programmes, some improvements in drug supply, improved cleanliness of facilities, and improved attitudes and capacities of those staff who are available. At the same time, there remain critical challenges in improving service quality further and, other than local initiatives, there is little evidence of improvement in services aimed at preventing maternal mortality.

Tanzanians who are able to use the health system on a regular basis report that there has been an improvement in the quality and value of the services they receive, including those requiring fees for service.

On the other hand, equity of access continues to be hindered by geographic isolation and poor transport links, by weaknesses in emergency obstetric care, and by cost-sharing and risk pooling mechanisms which are unable to effectively implement systems of waivers for those who cannot pay. There has also been no apparent systematic attention to issues of gender equity during the evaluation period.

Achieving Goals in Health Outcomes

Tanzania has made significant progress towards goals in reducing infant and child mortality and some progress in aspects of child malnutrition. However, no measurable progress has been made in reducing maternal mortality although iron supplementation and the percentage of births attended by skilled staff has increased. There has also been little progress in reducing neonatal mortality.

Information gathered at both the national and local levels suggests that positive contributing factors have included, among others: continued strengths in immunization and improved micronutrient supplementation; improved diagnosis and treatment of malaria, especially among children; improved availability of drugs; and increased use of insecticide treated nets. Factors limiting further progress towards achieving targets in health include continued shortages of health workers, poor infrastructure, intermittent shortages of drugs (despite the noted improvements), shortages of other medical supplies, and poor and inefficient use of transport.

Development Partnership

Within the context of the SWAP, the evaluation period has been characterized by a more harmonised and aligned system of development cooperation in the health sector, partly through the development of structures for formal dialogue. But while these formal structures help to maintain a common sense of direction and foster alignment, they have been cumbersome and each has varied in effectiveness over time. There is clearly an opportunity to streamline these structures and processes.

Informal policy and technical dialogue between the Government of Tanzania and Development Partners has been effective as a means of exchanging views and information during the evaluation period, but Tanzanian faith-based and civil society organizations and private service providers have tended to be relatively excluded from planning and coordination.

While all available project and programme aid modalities are in use in the health sector in Tanzania, the Health Basket Fund has played a particularly important role in supporting the meaningful implementation of decentralization of responsibility for health services to Local Government Authorities. National ownership has been strengthened during the evaluation period, but the increasing importance of Global Health Initiatives and large bilateral programmes tends to threaten this as they remain largely outside established coordination and alignment mechanisms.

Main Evaluation Conclusions

1. The joint entry of the Government of Tanzania and the Development Partners into a Sector Wide Approach to collaborative development work in the health sector has resulted in greater sector coherence and consistency. In turn, this has secured higher levels of both domestic and external financial resources for health throughout the evaluation period. Comparing the situation in 2006 with the set of loosely or non-coordinated projects and programmes in place before the health SWAP was launched in Tanzania, there is little doubt that the SWAP has delivered real improvement. But, as further streamlining of the co-operation and dialogue mechanisms is still required, the current approach is not yet delivering optimal value for money.
2. Under the general framework of the SWAP, Development Partners have used a wide range of funding mechanisms to support the health sector, ranging from direct project funding to general budget support. Given the importance of the strategy of supporting Local Government Authorities in their efforts to strengthen council and district health services, the Health Basket Fund has been a particularly effective mechanism, alongside of the system of Health Block Grants instituted by the Government of Tanzania.
3. While Global Health Initiatives and large, multi-country bilateral, disease specific programmes have provided very significant financial (and material and technical) resources during the evaluation period, they have remained largely outside the planning and priority setting structures in place at national and local level. These programmes need to be more integrated into common funding, planning and programming systems if they are to avoid distorting local priorities.
4. The programmes, projects and activities implemented under the SWAP have contributed to improvements in health outcomes and to some improvements in the quality of health services at community level. These improvements can, in turn, be plausibly linked to progress toward MDG and PRSP/MKUKUTA goals, especially relating to infant and child mortality.
5. There has not, however, been significant progress towards achieving goals and targets relating to maternal mortality and maternal health (and to neonatal mortality) during the evaluation period. This should be a key area of emphasis for HSSP3.
6. What has worked and what has made a difference in the health sector in Tanzania has been the devolution of responsibilities for health facilities and health planning to Local Government Authorities – supported by financial resources (through the Health Basket Fund and Block Grants). Many of the organizational elements have also been established to allow the councils and their health management teams to undertake meaningful budgeting through the CCHP and to supervise and operate local health facilities. This strengthening of council level health services, supported by the upgrading of staff skills, and coupled with some improvements in centrally provided services (and the contribution of strengthened national vertical programmes) has contributed to improvements in service quality at health facility level

7. Despite these notable gains, further progress towards achieving some of the most important MDG and MKUKUTA goals can be expected to be inadequate unless actions are taken to overcome the important constraints identified in repeated studies and noted by the evaluation. In particular, more effective management of human resources is an urgent requirement. Tanzania needs to employ more of the trained health sector staff it produces and to ensure those working in the system are managed more effectively.
8. While the evaluation has identified progress in strengthening local health services, it has also noted that several strategic priorities set for the health sector during the evaluation period met with relatively little progress. Most evident has been the relative lack of progress in hospital reform and in the implementation of an effective public private partnership.
9. While the evaluation period has seen an improvement in some health services, the benefits of these improvements have not been shared equitably. Some of the constraints to equitable access to service are outside the direct control of the health sector as they are based on geographic isolation and high transport costs. Nevertheless, the sector has not responded effectively to address some sources of unequal access.
10. Efforts to make the sector more sustainable and improve quality through the use of cost-sharing mechanisms, user fees, and risk pooling arrangements have not been accompanied by effective measures to provide any reasonable expectation that those who cannot pay will be provided access to essential health services. Finally, problems related to recruiting, posting and retaining staff at geographically isolated hospitals, health centres and dispensaries have not been effectively addressed by the sector. This further disadvantages patients outside urban areas.

Major Recommendations¹

1. The Government of Tanzania and Development Partners should maintain the SWAP programming format to structure their cooperation in the health sector in Tanzania during HSSP3 along with detailed adjustments and improvement aimed at streamlining review and decision making structures and processes as specified in later recommendations. **(1,2 and 3)**
2. The Government of Tanzania and Development Partners should make every effort to provide increased funding so that the goals of increasing per capita expenditure and of ensuring that at least 15% of national public expenditures are allocated to health can be achieved as soon as possible during HSSP 3. **(1 and 2)**
3. MOHSW and the Prime Minister's Office-Regional and Local Government should agree on a target for the percentage of public health budget estimates (and expenditures) to be allocated to Local Government Authorities. This should be accompanied by improvements in systems and procedures for tracking budget allocations and expenditures. **(1 and 2)**

1) *The bold numbers after each recommendation refer to the timeframe in which they can/should be started. A full explanation is provided on page 25 of the Report.*

4. A Health Basket Fund and direct GoT grants to councils for the operation of health services based on a transparent resource allocation formula should remain a feature of the sector during HSSP3. Over the course of HSSP3, the Health Basket Fund may be merged with the Health Block Grant. (1 and 2)
5. HSSP3 should be used to consolidate the achievements of HSSP2 and to address identified constraints related to already agreed reforms, rather than embarking on new reforms (although some ideas for long term system changes will be offered below). (1,2 and 3)
6. HSSP3 should retain the strategic priorities of HSSP2, but should also include concrete steps to considerably accelerate progress in both hospital reform and public private partnership as set out in the detailed recommendations below. (2 and 3)
7. Effective action to reduce maternal mortality and improve delivery services, including emergency obstetric care, should be a stated strategic priority of HSSP3. (1, 2 and 3)
8. Improving equity of access should be a cross-cutting theme of HSSP3. MOHSW should strengthen its capacity to review and modify policies and programmes with a view to improving equity and taking action to remove barriers to access. This should include the development of a strategy for improving access and establishing a focal point within the Ministry whose mandate will include all aspects of equity, including gender equity. (2 and 3)
9. HSSP3 should include specific strategies to improve efficiency of service delivery both in Primary Health Facilities and hospitals, by increasing the productivity of health sector personnel and better matching staffing levels to work loads (including piloting and, where appropriate, scaling the introduction of performance based pay). (2)
10. A health inspectorate (for which legislation has been prepared) should be established. The Health Services Inspectorate Unit in the MOHSW should be strengthened and regional offices should be established. The MOHSW should consider the option of transforming the RHMT into regional health inspectorate units. (2 and 3)
11. HSSP3 should include the development and implementation of an overall monitoring and evaluation framework for the health sector which incorporates existing data collection and analysis systems and which encompasses both regular performance monitoring and periodic effectiveness evaluation.

1 Evaluation Approach and Methodology

1.1 Evaluation Focus and Key Issues

Background and Objectives of the Evaluation

At the April 2006 Joint Annual Health Sector Review (JAHSR), the Ministry of Health and Social Welfare (MOHSW) pointed out that any contemplated external evaluation of the health sector in Tanzania should be coordinated with the national health sector planning process to provide useful input in the development of the Third Health Sector Strategic Plan (HSSP3) covering the years 2008-15.

Development Partners (DPs) and the Government of Tanzania (GoT) had been discussing for some time plans to undertake a joint evaluation of the sector in light of the eight-year history of support through a sector-wide approach (SWAP). As a result of the convergence of planning for an external sector evaluation and the need to provide input to the development of HSSP3, an international tender was issued calling for proposals to conduct a joint external evaluation of the health sector in Tanzania. The tender was awarded in November 2006 to a consortium comprised of COWI A/S (Denmark), EPOS Health Consultants GmbH (Germany) and Goss Gilroy Inc. (Canada).

The evaluation was carried out from December 2006 to September 2007.

The Terms of Reference (ToR) of the joint evaluation provide a clear statement of its overall and specific objectives:

Overall Objective

The overall objective of the Joint External Evaluation is to provide solid evidence about the relevance and effectiveness of the joint development work in the health sector. The purpose is to demonstrate results, and show “what works” and “what made/makes the difference” in order to learn from experience and to link evidence to policy and strategic development.

Specific Objectives

1. Evaluate the performance of the health sector in the period 1999-2006 against the Millennium Development Goals (MDGs) and the objectives of the PRSP/ MKUKUTA² in general and HSSP1 (1999-2002)³ and HSSP2 (2003-2008)⁴ in particular in light of the needs of the Tanzanian population.
2. Evaluate partnership in terms of cooperation modalities, harmonisation, alignment and dialogue between the Government, the DPs and other stakeholders over the same period.

2) *National Strategy for Growth and Reduction of Poverty (NSGRP)/MKUKUTA. Vice President's Office, United Republic of Tanzania. 2005.*

3) *The Health Sector Reform Programme of Work: July 1999 - June 2002. Ministry of Health, United Republic of Tanzania. 1999.*

4) *Second Health Sector Strategic Plan (HSSP) (July 2003 - June 2008). Ministry of Health. United Republic of Tanzania. 2003.*

Focus and Key Issues

The Terms of Reference (ToR) for the evaluation encompassed an extensive set of evaluation issues and questions. A strategy to refine the focus of the evaluation was developed and discussed in detail in the Inception Report and during an Inception Workshop held in Dar es Salaam on March 20, 2007.

The original thematic structure of the evaluation was modified during the inception phase to incorporate the strategic themes of the health sector reform process during the evaluation period. This reorganization brought the evaluation issues into better alignment with existing reports and reviews on the sector. The four key evaluation themes encompassed by the reorganized evaluation issues can be summarized as follows.

1. The relevance of health sector strategic and implementation plans to achievement of the MDG in health and the National Strategy for Growth and Reduction of Poverty/ MKUKUTA health sector goals and targets. And the appropriateness and relevance of external support to achievement of the sector goals and objectives.
2. The progress and achievements realized under health sector strategic plans during the evaluation period (from 1999 to 2006), including progress in:
 - Strengthening District Health Services;
 - Role of the Central Ministry;
 - Hospital Reforms;
 - Central Support Systems for Health;
 - Human Resources for Health;
 - Health Sector Financing;
 - Public Private Partnership;
 - Sector Coordination; and,
 - HIV/AIDS Programming.
3. Achievements in improving access, service quality and health outcomes during the evaluation period.
4. Changes in partnership during the evaluation period, including the evolution of efforts at harmonization and alignment and the use of different aid modalities.

1.2 Coverage of OECD/DAC Evaluation Criteria

While covering the evaluation issues listed above, the evaluation has been able to also address the main evaluation criteria adopted by the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD). The OECD/DAC criteria require evaluation's to provide information on the relevance, efficiency, effectiveness, impact and sustainability of international development programmes. Section 1.6 (Structure of the Report) provides a brief overview of where the report addresses different OECD/DAC criteria.

1.3 Methodologies Used

The evaluation relied on the following six main methodologies:

1. Document Review;
2. Key Informant Interviews and Focus Group Discussions;
3. District Self-Assessments and Case Studies;
4. Review of Health Outcomes Data;
5. Profile of and Modelling of Resource Flows; and,
6. Triangulation.

Document Review

The evaluation included a systematic review of documentation on the health sector in Tanzania as provided by DPs, the GoT, Tanzania-based researchers, faith-based organizations (FBOs) and Non-Governmental Organizations (NGOs). In addition, the evaluation reviewed research and evaluative material available on the Internet.

The evaluation developed a document classification structure based on the key evaluation issues. Each document identified was classified according to one or more subject codes related to the evaluation issues and then reviewed, annotated and posted on an internal project web portal. There it could be accessed and collated by keywords. Annex 3 provides a listing of the documents reviewed.

Key Informant Interviews at Central Level

During the inception and data collection phases of the evaluation, structured and semi-structured interviews were carried out with representatives of all relevant Ministries, Departments and Agencies (MDA) of the Government of Tanzania, a considerable number of Development Partners (DP), institutions conducting research into the health sector in Tanzania as well as stakeholders from outside government in Tanzania.

Annex 4 presents a listing of key informant interviews carried out during the evaluation.

District Self-Assessments and Case Studies

The evaluation relied on two different sets of district assessments and case studies⁵. The first was carried out by the MOHSW, with the assistance of the Economic and Social Research Foundation (ESRF). These district self-assessments covered 16 districts of the 123 on mainland Tanzania. They were chosen to provide coverage of all eight Health Zones in Tanzania, to include districts with high, medium and low rates of Under Five Mortality (U5MR) and to include both urban and rural districts.

5) *While the term district assessments is used here and in the ToR it is perhaps more accurate to refer to Councils since the term covers local government authorities and their responsibility for rural districts, urban districts, and municipalities. The evaluation retains the term district self-assessments and district case studies to refer to evaluative work done below the regional level, but will refer to council level evaluation results to be more consistent with current practice in Tanzania.*

In addition, the evaluation relied on case studies of developments in the health sector in six districts carried out by the external evaluation team. These were chosen based on infant mortality rates (IMR), poverty ranking, coverage of maximum number of health zones,⁶ urban and rural districts, districts with service delivery by FBO and private providers and districts with significant levels of activity supported by Global Health Initiatives (GHI) or large bilaterally funded vertical programmes. The selected districts included two districts already covered by the district self-assessments.

The six districts chosen were Same District, Mwanza City Council, Kigoma/Ujiji Town Council, Masasi District, Singida Rural District, and Njombe Town Council.

Each of the six districts was the subject of a case study conducted by at least two members of the external evaluation team. Data collection activities included interviews with and site visits to:

At national and regional level;

- Prime Minister's Office – Regional and Local Government (PMO-RALG) officials in Dodoma;
- A national referral hospital in Mwanza;
- Regional Secretaries for each of the six councils;
- Regional Medical Officers (RMO) and the Regional Health Management Teams (RHMT) in six regions associated with the district case studies;
- Six Regional Hospitals; and,
- Three Zonal Medical Stores and five Zonal Training Centres (ZTC).

At district/council level:

- Six District Executive Directors (DED) as representatives of local government authorities;
- Council Health Services Board (CHSB) Members for five of the six districts;
- Current or acting District Medical Officer (DMO) and the Council Health Management Team (CHMT) for each of the six district case studies;
- Hospital Management Teams (HMT) for four District Hospitals (two Councils did not have a District Hospital but relied on the Regional Hospital);
- Seven other hospitals at hospital level operated by FBOs and the private sector;
- 15 Health Centres and 21 Dispensaries; and,
- Focus group discussions to assess changes in health services with 21 different groups (19 of which were separate male and female groups) encompassing 293 individuals chosen from the communities in each of the six council areas.

6) *As of November 2006, mainland Tanzania was divided into 123 Districts for the purposes of local government administration. These districts are, in turn organized into 21 Regions. Line ministries of the central government maintain offices at the regional level. For the purposes of administering the health sector, there are eight different Health Zones in Tanzania, each encompassing from as few as two to as many as four different Regions.*

In addition the evaluation conducted a document review of all available and completed Comprehensive Council Health Plans (CCHP) prepared by the six Councils as well as facilities level data at regional and district hospitals.

Review of Health Outcomes

The evaluation has relied on existing primary and secondary data sources to assess changes in health outcomes during the evaluation period, especially as they relate to the achievement of goals and targets in health as set out in MKUKUTA and the MDGs.

Reviewing Financial Flows

The evaluation undertook a review of available sources of financial information on the health sector during the evaluation period. Sources included:

- Public Expenditure Reviews (PER) for Health in Tanzania;
- GoT Budget Execution Reports;
- The Ministry of Finance Integrated Financial Management System;
- Votes and sub-votes as reported in the Budget Estimates;
- Medium Term Expenditure Frameworks;
- The Tanzania PER Multi-Sectoral Review: HIV/AIDS; and,
- Data provided by specific DPs and the Ministry of Finance (MOF).

In addition, this methodology encompassed interviews with officials of MOHSW and MOF and selected DPs in Dar es Salaam. It also included a set of finance and financial systems focussed interviews with representatives of Kigoma/Ujiji Municipal and Rural Councils and the Kigoma Regional Hospital in order to better map the operations of budgeting and expenditures at council level, including transfers from the central government and to gain a better understanding of the management of cost-sharing funds.

Assessing Development Partnerships

In addition to touching upon cooperation modalities and different dimensions of harmonisation, alignment and dialogue in relevant interviews, and searching for information on this in the document reviews, a number of separate efforts were pursued in order to respond to the evaluation issues in this area. This included participant observation by members of the evaluation team in the December 2006 meeting of the Development Partner Group Health (DPG Health) and the January 2007 Health Sector Wide Approach (SWAP) Committee Meeting. The reports and minutes from all the JAHSRs (main reviews and technical reviews) and minutes of the Health SWAP Committee and Basket Funding Committee (BFC) were compiled and systematically screened. Interviews were conducted with representatives of the MOHSW to specifically address the questions of development partnerships.

Triangulation and Cross Validation

Finally, the methodological approach of the evaluation included a systematic effort to triangulate data from document reviews, key informant interviews, direct observation of facilities, and focus group discussions in order to strengthen the validity of findings and conclusions.

1.4 Challenges and Limitations

The evaluation faced a number of important methodological challenges. The major challenges and the strategies developed to deal with them included:

Integrating District Self Assessments and Case Studies

A methodological feature established clearly in the ToR was a requirement that the evaluation should make use, to the extent possible and justified, of the district self-assessments as well as the district case studies carried out by the team of external evaluators. Indeed, this was essential if the evaluation was to achieve coverage of more than 10% of the districts in mainland Tanzania as also required by the ToR.

There were important methodological differences between the district self-assessments and the case studies carried out by the external evaluation consultants. The former were focused on the perceptions of staff and system users at a single point in time as self-reported through focus group discussions. The case studies focused on changes over time as distinct from a situation or perceptions analysis, and included document reviews and site observations as a check on the perceptions of managers and health facilities personnel.

This challenge was addressed through an analysis of the individual reports of the 16 district self-assessments. First, each of the 16 reports was summarized by issues area and by reported findings on positive achievements, constraints and challenges and recommended actions. These were then coded to display each finding and associated district.

This was the basis for assessing the extent of alignment in both positive and negative evaluation findings between the district self-assessments and district case studies. Because of the purposive sampling of two districts for both approaches (Njombe and Mwanza City) it was possible to review the fit between the self-assessment and case study findings.

This analysis demonstrated that the evaluation could rely on both sources of information with the proviso that they should be dealt with as two distinct sources. As a result, the evaluation covers twenty (16 plus six with two overlapping) districts on the Tanzania mainland.

Ensuring Diverse Representation and Lack of Bias

Some key stakeholders worried that discussions with community members could be biased since the primary responsibility for organizing them would be with health services staff.

Some also expressed concern that the health facilities visited by the evaluation might represent the best or most advanced in a given district.

The evaluation responded to these concerns in several ways;

- On arrival in a district, the evaluation consultants reviewed the planned itinerary and made suggestions for the addition of new health facilities where needed;
- During district visits, the evaluation team sometimes asked for changes in itinerary to include private and public facilities not on the original list;
- Evaluators took care to observe any evidence that health facility staff were prepared in advance or inhibited in providing answers and observations;
- Community members were often gathered at short notice from houses, shops and/or schools in the vicinity of a primary health facility.

The variety of conditions observed by the external evaluation consultants suggests that there is little probability that only more advanced or well-managed health facilities were included in the sample. Community members consulted were clearly capable of directing criticism at the health facilities and their staff.

Accessing Comprehensive Data on Financial Flows

While mapping the volume of off-budget financial resources flowing to the public health sector in Tanzania, the evaluation has relied on less than exact data for both the domestic and foreign component.

As regards the domestic component, which mainly includes cost-sharing revenue from the Health Services Fund (HSF), Drug Revolving Fund (DRF) and Community Health Fund (CHF), the evaluation did not obtain any comprehensive aggregated picture. Although a requirement exists for hospitals, health facilities and councils to report collection and expenditures to the central level, this is not done in any comprehensive way. Accordingly, the data available to the MOHSW is downward biased.

With respect to the foreign component, the evaluation relied on data provided through the PERs for health. This data in turn has been constructed on the basis of a database maintained by the Ministry of Finance on externally financed projects and programmes.

It was particularly difficult for the evaluation to track the flow of financial resources to district level (more precisely to the Local Government Authority (LGA) level) and to establish the relative shares of local and central administrative levels in Tanzania. An undetermined amount of the resources allocated and reported at national and regional level are actually spent at local level. As reported in the PER 2006, “a significant proportion of MOHSW headquarters budget reflects items intended for lower levels of the health system”. Examples cited include funding for drugs and supplies, transfers to Voluntary Agency (VA) and District Designated Hospitals (DDH), and technical programme activities implemented by LGAs but still captured as financial data under central level programmes.

1.5 The Evaluation Team

A team of eight consultants from six different countries (Canada, Denmark, Germany, Malawi, the Netherlands and Uganda) carried out the evaluation.

Ian Freeman of GGI provided research assistant support to the evaluation team. The external evaluation team was also assisted by an able group of professionals in the MOHSW, especially in the organization and completion of the district case studies. Yusuf Mwita, Gradeline Minja, Charles Mambali, Anna Tsaba and Dorothy Mbuya provided direct support to the evaluation team.

Table 1: Evaluation Team Members

Position	Team Member	Organisation and Country
Team Leader	Ted Freeman	GGI, Canada
Senior Health Specialist	Maria Paalman	the Netherlands
Senior Evaluation Specialist	Tom Dahl-Østergaard	COWI, Denmark
Financial Analyst	Thomas Nikolaj Hansen	COWI, Denmark
Health Policy	Karin-Annabella Revuelta	EPOS, Germany
Health Sector Management	Dr. Paul Kiwanuka-Mukiibi	Uganda
Human Resources for Health	Soyapi Lungu	Malawi
Local Health Services	Dr. Gimono Wamai	Uganda

1.6 Structure of the Report

Overall Structure

The evaluation report begins with this methodology chapter followed by a short description of developments in the health sector in Tanzania during the evaluation period.

The subsequent chapters from three to 14 are structured around the main evaluation issues.

- Chapter Three deals with the relevance of health sector strategies, priorities, plans and of external support from Development Partners (DP);
- Chapter Four is the first of eight dealing with progress and achievements under the key sector strategies in place during the evaluation period. It deals with efforts to strengthen health services at the council level;
- Chapter Five assesses the changing roles of central ministries in the health sector, the Ministry of Health and Social Welfare (MOHSW) and the Prime Minister's Office – Local and Regional Government;
- Chapter Six presents findings on progress and achievements in hospital reform;
- Chapter Seven examines efforts to improve central support services;
- Chapter Eight presents findings on human resources for health;
- Chapter Nine examines health care financing during the evaluation period;
- Chapter Ten presents findings on Public Private Partnership;
- Chapter Eleven discusses achievement in combating HIV/AIDS.
- Chapter Twelve presents findings on service quality and access;
- Chapter Thirteen examines the achievement of targets in health outcomes;
- Chapter Fourteen discusses issues in development partnership;
- Chapter Fifteen presents the main evaluation conclusions and major recommendations;
- Chapter Sixteen summarizes the evaluation findings in relation to the evaluation criteria of the OECD/DAC.

Detailed Recommendations

Detailed recommendations are presented at the end of each of the findings chapters. They represent the evaluation's best effort to identify very practical concrete actions to advance progress toward improving the quality and accessibility of health services at all levels. The recommendations have a number code attached according to the time period in which they should start and/or be implemented:

1= can be implemented or started in the last year of HSSP2

2= can be implemented or started in the first 3-4 years of HSSP3

3= can be implemented or started in the second 3-4 years of HSSP3

Covering the OECD DAC Evaluation Criteria

The key themes and issues agreed by stakeholders during and after the Inception Workshop of March, 2006 have been used as the organizing structure for the evaluation report. At the same time, it is important to point out that the material presented in the report does address the OECD/DAC evaluation criteria of relevance, efficiency, effectiveness, impact and sustainability.

Relevance is the main focus of Chapter Three, while findings and observations on efficiency are presented in an integrated way in Chapters Four through Eleven describing the achievements and progress made under key health sector strategies and in Chapter Fourteen on Development Partnership. Effectiveness is also dealt with in terms of progress under health sector strategies in the chapters already noted but is especially the subject of Chapters Twelve (Service Quality and Access) and Thirteen (Outcomes). Impacts are also touched on in Chapter Thirteen but the evaluation did not conduct a rigorous impact evaluation. Sustainability, particularly financial sustainability, is addressed in Chapter Nine on Health Financing. Finally, Chapter Sixteen presents a table briefly summarizing key findings of the evaluation matched to the OECD/DAC evaluation criteria.

2 Health Sector Reform

2.1 The Roots of Health Sector Reform

Health sector strategic priorities and higher level goals and targets for the period covered by the evaluation (1999 to 2006) are described in a series of documents including the Health Sector Reform Program of Work (POW) 1999 to 2002, the National Health Policy (2003), the Second Health Sector Strategic Plan (HSSP2) 2003 to 2008, the Poverty Reduction Strategy Paper (2000) and its successor the National Strategy for Growth and Reduction of Poverty (NSGRP)/MKUKUTA (2005).

All of these documents are directly connected to a process of health sector reform beginning in the 1990s. There are antecedents to health reform in the earlier Decentralization Act (1974), the un-banning of private medical practice in 1991/92 and the introduction of cost-sharing in 1993⁷.

More formally, health sector reform in Tanzania can be dated directly from a joint mission with DPs convened by the GoT in October 1995 and the resulting Proposal for Health Sector Reform (Dec. 1995). In discussions and deliberations on the proposals it contained, the DPs and the Government resolved to develop the Health Sector Reform Plan of Action (1996-99) specifying outputs, inputs and activities in six main areas: communications systems, management and organization, strengthening health services, health care financing, drugs supplies and logistics, and human resource development. All of these areas were carried forward, with subsequent additions, into the strategic documents governing the sector throughout the evaluation period.

2.2 Baseline Conditions in the Health Sector (1999)

During its inception phase from December 2006 to April 2007, the evaluation developed a detailed baseline of conditions in the health sector in Tanzania in 1998/99⁸. The key features of the sector at that time included:

- Burden of disease patterns and health outcomes which had generally not improved for the whole of the 1990s with persistent severe health problems which should have been amenable to primary health care interventions;
- Local health services characterized by severe shortages of essential drugs, equipment and supplies and deteriorating infrastructure and plagued by poor management, lack of supervision and lack of staff motivation;
- Stagnant or deteriorating hospital care;
- A Ministry of Health (MOH) which owned and operated over 60% of Health Facilities (HF);
- Poorly functioning system of drug allocations and shipments;
- Weak Health Management Information Systems (HMIS);

7) *Health Sector Reform Plan of Action (1996-1999)*. Ministry of Health. 1996. P.5.

8) *Joint External Evaluation of the Health Sector in Tanzania: Inception Report*. 2007. P.13-18.

- Severe under-funding with public health sector spending at USD 3.46 per capita annually;
- Little coordination and cooperation in health service delivery between public and non-government providers including FBOs and private service providers; and,
- Little coordination among DPs.

The evaluation refers to these conditions as the baseline for assessing achievements and identifying areas of improvement or lack thereof during the evaluation period.

2.3 Major Developments in the Health Sector

As already noted, health sector reform as a process began some considerable time before the 1999 to 2006 period. Similarly, there were major developments in the health sector during the evaluation period. They are too many to list in detail at this point but many are described in the findings chapters below. A listing of just the most important would include:

- 1995: Government/Development Partner Appraisal Mission on the Health Sector;
- 1995: Proposal for Health Sector Reform;
- 1998: Agreement to enter a SWAP Program in health;
- 1998: Establishment of the Ministry of Regional and Local Government;
- 1999: Poverty Reduction Strategy (PRS) identifies health as a priority;
- 1999: Health Sector Reform Program of Work (1999-2002);
- 1999: Comprehensive Community Health Plans introduced;
- 1999: Health Basket Fund introduced;
- 2000: National Package of Essential Health Interventions approved;
- 2001: Tanzania Commission for AIDS (TACAIDS) established;
- 2001: National Policy on HIV/AIDS;
- 2002: National Health Policy;
- 2002: National Malaria Medium-Term Strategic Plan;
- 2002: National Health Insurance Fund (NHIF) established;
- 2003: Health Sector Strategic Plan 2 (HSSP2);
- 2003: National Multi-Sectoral Strategic Framework on HIV/AIDS;
- 2003: Tanzania receives first round Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) funding;
- 2004: Emergency Infrastructure Rehabilitation Program;
- 2005: Tanzania Essential Health Intervention Project (TEHIP) tools rolled out;
- 2006: Joint Assistance Strategy for Tanzania.

2.4 Financial Resources for Health: 1999 to 2006

Financial resources for health, their sources, how they have been allocated, and the quality of budgetary performance are all discussed in detail in Chapter Nine below. Nonetheless, it is useful to point out a few important features of the raising, allocation and expenditure of financial resources in the health sector in Tanzania.

From 1999 to 2006, estimated total public expenditures on health in Tanzania rose from USD 143.6 million to 427.5 million in real terms. In the same time period the domestic share of those expenditures rose from 46 to 56%, with a similar decline in the

share of foreign funding, although both sources grew significantly during the evaluation period.

In per-capita terms, public spending on health was estimated in 1996 at USD 3.46. By fiscal year (FY) 2000 it had risen to USD 4.1 and to USD 9.2 by 2005, against a GoT target of USD 12.0 in the same time frame. As a share of total government spending, health sector expenditures rose from roughly 9 to 12.5% in the period from FY 2000 to FY 2003. They declined in the following year and recovered modestly in the following three years, so that they remain below the FY 2003 share and well short of the target of 15% agreed by the GoT in Abuja in 2001.

3 Relevance

Conclusions: Relevance of Strategies and Plans

1. Assessed in total, health sector strategies, priorities, plans, budgets and programmes have been relevant to achieving the MDGs and health sector goals and targets throughout the evaluation period. They have not been as clearly directed at achieving goals related to maternal mortality as to other MDG and MKUKUTA goals and targets.
2. While relevant to overcoming key constraints identified both before and during the evaluation period, the health sector strategic priorities expressed in the POW and HSSP2 have not been explicitly linked to verifiable targets and to an integrated framework for monitoring and evaluation (even though progress toward MKUKUTA and MDG goals and targets is monitored).

Conclusions: Relevance of External Support

3. Organization of external support under the SWAP has helped to insure that most support remains relevant to national priorities and the needs of the health sector. However, while GHIs and large multi-country bilateral programs are relevant to national priorities, they remain largely outside health planning and management systems with attendant negative effects.

Issue Focus: This chapter deals with the issue of the relevance of health sector strategic plans and programmes to achieving the MDG and MKUKUTA goals in health. It also addresses the issue of the relevance of external support to the achievement of the same goals.

3.1 Relevance of Strategies, Plans and Programmes

In Tanzania, high-level strategic documents (PRSP 2000, MKUKUTA 2005, Health Sector Reform Strategies, National Health Policies, etc.) demonstrate coherence across different documents with consistent identification of priority problems and, in the case of the PRSP, identifying goals consistent with the MDGs in health.

In turn, the key strategies of both the POW and the HSSP2 are plausibly linked to diagnosis of the constraints impeding progress to achieving the MDGs. Moreover, the district self-assessments and the district case studies also confirm the continuing need for strategic emphasis on each of the nine priorities of HSSP2. In that sense, they remain relevant to achieving the MDGs and the health goals of MKUKUTA.

The achievements (and constraints) detailed in the following chapters support the conclusion that health sector strategies, plans and programmes have been relevant to the needs of the sector in Tanzania and to the achievement of the MDG and MKUKUTA goals and targets.

However, the effort to achieve MDG number five relating to maternal health and the reduction of maternal mortality rates (MMR) has not received the emphasis its strategic priority would seem to imply. While the subsequent Demographic and Health Surveys clearly demonstrated that there is an unmet need for family planning and that the contraceptive prevalence rate has stagnated at an even for Africa high rate of 5.7%⁹, there is hardly any attention for this issue in the POW and the HSSP2. While pointing to significant achievements in other areas, the *Draft MOHSW Millennium Development Goals Implementation Report 2006* makes the frank statement: “No significant gains in maternal and newborn survival call for greater innovation for these problems”. p. 43.

In addition, the relative lack of progress relating to stated strategic priorities in hospital reform and public private partnerships suggests that programmatic follow through in these areas has been lacking in comparison to the other strategies such as decentralization.

Finally, the strategic priorities of the POW and HSSP2, while they are plausibly linked to a diagnosis of major constraints in the sector are not, themselves, explicitly linked to verifiable targets and an ongoing monitoring and evaluation system. Progress towards MDG and MKUKUTA goals and targets is monitored but not progress in the implementation of the key strategic priorities at system level.

3.2 Relevance of External Support

External support to the health sector in Tanzania continues to take many programming and financing forms mostly within but sometimes outside the umbrella of the SWAP as agreed among the DPs and GoT. These forms include: Global Budget Support (GBS); contributions to the HBF; bilateral projects and programmes (sometimes coordinated with the SWAP planning and priority setting processes); Global Health Initiatives (GHI) such as the GFATM; and large multi-country bilateral programmes such as the President’s Emergency Programme For AIDS Relief (PEPFAR). A number of DPs also provide technical assistance in the form of advisers.

All of these forms of external support remain relevant to the needs of the health sector as demonstrated in the district assessments. All are also capable of being incorporated into the overall structure of a SWAP approach to development cooperation although it would be reasonable to expect a transition over time to more programmatic than projectized forms of cooperation.

The establishment and operation of the Health Basket Fund (HBF) (as an example of a more programmatic form of development financing) has been a key factor in providing a stable and predictable resource base for local councils in the districts as they have engaged in planning and operation of health services in the context of the Local Government Reform Programme. Along with GoT block grants for health, the HBF has contributed a stable and predictable resource base for local council plans and programmes in the health sector;

9) *Tanzania Demographic and Health Survey 2004-2005. National Bureau of Statistics Dar es Salaam, Tanzania & ORC Macro Calverton, Maryland, USA.. December 2005. Page 16.*

The continuing rapid and significant increase in resources for programming to deal with HIV/AIDS has also been relevant to addressing a critical problem and a national health priority. Unfortunately, it also distorts priorities and results in inequities, especially at local level.

As just one example, health service staff involved in HIV/AIDS programming are often rewarded with higher compensation than their counterparts working in other areas (in case study districts this often took the form of overtime payment at higher hourly rates for staff providing HIV/AIDS counselling and testing services). Similarly, most of the new investment in equipment, infrastructure, staff and supplies observed in the district case studies (and regional hospitals) relates to programming in HIV/AIDS. While some of this investment may strengthen the system as a whole, it also diverts human and other resources away from high priority problems.

A review of the MOF data base on external support to the health sector points out that the period of the SWAP has not lead to a decline in the use of projects as a modality for planning, implementing and financing external support. The MOF data shows that the recorded volume of non-basket disbursements from DPs rose from TSH 24.7 billion in 2002/03 to 57.0 billion in 2005/06. In the same period, the number of disbursing non-basket programmes rose from 46 to 66 according to MOF.

At the same time, it is important to note (see Chapter 9 below) that the portion of external support to the health sector provided “on-budget” has risen significantly during the evaluation period. Despite the rise in the number and value of projects, more external funding is now subject to the budgetary process of the GoT.

4 Strengthening Council Health Services

Conclusions: Strengthening Health Services

1. The evaluation period has seen significant progress in decentralizing planning, budgeting and management of health services to council level, although important controls by the centre remain.
2. Institutional bodies, such as Council Health Management Teams, Primary Health Facility Committees and Hospital Management Committees are in place and functioning, but Council Health Services Boards and Hospital Governing Committees are weak or non-existent and need to be strengthened and empowered.
3. There is not yet an optimal fit between the composition of the CHMT and sector reform strategies.
4. Councils are engaged in the Comprehensive Council Health Plan process in a meaningful way. However, the process is complex and time-consuming. Planning remains dominated by local health system managers and has neither been made truly participatory, nor bottom-up. The CCHP is more a budgeting tool than a dynamic planning tool.
5. Supportive supervision of public, FBO and private facilities by CHMTs has improved quality of care, but remains more focused on administrative and logistical matters than on improving clinical practice.
6. At least as summarized in the Essential Health Interventions Package (EHIP), there has not been an effective prioritisation of the components of publicly financed health care.
7. There is an opportunity to increase the level of collaboration between the health sector and, for example, activities in water and sanitation, education, hygiene and nutrition in an effort to improve health outcomes at local level.
8. There is no evidence of significant improvements in the effectiveness of the referral system during the evaluation period.
9. More emphasis on increasing productivity could lead to more efficient use of human resources at local level.

Issue Focus: This is the first of the chapters in this report dealing with achievements under the key sector strategies in place during the evaluation period. It deals with perhaps the most fundamental of these strategies: the effort to strengthen the provision of health services at district or council level.

The chapter deals with some of the most important system-wide efforts to strengthen council health services during the evaluation period. Namely efforts to:

- Devolve and decentralise responsibility for council health services;
- Strengthen institutional and organisational structures;
- Improve planning and budgeting (and implementation of plans and budgets);
- Strengthen community participation;
- Strengthen inter-sector collaboration;
- Provide cost-effective essential clinical and public health packages;
- Strengthen the referral system;

- Advocate with health sector staff and community members for health sector reform.

4.1 Decentralisation by Devolution

Since the beginning of the period under evaluation, the strategy for strengthening council health services has been linked to the national strategy of decentralization by devolution (DbyD) as implemented by (sequentially) the Ministry of Regional and Local Government, the President's Office-Regional and Local Government and most recently, PMO-RALG.

Documents and key informants support the claim that the health sector was one of the pioneers¹⁰ in meaningful “decentralisation by devolution”.

However, the decentralisation process has not yet been completed. Twelve out of 16 district self-assessments indicated that councils in general possess sufficient autonomy, but district staff interviewed for the case studies pointed out¹¹:

- Very specific guidelines and ceilings for allocation of funds to different budget lines sometimes hamper planning to respond local needs (as mentioned in nine out of 16 district self-assessments and in the visited councils);
- Human resources planning is heavily dependent on centrally decided staffing levels, which take into account neither population served or utilization of HFs;
- Seven out of 16 district self-assessments (of which six were rural) reported that district autonomy is restricted by the MOHSW, although CHMT members in the case study districts supported the recent recentralization of recruiting;
- Councils also feel restricted in their ability to procure drugs and supplies, as they can only use their MOHSW allocation to procure from Medical Stores Department (MSD).

DbyD has made significant progress during the evaluation period but there are still important controls on local decision makers by the centre. While this seemed justified during the initial years, more responsibility, financial power and freedom to prioritise and take decisions could be transferred to lower levels of the administration.

4.2 Strengthening Institutions and Organisational Structures

A key element in efforts to strengthen council health services during the evaluation period has been the effort to establish and/or strengthen the institutions and organizations crucial to governance, planning, budgeting, implementation and monitoring of local services. These can be examined in relation to the most important organizational units in the health system at local level.

- 10) *Most of the interventions mentioned were initiated around 2000, at the start of the evaluation period, although the decision to decentralise by devolution was already taken in 1982.*
- 11) *In general the district self-assessments and district case studies have concurrent findings on improvements in health services as viewed by the community and on constraints to greater improvement. Where they sometimes disagree is on findings relating to the balance of authority and relative performance of different levels in the system.*

Council Health Management Teams

As part of the health sector reforms, the former District Health Management Teams (DHMT) were transformed into the present CHMTs. During this process the roles of the CHMT and its members have been clarified and members interviewed have a good understanding of their responsibilities. CHMT members have also been trained in planning and budgeting according to CCHP guidelines, as well as in HMIS, supportive supervision and other areas of council health management. As an example of progress in training, the target in the POW to ensure all District Medical Officers (DMOs) have a Masters in Public Health (MPH) has almost been reached, as 121 DMOs out of 132 now have an MPH.¹²

Composition of Council Health Management Teams

The CHMT is headed by the District Medical Officer or in the case of urban councils by the CMOH, who is adviser to the District Executive Director (DED) on health matters. Other staff on the core team generally hold the following positions: Health Officer (responsible for preventive services,) Nursing Officer, Laboratory Technician, Pharmacist or Pharmaceutical Assistant, Dental Officer and Health Secretary (responsible for budgets, HR, planning of supervision, vehicle use and other management tasks). This composition was centrally decided by the MOHSW in 2000. Other, co-opted, members of the council health team vary by council, but may include: Tuberculosis and Leprosy Coordinator, Cold Chain Operator, Aids Coordinator, Malaria Focal Point, Reproductive and Child Health Coordinator, School Health Officer, Cost-sharing Coordinator, Food & Drug Coordinator, Preventive Maintenance Coordinator, Water and Sanitation Coordinator, HMIS Coordinator etc.

On the other hand, there are grounds for questioning whether the composition and location of the CHMT is optimal for the tasks they have to perform. Except the Health Secretary, all CHMT members are clinical staff. Rural CHMTs are invariably housed in the district hospital, because most members combine their work for the CHMT with duties in the hospital. For the time being this is understandable, because of the staff shortages and the lack of non-medical health personnel that can be recruited into the health sector to perform non-clinical tasks. During the district case studies, DMOs said that, although the CHMT was supposed to have access to the skills of non-medical council experts (accountant, planning officer, engineer, HR specialist etc.), in practice these people were not available.

Council Health Services Boards and Hospital Governing Committees

One important part of the effort to improve the governance dimension of health services at council level during the evaluation period has been the drive to establish functioning Council Health Service Boards (CHSB) and District Hospital Governing Committees in all districts.

12) *Interview HSRS, 4 June 2007.*

The Council Health Services Boards

According to the 2001 Bylaw for Council Health Service Boards the CHSB shall ensure appropriate and affordable health care services, submit health plans and budgets to the Council (the CCHP), approve CHMT progress reports, mobilise financial resources, ensure equitable access to health services, support the CHMT in managing resources etc. At least formally, this mandate makes the CHSB a most powerful player in health at council level. The board usually consists of four ex-officio council staff, including the DMO, who is the Secretary, four elected community members and representatives of FBO and the private sector, as well as a representative of the RHMT. The CHSB is supposed to meet quarterly.

Council Health Services Boards

With regard to the former, the Joint Annual Health Sector Review (JAHSR) Report for 2005 noted CHSBs had been established in all councils, and more than half were not functioning. The situation may have worsened further since then as the district case studies found that, in all but one district visited, the boards are not functioning according to the mandate given to them in the Bylaw¹³. They meet infrequently, have little or no budget at their disposal, and are not able to fulfil their responsibilities. This means that plans, budgets and progress reports are hardly ever approved by the CHSB. The council, as well as the RHMT, the MOHSW and PMO-RALG, all apparently accept these documents from the DMO without seeking the advice of the CHSB, as required¹⁴.

Equally importantly, cost-sharing revenues accumulate in council accounts rather than being assigned to cover health facility costs because the proposals to use them should be decided upon by the CHSB.

The functioning of the CHSB depends to a large extent on the willingness of the DMO to include them in key management processes. According to the Bylaw, the Chair should convene the CHSB, not the DMO (as is almost always the case). If the Boards are to be given an independent voice, the Chair should also represent the CHSB in council meetings, supported in technical matters by the DMO.

Finally in regard to CHSBs, members representing the community have had minimal training (one day orientation) and cannot be expected to have sufficient knowledge and experience to oversee all health activities in the council.

Hospital Governing Committees

Also in an effort to improve governance and oversight, each district hospital was to establish a Hospital Governing Committee¹⁵ to support and supervise the Hospital Management Team (HMT). In turn, the Committee is formally answerable to the CHSB.

13) *Establishment of Bylaw for Council Health Service Board. MOH & PORALG, 2001.*

14) *The Assessment of CCHPs 2006/2007 by Nyaywa and Petersen covered many important aspects of CCHPs but was not able to report on the percentage that had been approved by the CHSB.*

15) *In the POW 1999 these are called hospital boards, but in the 2005 Guideline for Reforming Hospitals at Regional and district levels the governing body for a district hospital is called governing committee, while that for a regional hospital is called hospital board.*

Under current guidelines its main responsibilities¹⁶ are to receive, discuss and approve annual hospital plans and progress reports and to monitor and follow up the availability of funds from different sources, including those from cost-sharing. The committee should also ensure that hospital health services meet the required standards and satisfy the needs of the target population. Perhaps most importantly, Governing Committees are charged to raise, supervise, monitor and control hospital resources and to administer and monitor the discipline of hospital personnel and their adherence to ethical codes of conduct.

In the six district case studies, the evaluation was unable to find evidence of functioning district hospital governing committees responsible for the above. Most of these duties were carried out by the Health Management Team.

In practical terms the council and hospital management teams operate with limited external governance and supervision, as these two institutional checks and balances on their work are largely absent. With the RHMTs limited in their actual capacity to supervise and no longer holding line responsibility for management of the DMOs, devolution has given the DMO and the Hospital Director increased technical and administrative freedom. At the same time, it should be acknowledged that DMOs must work much more closely with the DED and Council. Indeed, some question the practicality and the need for oversight bodies such as the CHSB and Hospital Governing Committees in the context of a devolved system wherein the DMO and CHMT are increasingly accountable to local government authorities represented by the local council and the DED.

Village Health Committees and Health Facility Committees

Ward and village health committees have been established for a considerable time and deal with all health matters in their respective geographical areas, but they are not involved in the direct management or governance of health facilities. Rather, specialised dispensary and Health Centre committees are responsible for governing all health facilities below the hospital level. There is no structural relationship between the ward and village health committees on the one hand and the HF committees on the other.

All Primary Health Facilities (PHF) visited during district case studies have a committee that is meeting regularly, and typically discusses annual plans and budgets, problems and ways to solve them, as well as complaints of community members about the HF and community education on health.

Some key informants question the wisdom of creating special governing committees for each HF when village and ward level health committees are already functioning and are linked to local government authorities. They suggest that creating governing committees for the HF dilutes the relationship between the HF and local government authorities, especially as these HF committees have a major role to play in monitoring the use of service fees and CHF contributions.

Institutions such as CHSBs, hospital and PHF governing committees are useful control and/or advisory bodies in a democratic society, if and when they are capable and accepted by the bureaucracy. However, the mandate of the CHSB seems to be too broad and needs to be revisited.

16) *Guideline for Reforming Hospitals at Regional and district levels. MOH, 2005.*

4.3 Planning, Budgeting, and Implementation

Comprehensive Council Health Plans

The most important single initiative to strengthen local health service planning, budgeting, implementation and reporting during the evaluation period has been the introduction and support of the system of CCHPs prepared annually by each local council.

The annual CCHP process began in 2000 and coincided with the launching of the Local Government Reform Programme. Council planning using the CCHP was phased in, starting with 37 districts in 2000, 45 districts in 2001/2 and the remaining districts in 2003. In order to facilitate the CCHP, CHMT members received considerable training and a Procedures Manual was distributed in 2000 and revised in 2004. A third version (aligned with PlanRep2 software and including Tanzania Essential Health Initiative Project (TEHIP) planning tools) was published in 2007.

The CCHP is the principal prerequisite for any well functioning district health system.¹⁷ It includes objectives; strategies, activities to address health priorities and indicators to measure progress. The CCHP should plan for all financial resources available for health in each district.¹⁸ Especially in the early years, some districts mistakenly included only the HBF in their CCHPs, but that has been redressed. The close link between the CCHP process and the HBF is evident from the objective statements of the assessment reports on CCHP implementation; invariably, this is to “recommend them for Basked Finance Committee (BFC) approval of the release of the next quarter [basket] funds.”¹⁹

CCHP Preparation

The guidelines state that the establishment of the CCHP is the most important task the CHMT/Planning Team has to fulfil during the year²⁰ and stipulate that the CCHPs have to include the plans and activities of all health providers regardless of the ownership.²¹

Actual planning techniques vary from district to district, but a fairly common procedure is that Heads of HFs and members of Health Committees identify health problems and send a list of these to the CHMT. The planning team analyses the health problems by cost centre, then ranks them in order of priority for inclusion in the CCHP. Beyond this exercise, the district case studies found no evidence that the CCHP benefits from a bottom-up consultation and planning process.

17) MOH & PORALG. 2004. *Guidelines for the Preparation of Comprehensive Council Health Plans*. 12th March 2004. Page 30.

18) *Block, Basket and Council Grants; CHF, NHIF, cost-sharing and contributions from the community, development partners, NGOs, CSOs, etc.*

19) See, for example, *Report on Assessment of 4th Quarter Progress Reports for October-December 2002 for 82 Phase I and II of Local Government Reform Councils, and Re-assessment Financial Quarterly Report for 121 Councils Implementing CCHPs (July-September 2006)*.

20) MOH & PORALG. 2004. *Guidelines for the Preparation of Comprehensive Council Health Plans*. 12th March 2004. Page 45.

21) Same as 17. Page 13.

The process of preparing the annual CCHP also appears to require significantly more time from more people than foreseen. In the six districts covered by case studies, the average number of members on the planning teams rose from 10 to 15 over the evaluation period, and the length and complexity of the CCHPs grew steadily.²² In one of the six districts, members of the Planning Team estimated that each member on the team had worked an average of 30 working days to prepare just last year's CCHP.

Content and Quality of the CCHPs

In response to the different guidelines, the contents of CCHPs have changed over time. Most of the changes and tool refinement have occurred at the level of financial details and not in the coherence of the plans or their analysis and reflection on health problems. In fact, none of the CCHPs reviewed by the evaluation contain any discussion of previous efforts to address health problems or options for the future.

Although the overall health priorities presented in the CCHPs are in accordance with MDGs, MKUKUTA, burden of disease and the National Health Policy, the targets are not consistently linked to the stated priorities and the use of data is inconsistent. Interestingly, while staff shortages, poor infrastructure, and problems with drug supplies clearly constrain council health services, they are seldom mentioned in CCHPs reviewed during the evaluation. As a result, plans are more disease-focused than system-focused.

Given that the CCHP has not yet become a dynamic planning tool, but remains mainly a rather costly budgeting tool, it is possible that a simpler and less ambitious planning process could achieve the same outcomes.

CCHP Quarterly Reporting

All CCHPs and quarterly reports are assessed and scored by the RHMTs and forwarded to the central level. A team of staff from MOHSW/PMO-RALG then compiles a report for the BFC²³. This process is strongly focused on procedural compliance, financial matters and issues relating to eligibility for Basket Funds. Comments on the substance and the planning process itself are very rare.

Implementing CCHP Activities

According to Nyaywa and Petersen (2007) two thirds of councils did not provide data in the CCHP on the implementation level reached for activities planned in the previous year. The district case studies generally found that CCHPs were not being used to track progress against either activity or outcome targets.

Supervision

The word supervision does not occur in the POW, but in the HSSP2 "*supportive supervision regularly provided to all health facilities*" is mentioned as an indicator of quality improvement. The district case studies indicate that the general orientation of supervision has become more supportive, rather than controlling or for pure accountability purposes, which was much appreciated by health staff of the facilities visited. One achievement has been to extend supervision beyond the public system to include all FBO and private

22) *The length of the Mwanza CCHPs, for example, grew from about 60 pages in the early years to an average of 175 pages over the last four years.*

23) *Because many RHMTs are presently not functioning fully, the MOHSW/PMO-RALG team also has to assess and score many progress reports themselves.*

Health Facilities (HF). On the other hand, three of the six district case studies noted weaknesses in supervision. The district case studies note that supervision by the CHMT tends to focus on logistics, administrative and data management matters (HMIS) rather than improving clinical practice.

This is not necessarily negative in the light of core tasks of the CHMT, as an arm of the Council. But quality of care should also be regularly supervised. Whether staff adhere to diagnostic and treatment standards and protocols is, however, better supervised by more clinically oriented hospital teams, possibly contracted by the Council, than by the CHMT.

4.4 Community Participation

The most important way in which community members are involved in the planning and management of council health services is through their participation in PHF committees. This seems to work relatively well because the HF is close to the members, committee members are regular users, and their contributions have reportedly resulted in visible changes/improvements.

In contrast, participation by community members in planning and monitoring at the wider council level is minimal. In particular, the CCHP process in the six case study districts saw little involvement from community members. Nyaywa and Petersen's assessment of CCHPs for 2006/07 from 60 districts found that only 12% had participation from FBO/VA/CSO/private sector agencies and only 3% had representation from the wider community. Representatives of these organisations interviewed during the district case studies often, but certainly not always, rated their participation as minimal.

There are a number of possible causes for this lack of community participation in health planning. One may be the time constraints faced by CHMTs and the tendency to focus on the CCHP as purely a budgeting rather than a planning exercise. Another possible explanation could be the scarcity of competent community members to serve on the CHSB or take part in the CCHP exercise.

Ultimately, of course, the lack of community participation in preparing CCHPs may reflect an ongoing and in-built tendency for the managers involved to see health sector planning as their domain of expertise, at least at the overall council or district level. It may also be due to a genuine lack of interest on the part of community members at any level above their own health facility, in which case it may not be possible to make CCHP development truly participatory.

It was clear in the case study councils that, once the CCHPs are produced, they are not distributed beyond the members of the planning team, PMO-RALG and MOHSW. The evaluation did not meet anyone who had a copy of the CCHP or even extracts of the relevant pages of this. In fact, most had never seen a CCHP for their council.

4.5 Intersectoral Collaboration

The importance for health of close collaboration with other sectors is emphasised in the POW (but not in the HSSP2). Nyaywa and Petersen (2007) found in their assessment that water and sanitation was the number 10 priority listed in CCHPs, so there is some

evidence that concerns outside the traditional health sector are reflected there. On the other hand, the district case studies did not find significant evidence of multisectoral activities at council level. TACAIDS, however, is one example of a multisectoral programme working at regional and council level.

Devolution should in theory facilitate cross-sectoral cooperation at council level. Given the fact that clean water and sanitation, hygiene measures, nutritious food and basic education all substantially contribute to health, active cooperation across sectors could be expected to feature more largely in health plans. Village and ward level health committees could play an important role in building linkages to other sectors in the development of CCHPs.

4.6 Essential Clinical and Public Health Packages

In 1999/2000 Tanzania defined a national Essential Health Interventions Package (EHIP) to be delivered in the districts²⁴. To be included in the package interventions should: address major health problems, have significant impact on health status, be cost-effective, improve equity, respond to demand and have a 'public good' character. The EHIP has five major components: reproductive and child health, communicable diseases, non-communicable diseases, common diseases and health promotion. Each category contains a number of disease groups, specific diseases and/or intervention groups.

While this list was already quite long compared to that of other countries (including e.g. diabetes, mental disorders and neoplasm), in the subsequent National Health Policy more items were added. Almost every intervention regularly provided at the district level is considered a priority. The list is therefore more useful as a classic example of consensus policy than as an effort at painful, yet realistic priority setting. Moreover, the package was only partly costed and it is very doubtful that the limited resource envelope available to councils is sufficient to fund delivery of the whole package.

The criterion that the intervention should be a public good in order to be included in the package has not been adhered to. Had this been done, then the unavoidable conclusion should have been that most interventions presently in the package can be privately provided in the market, while the scarce public funds would go to provision of true public goods or to subsidising the FBO/private sector to provide the same, as well as to ensuring that the poor can afford to make use of the services.

The HSSP2 notes that priorities in the EHIP should be better defined, but document reviews and interviews indicate that, outside of the TEHIP pilot project in two districts, the topic has not received as much attention over the evaluation period as could be expected. At least as summarized in the EHIP, it seems clear there has not been an effective prioritisation of the components of publicly financed health care. The TEHIP tools (district health accounts and burden of disease estimates), now included in the new PlanRep2 software, could be effectively used to establish a limited number of high priority interventions, which could then possibly be included in the Community Health Fund (CHF) package. The tools also allow planners to compare expenditure plans with the actual burden of disease.²⁵

24) *National package of essential health interventions in Tanzania. MoH, January 2000.*

25) *PlanRep2 Operating Manual version 6.8b. PMO-RALG, 2007, page 44.*

4.7 Referral

Although 10 out of 16 district self-assessments conclude that the referral system has improved at least somewhat, the six district case studies strongly indicate that referrals are still not functioning properly (as in many other developing countries). A number of reasons have been mentioned for this:

- There is no clear distinction between levels of care: some regional hospitals function as district hospitals (but at a higher cost), some FBO district hospitals offer higher level services than the closest referral hospital, and some HCs are not very different from dispensaries;²⁶
- People go to the nearest HF for all their health needs, regardless of the level of the HF, saving time and transport costs;
- People have ample opportunity to bypass, as in general there is no bypass fee;
- Where there is a bypass fee, people are willing to pay it in order to receive higher quality care (as reported by Bugando Medical Centre ;
- Dispensaries report that they often refer patients straight to the hospital, rather than first to the HC, in order to prevent them having to be referred by HC to the hospital all the same.

The fact that the referral system is not working leads to cost increases, largely because many people are treated at a higher, more costly, level than necessary. It also leads to overcrowding of the higher levels, as the evaluation was able to observe very clearly at all six regional hospitals visited.

4.8 Advocacy on Health Sector Reforms

CHMT members generally have reasonable knowledge of health sector reforms and can name most when asked to do so. Beyond that, however, lower level health workers can seldom identify reforms without being prompted. Similarly, community members often do not seem to be aware of the strategic directions of health sector reforms. It is important to point out, however, that both Public Health Facility (PHF) workers and community members have a strong sense of very concrete changes occurring in the system over time, many of which can be related back to the process of reform. For example, it was clear in the interactions with community members during the focus group discussions that many understand the concept and reasons for cost-sharing, are aware of efforts to increase health worker skills, and are keenly aware of shortcomings or improvements in the drug supply system.

It can hardly be expected that lower levels health workers and community members have in-depth knowledge of health sector reforms. This knowledge is not necessary, as long as they have been involved in planning for concrete changes, understand the reasons for them and are broadly in agreement with them, so they will be implemented. The latter seems to be the case.

26) *The fact that levels of care available in one type of facility often cannot be distinguished from those in a facility of a lower level, was also already mentioned in the POW 1999 as a problem with referral.*

4.9 Detailed Recommendations

Central Health Services Boards (CHSB) and Governing Committees

To give boards and committees an independent voice and allow them to become fully functional, the following should be done:

1. The mandate of the CHSB should be revisited. CHSBs should be empowered to perform their tasks by receiving their own budget from the council, covering sitting allowances, transport costs and office costs; (1)
2. Develop adequate training courses for boards and governing committees in order to allow members sufficient knowledge and experience to oversee/advise on all health activities in the council/HF or village; (1 and 2)
3. Emphasize a multi-sectoral approach to health matters by the CHSB and encourage intra-council cooperation between health-related departments; (2)
4. Ensure that CCHPs and progress reports are only accepted by councils and higher levels with official CHSB approval; (2)
5. Designate the CHSB Chair to call meetings of the Board and represent the CHSB in council meetings, supported in technical matters by the DMO, as needed; (1)
6. Create a post and provide office space for a full time CHSB secretarial assistant in the council office, in order to make the CHSB independent from the CHMT; (1)
7. Establish an independent national support institute for CHSBs, hospital and PHF governing committees and village health committees; (2) and
8. Strengthen links between the CHSB and Ward and Village Health Committees. (1 and 2)
9. Evaluate the performance of CHSBs during HSSP3. (3)

Council Health Management Teams (CHMT)

10. The CHMT should focus on all non-clinical aspects of health in the council, including public health, epidemiology, planning, logistics, human resources, training, financing, M&E, multi-sectoral issues, public private partnerships etc. (1)
11. Clinical aspects of CHMT operations should become the responsibility mainly of hospital staff, who can be called on by the health facility or the council/CHMT to supervise or troubleshoot diagnosis and treatment in primary health facilities. Some support could be provided by pre-service training institutes where they are located in or near a district. (2)
12. The composition of CHMT should be adapted to better reflect these tasks: it would need to include the DMO (public health and overall management), Health Secretary (office management, including human resources), planning officer (policy development, CCHP, reporting), financial officer (budget, accounting, cost-sharing, NHIF), logistics officer (drugs and supplies, cold chain), health information officer (data management and analysis), health education expert (community mobilisation, IEC, advocacy, campaigns, school health) and quality improvement officer. There would be no need for co-opted members (2 and 3)
13. The CHMT should be housed in the council office. (2)
14. The budget to attend and/or organise workshops/seminars etc. should be devolved to the councils/CHMTs. On the basis of their priorities they would then decide which ones to attend and pay costs from their devolved budget. (2)

Comprehensive Council Health Plan

15. The Essential Health Interventions Package (separate for primary and secondary levels of care) should be costed and further prioritised until a package of public health and clinical interventions is identified and can be funded out of the available council resource envelope. The chosen interventions can then be included in the CHF package. The TEHIP tools for estimating the burden of disease and establishing council health accounts, now included in PlanRep2, would be very useful for this purpose. (2 and 3)
16. The CCHP guidelines should be amended to ensure real and broad-based participation of health stakeholders (such as the officers in charge of HFs, ward and village health committees, FBO staff, NGO/CSO representatives) in the CCHP planning and monitoring process to generate local ownership and better identification of health needs and priorities. To this end use can be made of existing avenues for structural involvement of stakeholders, such as Opportunities and Obstacles for Development Guidelines for village planning. (1)
17. A simpler and less ambitious format for CCHP should be designed. This should include a better balance between the financial (less details) and technical aspects (more emphasis) of the CCHP. Also the progress reports should focus more on content, e.g. by reflecting on the implementation of activities included in the CCHP. (2)
18. Copies of the CCHP, or summaries, should be distributed to all major stakeholders within the districts and all CCHPs should routinely be placed on the District Health Web-site (www.districthealthservice.com/). (2)

Quality of care

19. Councils should be encouraged to enable all primary health facilities to do basic laboratory tests and train staff to properly use them and interpret the results. (3)
20. MOHSW and DPs should closely follow the performance-based financing experiment in five Catholic Dioceses and make a provision in HSSP3 to pilot the approach in public facilities should the current test prove promising. (2 and 3)
21. More clinical supervision and regular refresher courses for all staff on clinical issues is required. Staff of PHFs can best be supervised by council hospital staff, who in turn can be supervised by a higher-level hospital. (2 and 3)
22. Health facilities should give urgent priority to infection control, adherence to the IMCI protocol and, most importantly, emergency obstetric care. In order to decrease maternal mortality more resources of all kinds should be invested in safe motherhood, including family planning. (2)

Inter-sectoral collaboration

23. More emphasis should be given at all levels to the important contributions of other sectors to improve health (water and sanitation, education, hygiene and nutrition), but impact can in particular be made at the council level and below. Devolution should facilitate cross-sectoral collaboration between relevant sections within the council administration. The fact that ward and village health committees already deal with health in its wider context, offers opportunities, which deserve to be supported by the council/CHMT. (2)

5 Changing Roles of the Central Ministry

Conclusions: The Changing Roles of MOHSW

1. MOHSW has been largely successful in transitioning from its extensive operational responsibilities at local level to a policy and technical support role during the evaluation period, partly through the production of a significant body of guidelines. However, the sheer volume of MOHSW initiatives has often overwhelmed capacities at council level.
2. MOHSW and PMO-RALG continue to experience difficulties in aligning their organizational cultures and structures, policies and processes.
3. The regional level (as represented by the Regional Health Management Team) is not functioning well and funding is insufficient and/or not available.

Issue Focus: This chapter deals with the issue of the transformation of the Ministry of Health and Social Welfare into a facilitative policy organization during the evaluation period. It examines this transformation in terms of the actual products of MOHSW during the period and of its relationships with its main GoT partner in the devolution process, PMO-RALG. It also assesses the implications for MOHSW roles at regional and council level. Although relationships with other key ministries, such as MOF, Planning, President's Office-Public Service Management (PO-PSM) etc. are also important, they are not the focus of this report.

5.1 Policies, Guidance and Technical Support

During the evaluation period the MOHSW, with support of DPs and other stakeholders, produced an impressive number of policies, strategic plans and guidelines, as well as tools to support health sector reform. The document review and key informant interviews at central, regional and council level agree that the technical quality of this policy development and facilitation material has generally been high.

Examples of operational guidelines produced include:

- treatment guidelines for HIV/AIDS, cholera, malaria and infection prevention;
- guidelines and standards for counselling and supervision in HIV/AIDS;
- guidelines for Prevention of Mother To Child Transmission (PMTCT);
- training guidelines for home-based care and treatment of Sexually Transmitted Infections (STI);
- guiding principles for integration of vertical programmes;
- supportive supervision guidelines for quality health care services;
- guidelines and standards on cross-cutting issues for health care practice;
- guidelines for CCHPs in 2000, 2004 and PlanRep2 in 2007 (with PMO-RALG);
- guideline for reforming hospitals at regional and district levels;
- CHF operational guidelines;
- health basket and health block grants guidelines;

- an operational manual for district integrated management cascade; and,
- health care technology policy guidelines.

The Changing Role of the Ministry of Health and Social Welfare

Local government reform and devolution have meant a very different role for the Ministry of Health (now MOHSW). Administrative and financial responsibility for implementing health services at the district level and below has been transferred to PMO-RALG. The MOHSW retains administrative responsibility for the regional and national/referral hospitals, as well as technical responsibility for the quality of health services at every level.

To this end the MOHSW formulates policies, strategic plans, regulations and legislation and develops guidelines. The central MOHSW is also responsible for preventive services, procurement and distribution of equipment, drugs and supplies through MSD, donor coordination, the overall health budget and MTEF, M&E, human resources planning and quality assurance.

The Ministry leads on health sector reform (HSR) with a dedicated Secretariat (HSRS). Lastly, the MOHSW maintains relations with FBOs, NGOs and the private sector, professional organisations, research institutes and the media, as well as with international organisations.

However, some issues have lagged behind: more work is urgently needed on regulation of the private sector and legislation to establish a health inspectorate, especially since quality of care is the main thrust of HSSP2. Another area of concern is the lack of progress on developing service agreements with non-state providers and performance-based incentive schemes for HF and/or workers, although both issues have been under discussion for many years. In order to post and retain staff in more remote or hardship areas, different incentive packages have been discussed over the years,²⁷ but a successful package still has to be developed and implemented.

It should be noted, however, that MOHSW cannot develop these outputs in isolation from other Ministries, Departments and Agencies of the GoT. Some of the slow progress in these areas can be attributed to inter-ministerial issues.

It is also worth mentioning that Tanzania has a number of research institutes that undertake a large number of studies covering major clinical areas as well as operational and health system issues. The National Institute for Medical Research, the Ifakara Centre for Health Research and Development, the Research on Poverty Alleviation group and the Central Bureau of Statistics all produce important health research on a regular basis. Organisations such as the Women's Dignity Project and the Health Equity Group also contribute to the knowledge base of the health sector. The results of these studies are known and used by the MOHSW, in particular by the HSRS. That said, a more systematic cataloguing of studies and results would improve the evidence-base of policy making and planning. To that end a special section in the Health Information and Research Section (HIRS) of MOHSW could be established.

27) A Presidential Committee has reportedly even been established on the issue (info PMO-RALG).

The district self-assessment and district case studies were in agreement that health staff at council level are generally positive regarding the quality and utility of the policies and guidelines issued by MOHSW. On the other hand, there was general agreement that the Ministry produces too many guidelines and other documents for the CHMT to absorb.

Moreover, distributing guidelines alone is not enough, initial training and persistent follow-up is needed to ensure that new ways of working truly become integrated into daily routines. RHMT and CHMT members wonder if central ministry staff realize the implications at regional and local level of dealing with so many change initiatives.

Key informants at all levels question whether MOHSW and PMO-RALG may have introduced too many reforms and other more minor changes in too short a period. They note that it may be more effective to focus HSSP3 on consolidation of reforms, and to limit the number of new initiatives to a minimum.

5.2 Relationship with PMO-RALG

As MOHSW and PMO-RALG have worked to implement DbyD it has become clear that administrative and technical responsibilities cannot always be easily separated. This in turn means that close day-to-day collaboration between PMO-RALG and the MOHSW is extremely important. The fact that PMO-RALG is located in Dodoma and the MOHSW in Dar es Salaam does not really facilitate regular contact. In response to these needs, PMO-RALG and MOHSW have recently established a Task Force to improve their working relationship.

Notwithstanding efforts to improve communications, key informant interviews strongly indicate that there are important differences in the vision of both ministries on how their cooperation should work at different levels. For example PMO-RALG staff voice the opinion that the decentralised structures in place should also be empowered to take on increasing responsibility by, for example, decentralising financial responsibility down to the primary health facility level. They cite evidence from the education sector suggesting if the lowest level manages its own funds they are spent more effectively than when managed at council level. While this view is consistent with the general thrust of DbyD, in the health sector it should probably be linked to establishment of some form of results-based financing and strengthened mechanisms to ensure that quality services are being delivered and the possibility to misuse funds is minimised.

PMO-RALG staff also differ with MOHSW on the size of the required investment in training and workshops for health sector staff, which they view as both too high and not that effective. MOHSW staff, on the other hand, point to the extensive training requirements of major reform initiatives under way.

Field observations during the evaluation suggest that, although the number of workshops, seminars, conferences etc. at the national level could be reduced, there is a need in the regions and districts for continuing training on sector reforms and the introduction of new forms of treatment. There have also been serious differences of opinion on the role of the regional level, as discussed in the following section.

5.3 Regional Health Management Teams

As the link between the MOHSW and the CHMT, the RHMT and the Regional Medical Officer (RMO) represent one of the most important elements of MOHSW's new policy making and facilitative role. Its roles are to interpret and adapt national policies to regional realities, provide support to the CHMT, and to evaluate CCHPs and progress reports before forwarding them to PMO-RALG/MOHSW.

Quote from an RMO

"I lost my hospital, I lost my authority, I have no funds. I am a senior medical officer, but I have nothing to do."

Legal and Reporting Status

Document reviews, district case studies and key informant interviews at regional and central level indicate that there are persistent difficulties in the formal status RMO and the RHMT.

The RHMT is headed by the RMO, who is the adviser on health matters to the Regional Administrative Secretary (RAS). The RMO, who used to be the medical officer in charge of the regional hospital, legally still holds that responsibility, but in practice the Health Management Team, headed by a new MO in charge, is now taking decisions, although the latter is not mentioned in the legal documents.

Officially, only the RMO is recognised by PMO-RALG, although it is not a substantive post²⁸ in civil service terms. Similarly, there is no act or legal tool that mandates the RMO and the RHMT. The regional level has not been the subject of any systematic review and has hardly benefited from the reforms. Despite having been on the JAHSR agenda several times during the evaluation period, these issues have still to be resolved.

Quote from MOHSW Staff Member

"With the reforms the regional level was simply forgotten!"

Funding the RHMT

Because the RHMT is not formally recognized by PMO-RALG, the Regional Secretariat (RS) funds the office costs of the RMO, but not the operational costs of RHMT activities.

28) A substantive post is recognised as a separate post with a grade and benefits.

Two years ago, under local government reforms, five administrative clusters were created in each regional headquarters under the RAS. One of them is the social services cluster, of which health is a section or department with only one health expert, the RMO. This additional change means that the RMO is now responsible to an Assistant Administrative Secretary (AAS) heading the cluster and has lost his/her direct access to the RAS, further devaluing the RMO position.²⁹

When the RMO was still directly under the MOHSW, the RHMT did not have a separate budget. Its operations were financed from the regional hospital budget. Since 2004 there is one operating cost budget line in the Medium Term Expenditure Framework (MTEF) for the social sector in the RAS office, but no specific amount allocated for health.

In order to enable the RHMTs to fulfil their duties, the MOHSW, while discussing the issue with PMO-RALG, temporarily earmarked a part of the central HBF for operational costs of the RHMTs. These funds are to be transferred by the MOHSW to PMO-RALG, and from there to the RAS Office. However, in all six regions visited by the evaluation the RMOs said that this money is not available to them, despite the fact that they make plans and budgets, which are approved. In some cases this is related to audit queries in relation to (mis)use of previously provided funds but in other cases there is no obvious reason. This means that the RHMTs have no funds for fuel and per diems to undertake visits to the districts, unless they are able to use vertical programme funds.

Composition and Capacity of the RHMT

As with the CHMT, the composition of the RHMT remains very clinically oriented and does not reflect health reform initiatives such as the multi-sectoral approach, the development of the CHF, and the development of PPP. While the RHMT is supposed to support and supervise the CHMTs, the latter have been more extensively trained. One RMO commented on the lack of effective capacity (including lack of funds) of the RHMT by saying *“giving councils more responsibility is good, but if they are not performing well, there should be a hand to correct them. But we can only give advice, which can be accepted or not”*.

The Search for A Solution on the Roles and Capacities of the RHMT

In June 2007 (during the main data collection mission of the evaluation) the Permanent Secretaries of the MOHSW and PMO-RALG agreed that a seven-member RHMT would be recognised in the RAS office as a separate cluster, giving the RMO his/her team back as well as a direct reporting link again to the RAS. This agreement could help to resolve the difficult financial state of the RHMTs.

During the evaluation three possible core functions at regional level were noted:

1. clinical supervision (more or less the classic function of the RHMT);
2. support to CHMT in planning, finance, HR, logistics, administration etc. (the renewed function of the RHMTs, which they have not been able to fully exercise, due to lack of funds and competence); and
3. health inspectorate (at present non-existing, but necessary for quality assurance).

29) *Unless the RMO is the AAS, as is the case in Iringa Region. The AAS is one of the departmental heads, making the cluster head a primus inter pares position.*

These functions need to be studied in parallel with the suggested tasks and composition of the CHMT and an assessment of how much support the CHMT is likely to need in the future. While teams from the regional hospitals can be contracted to clinically supervise council hospitals, RHMTs in the RAS office could support the CHMTs and a separate (semi-autonomous) small health inspectorate team could be established at the regional level to inspect quality, safety and access to health care, as well as investigating complaints and safeguarding the rights of patients.

5.4 MOHSW and Local Government Authorities

There are some indications that local councils are becoming more engaged in the health sector over time. In Kigoma, for example, the municipal council agreed to fund a supplementary kit of drugs and supplies to augment the one provided to HFs by MOHSW through MSD. On the other hand, there is still a need to better link the pre-existing organs of local government, including ward and village health committees into health sector reforms and initiatives. Health committees could have inputs to the CCHP process, for example. Similarly, there could be some form of linkage between facilities governing committees, sponsored and created by the MOHSW, on the one hand and ward and village health committees on the other.

Also at the district level, the DEDs interviewed are well aware of the health needs and constraints in the Council. They generally are able to see possibilities for linking health initiatives to actions in other sectors such as water and education.

There is no doubt that the situation of the DMO and the CHMT has radically changed during the evaluation period so that they now have much closer ties to the DED and the council. They continue to rely on MOHSW for policy support, guidelines and capacity development, especially in relation to national initiatives like the CHF. They would also rely more on the RHMT for closer technical supervision if those bodies were properly funded.

5.5 Detailed Recommendations

MOHSW

1. MOHSW should place primary focus on finalisation of a number of issues that have been under development for many years: legislation to establish a health inspectorate, regulation of the private sector, service agreements with non-state providers, and introduction of an incentive package to attract health workers to rural or remote areas. (1 and 2)
2. The M&E function of the MOHSW should be strengthened. The Health Information and Research Section should be further strengthened to improve monitoring of indicators, and overall evaluation skills should be developed. (2 and 3)
3. The MOHSW function to liaise with non-state stakeholders in health should be strengthened. (2)
4. The number of workshops, seminars, conferences etc. at the national level could be reduced, while there is a need in the regions and districts for continuing training on sector reforms and the introduction of new forms of treatment. (1)

PMO-RALG

5. In the medium to longer term councils could be given full responsibility for human resources planning and budgeting (including salaries), allowing more flexibility to link financial resources to local priorities. (3)
6. Financial responsibility should be decentralised to the health facility level: these could have their own budget, directly order drugs and supplies from MSD or other suppliers, and decide themselves how to use cost-sharing funds. This should be linked to establishment of some form of results-based financing and oversight mechanisms to ensure that quality services are delivered and possible misuse of funds is minimised. (3)

Regional level

7. MOHSW/PMO-RALG should immediately inform RMOs of funds transferred to the RAS for the operational costs of the RHMT. (1)
8. The misalignment of the legal mandate and the practical role of the RMO vis-à-vis the regional hospital and the hospital management team should be resolved. (1 and 2)
9. Regional level roles in support of health services should be re-considered, including the roles of the RMO and RHMT. A study is warranted to assess which functions are needed at the regional level, which professionals are needed to fulfil these functions, and within which institutional framework the corresponding services could best be provided. Three potential functions, from which a choice would have to be made, have been mentioned: clinical supervision, support to CHMT and health inspectorate. (2 and 3)

6 Hospital Reform

Conclusions: Hospital Reform

1. Despite some improvements in the availability of drugs, provision of equipment and in-service training for hospital staff, hospital reform has not progressed at the same pace as other aspects of health sector reform.
2. There is little evidence of progress in improving the governance structure or management practices at hospital level.
3. Budgets for regional hospitals have increased, but they remain under-funded, and experience major shortages of qualified staff and drugs, as well as serious problems with utilities

Issue Focus: This chapter assesses the extent of progress in reforming and strengthening regional and national referral hospitals. It first examines policies and plans for hospital reform then assesses different dimensions of progress in reforms at each level (regional and referral).

6.1 Policies and Plans

The POW (1999) pointed out a number of key problems related to regional and national referral hospitals:

- They consumed a high proportion of the health budget, but quality, efficiency and access to services for the poor are seriously compromised;
- There was a continuing shortage of specialists, equipment, drugs and other medical supplies;
- They often served as primary health care providers for people living in the vicinity leading to overcrowding and ineffective use of resources; and,
- The infrastructure of many hospitals was in serious state of disrepair, partly due to transfers of funds to primary health care.

The POW also noted that efforts to try and reduce the number of hospitals and their budgets had been unsuccessful. The sector was characterized by a limited analysis of hospital services and a lack of systematic planning at the time. In turn, it laid out a comprehensive and ambitious plan for hospital reform in an effort to ensure quality, equity, efficiency, affordability and the financial viability of referral and regional hospitals.

Some of the strategies to reach those objectives included devolving management authority, broadening financing options, strengthening management, increasing efficiency, improving infrastructure, and concentrating on provision of referral services.

An impressive list of concrete steps to be implemented featured:

- introducing cost-sharing;
- establishing hospital boards with maximum control over physical assets and financial and human resources;
- production of strategic and business plans;
- working with performance targets and publishing performance information;
- internal decentralisation to hospital departments; and
- introduction of a bypass fee.

A five-year plan to phase in the reforms was established, starting with Muhimbili national referral hospital in Dar es Salaam.

The HSSP2 did include most of the previous strategies for hospital reform, but its strategic framework clearly situated them in the context of support to council health service delivery. New in the HSSP2 was more attention for staff motivation and retention and emphasis on specific HIV/AIDS services, as well as measures to mitigate the impact of HIV/AIDS on hospital staff.

Although the POW and HSSP2 include numerous objectives and activities to implement hospital reforms and improve hospital performance, the MOH only issued guidelines for reforming regional and district hospitals in 2005.³⁰ In those guidelines the same constraints are noted as in the POW six years earlier.

The implementation of both the POW and the HSSP2 have focused mainly on the district level. All stakeholders consulted by the evaluation confirmed the level of attention and investment in hospital reforms has been low.

6.2 Regional Hospitals

Funding regional hospitals

The period under review has seen improvement in funding levels for regional hospitals. Regional hospitals have also been able to raise additional revenues through the collection of user fees, the introduction of private wards, where affluent patients receive better services for a higher price, and through direct donor support.

Where regional hospitals also serve as the council hospital, they are allocated the HBF funds earmarked for the district hospital(s). Now that several Councils are building long-awaited council hospitals, these funds will be re-allocated to the new council hospital, seriously diminishing the financial resources of the regional hospital.

One could of course argue that the new council hospitals will take over a good share of the (less complicated) cases that now present to the overcrowded regional hospitals, therefore justifying a decrease in budget for the latter. However, regional hospitals are in general severely under-funded (and very heavily used) as it is, so any cut in revenues will impact negatively on their ability to provide quality services.

30) *Guideline for Reforming Hospitals at Regional and District level. MOH, March 2005.*

The district case studies noted other persistent challenges in funding the regional hospitals including:

- Continued delays in transfer of funds;
- An overall inadequate MSD allocation for drugs and supplies;
- Lack of financial management capacity, resulting in poorly prepared, and sometimes rejected, budgets;
- The fact that regional hospitals feel obliged to accept funding driven by specific donor interests, often not integrated into their planning and budgeting structures and sometimes not in accordance with priority needs.

Governance and Management

While Health Management Teams are established and functioning in many regional hospitals, like district hospitals, most do not yet have Hospital Boards in place. Only one of the regional hospitals visited by the evaluation has several reform experiments in place, due to the fact that its Director is a member of the National Hospital Reform Task Force. In general it was observed that whatever reforms in governance were taking place, these were more a result of local and individual initiatives than that they were facilitated by national guidance.

There has been some improvement, albeit slow, in the management capacity of the regional hospitals. Prior to health sector reform, managers were used to planning for resources on an incremental basis (approx. 10% per annum). Coupled with their low expectation of receiving the amounts budgeted for, this acted as a disincentive to proper planning and budgeting.³¹ Training of RHMT members in management practices has resulted in better management capacity, but whether these skills are also routinely utilised for improved hospital planning could not be established.

Infrastructure and Equipment

During the evaluation period, infrastructure development for hospitals has been very slow. The JAHSR noted in 2005 that physical rehabilitation of district and regional hospitals had not yet started.³² The low level of investment towards the rehabilitation of hospitals is reflected in the Development Expenditure Budget for Rehabilitation of (all) Facilities. In FY 2003/04, this was 11.5% of the total budget allocated to financing priority health interventions. In the same year, the budget for strengthening referral hospitals was 14.7% of the total. Projections made for the FY 2004/05 and 2005/06, showed a similar trend.³³

Even in regional hospitals, the utilities infrastructure remains very poor, both water and electricity supplies being intermittent at best. In many facilities, (in contrast to FBO facilities) the use of captured rainwater (in plastic tanks, for example) and identification of viable alternative power sources is not being pursued proactively.

31) *Sector-Wide Approach in Tanzania: The Health Sector Example*; Oliver Burki (Swiss Agency for Development and Cooperation), February 2001.

32) *Progress against the Milestones set in March 2004 to Joint Health Sector Main Review (4th-5th April, 2005)*.

33) *Poverty Reduction Strategy: Third Progress Report (2002/03)*.

The condition and availability of equipment however, has fared better in regional hospitals, and this has been largely associated with bilateral donor support. Ten regional hospitals received VHF radio-calls, office equipment, computers and emergency supplies and equipment. Four regional hospitals are documented to have received ambulance vehicles.³⁴ It must be stressed however, that transport and communication remain a severe problem.

The quality of equipment received from MOHSW through MSD has improved in the period under review, but still remains inconsistent and is said to be lower than the quality of equipment available from other suppliers. Maintenance of equipment however is still poor. Preventive and systematic maintenance practices are lacking and equipment is repaired, if at all, on an as-needs-emerge basis. Most hospitals lack the local technical capacity or support to effect necessary repairs.

Drug Supplies

Interviews and observations from the six district case studies indicate some improvement during the evaluation period in the supply of drugs to regional hospitals. However, there are still delays from MSD and shipments are often reportedly missing from 10 to 20% (reported by Mawenzi Regional Hospital, Kilimanjaro) or even 50% (Sekou-Toure Regional Hospital, Mwanza) of drugs ordered. Drug allocations are not based on the (real) burden of disease and some regional hospitals report that as little as 20 to 30% of their real drugs and supplies needs are actually met. On the other hand, regional hospitals have more cost-sharing revenues than district hospitals and are able to cover part of the shortfall by using these revenues to purchase additional drugs in the market.

On the positive side, the supply of anti-malarials and anti-retroviral drugs (ARV) has been consistent and stock-outs are now rarely experienced.

Human Resources

In spite of the improvements over the last few years (the emergency hiring programme, increase in public health worker salaries, etc), regional hospitals still face severe shortages of qualified staff while workload remains high. With no concrete Human Resources for Health (HRH) attraction and retention strategies in place, hospitals in hard-to-reach areas are particularly affected. Some extreme examples of the severity of the crisis include Singida Regional Hospital which currently has no medical officer. Sekou Toure is run mostly by Assistant Medical Officers (AMO). It is already difficult to find MOs in regional hospitals and medical specialists are even more scarce.

6.3 Referral Hospitals

This section examines the progress in reforms at the only national referral hospital included in the scope of the district case studies, the Bugando Medical Centre (BMC).³⁵

34) *Appreciation Remarks by the Minister of Health and Social Welfare (Hon. Professor David Mwakiyusa) at the Ceremony of Receiving Ambulance Vehicles from US Ambassador (30th Jan 2006).*

35) *The information on BMC is based on an interview with the Chair of the Hospital Board and the Director.*

The BMC has 910 beds and is a referral hospital for 13 million people in the regions of Mwanza, Mara, Kagera, Shinyanga, Tabora and Kigoma. The occupancy rate has slightly increased over the years and now stands at 76%, reflecting increased efficiency. BMC is also a teaching hospital for the Bugando University College of Health Sciences.

Funding the BMC

As owner of BMC, the Tanzania Episcopal Conference of Catholic Bishops is responsible for capital investment and rehabilitation of infrastructure. In principle, the GoT pays ongoing running costs. According to the Director, the real operating costs of BMC are TSH 6 billion per annum, but their budget is TSH 2 billion. Cost-sharing revenues have increased more than ten-fold over the period and now stand at TSH 1,200 million per year, while the contribution of the MOHSW to operating costs is TSH 800 million. BMC has an allocation with MSD, but report receiving only 20% of their allocation. Apart from the regular cost-sharing revenues and revenues from patients with insurance, the BMC has actively searched for alternative sources of income, such as donations, a twinning agreement with a German hospital and recently with a hospital in New York, bypass fees and a private and VIP ward. They are also trying to enter into contracts with private companies and raising revenue by marketing laundry and kitchen services.

Governance and Management

BMC functions as a partnership between the MOHSW, the Catholic Church, the Touch Foundation and other partners. The Bishop In-charge of the Department of Health of the Tanzanian Episcopal Conference acts as Chair of the governing Board with representatives from the Catholic Church and the GoT as members.

The Board meets four times a year and discusses plans, budgets, expenditures, audits, progress reports and political issues. The Board also approves employment of specialists and other higher cadre. An Executive Committee of eight people manages the BMC on a day-to-day basis. There is also a Management Committee, comprising of all heads of departments (25). With this management structure the BMC complies fully with the intended hospital reforms.

Access and Quality

The BMC has three social welfare committees, who decide on granting exemptions for the poor and vulnerable. Nurses assess the financial situation of eligible patients, who can either be fully exempted or be allowed to only pay part of the regular fees. Patients have the possibility to appeal, when they don't agree with the decision of the welfare committee. The costs of granting exemptions have to be recouped from other sources, as the government does not compensate for them. The annual value of granted exemptions in BMC is around TSH 400 million.

As referral hospitals are the highest level of care in the country, peer review is the mechanism used for quality control. There are no regular meetings between the four referral hospitals and the national Chief Medical Officer (CMO), but in 2003 a peer review was organised between three referral hospitals. These are supposed to happen every year, but due to lack of funding this has not happened since. BMC therefore organised its own peer review by the referral hospital of Nairobi.

BMC has a number of policies to promote quality of care: zero tolerance to corruption and theft, patients can get all treatment they need in the hospital, nursing attendants

cannot attend patients, patients never sleep on the floor or two in a bed, and relatives are not allowed to stay overnight in the ward.

While general conclusions on the four referral hospitals cannot be drawn from the above, it does appear that the BMC has been creative and successful in making ends meet, achieving good quality of care, addressing patients' rights and improving efficiency, possibly because of their relative autonomy to introduce reforms. They were able to give up-to-date financial information, not present in most public hospitals visited. Their experience could provide valuable lessons for other state and non-state hospitals.

It seems clear that hospital reform has not progressed at the same pace as other aspects of health sector reform. Some informants attribute the continuing problems in governance and management of regional hospitals to the lack of a management culture in the hospital sector and a continued preference for management by medical doctors with little or no training in management. The practice of having hospitals run largely by medical staff also reduces the number of higher trained staff available for clinical practice.

At the same time, it should be acknowledged that the reform plans were very ambitious. Such far-reaching reforms would be difficult to implement in a short time frame in any country. It might be more effective to set more explicit priorities within the reform plans for the health sector and to implement specific reforms sequentially.

6.4 Detailed Recommendations

1. Already agreed hospital reforms should be given a higher priority in HSSP3. (1, 2 and 3)
2. Policy and practices regarding bypass fees should be reassessed in light of their impact on referrals and, if permitted (to generate extra income), should be established at a high enough level to discourage bypassing, except in cases of emergency. (2)
3. The drug allocations for regional and referral hospitals should be reviewed. (2)
4. Patients should be consulted regularly on their perceptions of quality of and access to regional and referral hospitals, and hospitals should be required to respond with planned improvements. (2)
5. The (financial) incentive structure for MOHSW staff should be adjusted to make it more attractive for Medical Officers to do clinical work in regional and referral hospitals than to work in the administration (including the MOHSW itself). (2)
6. MOHSW should institute a policy of encouraging the employment of professional managers to run hospitals, not necessarily medical doctors, in order to foster better management and retain doctors in clinical practice. (3)
7. The exchange and sharing of information between regional hospitals in each zone and between referral hospitals in the country should be increased through such mechanisms as staff exchange visits, annual regional meetings, and use of web-based tools such as e-mail and web-portals. (2)

7 Central Support Systems

Conclusions: Central Support Systems

1. **Infrastructure:** Despite construction and rehabilitation activities, there are still substantial capital investment requirements. In addition, the lack of running water, electricity and communication equipment has negative consequences for the quality of care and staff housing in remote areas could potentially help in dealing with the human resource crisis. Building public facilities close to existing private ones is often inefficient.
2. **Drugs:** The supply of drugs, equipment and medical supplies provided by MSD has improved over the evaluation period, but shortages and delays in delivery are still common. First the Indent and now the Integrated Logistics System have been an improvement over the kit system for ordering drugs, but order processing remains overly centralised. More competition would increase efficiency and ensure better availability of drugs at facilities. Finally, fixed allocations for health facilities at a given level, unrelated to utilisation, are not efficient.
3. **HMIS:** The quality of the Annual Health Statistical Reports has improved and the inclusion of the FBO and private sector in the HMIS results in more complete data. At the same time, the reliability of data still problematic. Data analysis, information use and feedback to lower levels remains insufficient and capacity at all levels is a major constraint to improving the situation.
4. **Transport:** The difficulty and expense of public transport has negative consequences for access to care and contributes to maternal mortality. There is also no evidence of improvement in the organization and management of ambulance services during the evaluation period.
5. **Monitoring and Evaluation:** An overall framework for monitoring and evaluation is lacking and the roles and inter-relationships between Health Management Information, Sentinel Site Surveys, National Census Data, other surveys and specific studies are not clear.

Issue Focus: This chapter addresses the issue of the effectiveness of efforts to improve central support systems during the evaluation period especially as they support health services at the council level. It examines infrastructure planning, development and maintenance, the supply of essential drugs, the HMIS, transport, communication and monitoring and evaluation (M&E).

7.1 Health Infrastructure and Equipment

Health Infrastructure

According to the POW 1999, the total number of HFs (government, voluntary, parastatal and private) in 1997 was 4,844, which translates into 6,041 people per HF. By fiscal year (FY) 2005, according to the *Annual Health Statistical Abstract, April 2006* (AHSA), the total number of HF was 5,379, which translates into 6,807 people per

HF,³⁵ an increase of almost 13%. Between 1997 and 2005, the total number of hospitals actually decreased from 224 to 219. The theoretical patient load per HF has increased considerably. Whether this translates into a higher workload depends on actual utilisation, staffing and bed levels.

The MOHSW classifies the physical state of health infrastructure as good, average or poor. According to the AHSA 2006, the proportion of HFs in a good state of repair increased between 1999 and 2003, in particular for HCs and dispensaries but less so for hospitals (based on data from 10 districts in 10 regions). However, PMO-RALG officials indicated that the 2004 Annual Health Sector Review found that more than 50% of HFs in rural areas are dilapidated to the point of collapse and that an emergency response was warranted.

In response to this situation, a number of initiatives were undertaken. The Rehabilitation Strategy and Funding Mechanism for Health Facilities³⁷ is part of an emergency response coordinated by PMO-RALG to support infrastructure maintenance and upgrading at district level. The Joint Rehabilitation Fund, started in late 2004, allows districts to access basket funds for rehabilitation of health facilities. Communities can also request funds from the Local Government Capital Development Grant (LGCD) for the same purpose.

In addition some development partners support infrastructure rehabilitation and construction, for example a new blood bank in Mtwara, built by the Centre for Disease Control (CDC) with PEPFAR funds and staff housing in Masasi supported by several DPs. There are also many private initiatives, such as the Tanganyika Wattle Company supporting water and electricity supply in the district hospital in Njombe. In Mwanza the previous Regional Commissioner collected about three billion Tanzanian Shillings (TSH) from business owners, politicians and religious leaders to upgrade the regional hospital. Even local NGOs are active in health infrastructure construction. The Health Action Promotion Association in Singida finances the construction of dispensaries, while the MOHSW is responsible for staffing and equipping them.

All this was clearly visible: in the districts visited there has been major construction, renovation and upgrading of health facilities and 13 out of 16 councils that assessed themselves saw renovation and construction as a positive change. The single sector area that has benefited most from the construction of new health facilities is HIV/AIDS. The evaluation noted that new wards, consulting rooms for VCT, laboratories and stores were often built with HIV/AIDS funding, reflecting the large flow of resources to HIV/AIDS programmes and activities.

However, important issues such as water and electricity supply as well as communication equipment have not been resolved, hampering service delivery considerably. According to the administration and personnel department in the MOHSW, only 50% of government PHFs receive electricity from the grid. Some health centres do have a solar panel so that they can run their refrigerators and have light. Most public hospitals visited by the

36) *As the AHSA does not contain population figures, the census data for 2002 were used to calculate the population for 2005, using the 2.92% growth rate.*

37) *Preparation of Rehabilitation Strategy and Funding Mechanism for Health Facilities Final Draft. PMO-RALG, 2003.*

evaluation did not have continuous electricity supply, while generators, when present, are not always working. At the Masasi district hospital emergency operations are performed using torches and mobile phone lights and the blood provided by their new blood bank cannot be refrigerated.

The water situation is equally difficult. Outside urban areas, government PHFs often have no running water. On a positive note, health facilities visited during the district case studies were clean. This was confirmed in focus group discussions using the Change Assessment Scoring Tool (CAST). Three quarters of community members rated the change in cleanliness of HFs as positive or very positive.

While the infrastructure of the HFs themselves is improving, lack of staff housing is a major constraint in the rural areas as it makes it difficult for HC and dispensary staff to be available outside working hours (as they are expected to provide 24 hour service) and is also related to the unwillingness of staff to stay and serve at lower level and/or remote facilities.

There are, however, continuing questions about the rationalization of health care facilities in terms of location and investment in new facilities. The focus on the construction of new health facilities makes sense as the population of Tanzania has doubled in the past decades and many inhabitants of remote areas still live a considerable distance from any HF, but at the same time existing HFs cannot be properly staffed and equipped. The construction of new public facilities very near those operated by FBOs or the private sector, which are capable of delivering services to the same population, can also be questioned on grounds of efficiency.

In summary, reasonable progress has been made to construct and rehabilitate health facilities, but more capital investment is required and urgent attention is needed to improve water and electricity supply of HFs. New facilities should not be constructed without a strong prior indication that they can be made fully operational, i.e. equipped and staffed.

Equipment

Nine out of 16 district self-assessment reported that supplies of equipment had improved during the evaluation period. The district case studies also found improved, although still insufficient, supply of medical equipment, but heard consistent complaints about quality. In Singida, blood pressure machines made in India reportedly lasted less than a week and the district could not reclaim the funds used from MSD.

According to health staff in Mwanza, equipment from MSD is of lower quality and more expensive than that of private suppliers. In Mwanza reportedly only about 40-50% of required equipment for HFs is in stock at MSD. The 2003 *Technical Review of Health Service Delivery at District Level* by HERA³⁸ reports that it took MSD more than one-year to deliver major equipment like dental chairs and maternity beds. While insufficient, this is apparently an improvement on prior years. Some CHMTs use block grants or council funds to buy necessary equipment in the market.

The evaluation also noted problems with equipment maintenance and upkeep. The HERA Review of 2006³⁹ concluded that there is a lack of interest in maintenance and

38) *Technical Review of Health Service Delivery at District Level, Final Report, by HERA, March 2003*

39) *Technical Review: District Health Services Delivery in Tanzania, Where are we in terms of quantity and quality of health care provision? Final Report, by HERA, April 2006.*

upkeep of equipment and facilities, mainly because there is no budgetary allocation. Preventive maintenance does not routinely take place, with the exception of maintenance of HIV/AIDS related laboratory and of radiography equipment, as this is centrally organised and financed.

7.2 Health Management Information Systems

Because the Health Management Information System (HMIS) is based on routine service statistics it cannot provide population statistics, needed for review of MDGs, MKUKUTA targets and GBS conditions for example. Population-based indicators can only be reliably measured in large surveys, such as the Census, the Demographic and Health Survey (DHS) and Household Budget Survey.

Key informants, Annual Technical Review reports, and the summary reports for a number of JAHSRs (2002, 2003 and 2004) made the observation that HMIS data continued to be intermittent and unreliable despite considerable external support, and that utilisation and analysis at district level needs to be strengthened.

Notwithstanding those findings, interviews and observations carried out for the district case studies and interviews with key stakeholders point to some recent improvements in HMIS. Different dimensions of HMIS and their improvement (or not) over time are discussed below.

The Quality of Annual Health Statistical Abstracts

Due to reported staff shortages, the HMIS team has not had enough time for supervision of data collection at field level and has not been able to produce a health statistical abstract for every year during the evaluation period. From 1999 to 2006 only two abstracts have been compiled, one covering 2000/01 (published in 2002), the other covering 2004/05 (published in 2006). The quality of the abstracts has clearly improved over time. The most recent includes a narrative description, comparisons and analysis, where the previous one only contained tables. The chosen indicators included in the HMIS are relevant, although continuous updating is of course necessary.

Health Management Information Systems

Within the Health Information and Research Section (HIRS) of the Policy and Planning Division of the MOHSW the HMIS Unit processes and analyses routine data from all health facilities. The Section also conducts surveys together with the National Bureau of Statistics and has a National Sentinel Surveillance Unit (integrated into the MOH in 2002 after the completion of the Adult Morbidity and Mortality Project. On the basis of information collected through these various systems the section prepares all information required for the JAHSR, the MKUKUTA, GBS and the MDGs and is responsible for compilation of the Annual Health Statistical Abstract.

Completeness and Reliability

Despite improvements there is a persistent issue with the completeness of HMIS data submitted to the Health Information and Research Section (HIRS) at MOHSW. The main problem seems to be that many facilities fail to provide data on time, leading to large gaps in information and limitations in the resulting analysis.

Reasons mentioned for this delay include: time constraints at the HF hampering prompt filling of forms, lack of information technology facilities and/or experience at the district level (although software for data analysis and reporting exists), and non-functional RHMTs, delaying data checks and forwarding to the MOHSW. If CHMTs and RHMTs had access to electronic mail, the electronic forwarding of data could no doubt speed the process greatly.

On the other hand, reviews of HMIS books at facilities level and discussions with health workers indicate that the HMIS system has become more understandable and easier to use over time. This more positive view seems to be related to understanding the importance of data collection and the ability to analyse and utilise it. Still, HMIS focal persons complain about the time spent on correcting mistakes due to lack of both training of new HF staff and refresher training for existing staff as well as insufficient supportive supervision in some districts.

Where the focal person is active, all staff has been properly trained, and supportive supervision and regular meetings to discuss data with the in charges of HFs take place, the quality of data and utilisation can improve. In Mwanza for example the completion rate of HMIS reports has increased from 60-70% in the 1990's to 90% at present.

So despite its ongoing shortcomings, there is evidence that the HMIS has been strengthened during the evaluation period and that it is understood and used at health facilities including dispensaries, health centres, and district and regional hospitals.

Analysis of Data and Utilisation of Information

All Councils use the HMIS data for preparing their CCHP, but the collected information is largely forwarded without in-depth analysis at the lower level. The district self-assessments found that only five out of 16 districts claim that the HMIS enhances planning while six out of 16 claim that it facilitates drug procurement.

Based on interviews in the districts, one likely reason for lack of data analysis and utilisation of information is that the focal person and other CHMT members, including the DMOs, do not have sufficient expertise to optimally benefit from the system.

Vertical Programmes

The inefficiencies of the HMIS in the past resulted in vertical programmes developing their own systems for specific diseases such as malaria, TB and HIV/AIDS, thus overburdening already busy health staff and hampering efforts to establish one integrated system. MOHSW reports that some vertical programmes maintain their own data collection forms, because their funders require more detailed information. Proposals have been made to shift these information needs from the regular HMIS to the Sentinel Surveillance System. The district case studies found that the extra requirements of the vertical programmes are not prohibitively time-consuming in practice and the forms used to monitor them have been kept fairly simple.

FBO and Private Sector Data

A notable achievement of the Tanzanian HMIS is its coverage of all health facilities (government, private, NGO, FBO, parastatal). This allows comparison of data across all health facilities, as well as providing a more complete picture of the burden of disease and service utilisation. This information can be very useful for situation analysis and planning. Moreover, it offers opportunities for regular contact between the CHMT and the FBO/private sector and has reportedly improved relationships.

Feedback

All HF staff interviewed noted that there is not much quality feedback on the content and meaning of their HMIS reports from the level above. The most common feedback received concerns suggestions on how to correct calculation errors, rather than on how to interpret the data or utilise them. On the other hand, some districts organise regular meetings with the officers in charge of HFs to discuss data and learn from comparisons among them, which is appreciated by HF staff.

HMIS Focal Persons

In a recent effort to improve HMIS data, each CHMT and RHMT nominated a focal person for health information. They are responsible for follow-up on data collection in order to improve the response rate for the supply of information. In the visited districts, this task was the responsibility of a co-opted member of the CHMT additionally to his/her regular work. While an acceptable transitional measure, in the long run the HMIS would benefit from a full-time, well-trained information specialist in each CHMT and RHMT.

Other initiatives currently under way to further improve the system include the review of all data collection forms and the development of a health information data bank. In addition, the TEHIP information tools (district burden of disease assessments and district health accounts) have been incorporated into the new PlanRep 2 planning guidelines and software. This should enhance the potential use of information for planning at the council level.

7.3 Drug Supply

In the JAHSR 2001, it was noted that raising the reliability of essential drugs and medical supplies remains a key challenge and that the performance of the MSD would have to improve. During the financial years 2002/03 to 2003/04 the budget for drugs was basically doubled. According to the MSD information brochure, sales performance has increased 10 fold over the evaluation period.

Eleven out of 16 councils involved in the district self-assessments indicate that drug supply improved and those interviewed at national, regional, district, and community level (including HF staff) state that the drug situation has improved at least somewhat. The supply of drugs and supplies for vertical programmes is excellent. For example 100% of ARVs are supplied within one month (according to policy).

Despite this positive note, all HFs still experience major delays in supply. In all visited regions and councils the situation in hospitals has not improved as much as in HCs and dispensaries. Same, Iringa and Singida regional hospitals all complain that around 30% of all commodities are out-of-stock at any given time.

The Medical Stores Department (MSD)

MSD is an autonomous government department acting under the MOH. The Board is appointed by the MOHSW and the Chair of the Board by the President on suggestion of the MOHSW. The MOHSW, MOF, PMO-RALG, CSSC, referral hospitals, RMOs and the Attorney General's Office are represented on the Board.

MSD has eight zonal stores and a headquarters and central warehouse in the capital. MSD is responsible for procurement of all essential medicines, supplies and equipment for the public health sector and for distribution down to district level.

The older push system (each PHF receives a monthly kit with standardized contents) is being replaced by a pull system (each PHF orders according to need, called the indent system). The Indent system excludes items for the large vertical programmes, which are still supplied in fixed quantities. Hospitals have always been on indent. The new Integrated Logistics System (ILS) also includes items for vertical programmes.

At present only 5 regions are still on the kit system, 10 are on indent and 7 on ILS. MSD strives to have the whole country on ILS by 2010. MSD distinguishes 3 type of items: normal orders (high turnover, always in stock), special orders (low turnover, not in stock) and items for the vertical programmes. Except for the store serving the Lake Zone, all orders for the whole country are packed in DSM. Government approved FBO hospitals can also buy from MSD.

This is likely due to the fact that hospitals need more specialised drugs, which MSD does not stock in large quantities and which might also take longer to procure. Reliable estimates of future needs then become even more important. The 2005 *Evaluation of Drug Availability in Masasi*⁴⁰ found that 75% of the drugs and supplies had been out-of-stock during the observed period, ranging from time periods of three days up to more than 90 days.

The 2006 Technical Review⁴¹ also cited excessive stock-outs, especially of family planning commodities such as condoms with potential results in unwanted pregnancies, STI and HIV infections. Similarly, for several months emergency obstetric care items were out-of-stock, meaning that maternal deaths could not be prevented. Similarly, many laboratory workers complain of the lack of reagents. In the words of one key informant: "There is something wrong. MSD has money, but the health facilities have no medicines".

CHMTs do try to solve the shortage of drugs by procuring additional drugs and basic supplies in the market from their budget, or assist HFs in using cost-sharing revenues to procure essential drugs and supplies.

40) *Evaluation of drug availability in Masasi District and ways of improvement through Community Health Fund*, by Ute Steiner, Christopher Ndagala, Swedi Abdallah and Tino Mwihumbo, September 2005.

41) *Technical Review: District Health Services Delivery in Tanzania, Where are we in terms of quantity and quality of health care provision?*, Final Report, by HERA, April 2006.

Kits, Indent and the Integrated Logistics System

For councils still relying on the kit system of drug distribution, kits are distributed once a month, but almost never contain enough items to last the whole month. Reports vary on the kits lasting as many as three weeks or as few as one, but all facilities run out of key drugs and basic supplies such as syringes and needles before the kit is re-supplied. The advent in 2003/04 of the indent system and the even more recent introduction of its successor the Integrated Logistics System (ILS) is generally seen as a significant improvement by HFs staff able now to order what they need and accumulate smaller stockpiles of expired drugs. On the other hand, only two out of 16 district self-assessments claimed that the indent system has improved drug procurement, while six out of 16 districts were dissatisfied with MSD. The Masasi Drug Study found that the introduction of the indent system had not resulted in reliable supply of drugs through MSD. Instead, frequent and often long-term stock-outs still prevailed. The 2007 *Tanzania Drug Tracking Study*⁴² reports that “Essential drugs at MSD have consistently been out-of-stock over the last one and a half years”.

Several reasons have been mentioned for the supply problems: the drug budget is insufficient, in particular for hospitals; HF staff have not been sufficiently trained in how to calculate how much to order; delays in procurement and/or distribution by MSD; centralisation of processing all orders in Dar es Salaam and Mwanza; lack of a buffer stock; and other reasons such as expiration, misuse, and shortcomings in storekeeping facilities.

Processing Orders and Distribution

Zonal stores forward all indent and ILS orders to Dar es Salaam or Mwanza via the WAN (Wide Area Network), where they are picked and packed and sent back to the zonal stores in boxes, from where they are distributed to the CHMTs and the hospitals. The other six zonal stores only directly process orders for FBO facilities. The centralisation of the order processing is inefficient and MSD intends to decentralise everything except procurement to the zonal stores in the years to come⁴³.

The Drug Tracking Study found that medicines in the zonal stores are stored according to good storage practice, under secure systems, fully protected from sunlight and properly ventilated. A functioning system for cold storage is available as well as a system which manages the stocks of MSD and vertical programmes across all zonal stores.

Visits to the zonal medical stores in Mtwara, Iringa and Mwanza confirm these findings. The system of first expiry, first out for drugs as well as first in, first out for other supplies is being applied. The stores are well organised and clean. There is a separately fenced and locked area for addictive drugs and ARVs. On the other hand the storage of medicines in many PHFs is sub-optimal. In some PHFs visited during the evaluation, medicines are exposed to direct sunlight which can reduce their shelf life, storage rooms are not adequately ventilated and the majority of PHFs do not monitor the temperature of the store. An overall problem is lack of space.

42) *Drug Tracking Study, Final Draft Report, by Euro Health Group, May 2007, page xiii.*

43) *An example from Masasi: After MSD in Dar es Salaam does the packing of the council order, the shipment is sent to the zonal store. Problems arise from the fact that MSD does not inform the zonal store of any missing contents, meaning that by the time the facility receives its order, it has been recorded as a ‘filled delivery’, the process of redress taking a great deal of time, in which the health facility has to do without.*

Distribution of drugs to PHFs continues to be a problem. Many PHFs in Masasi reported that the last time they were supplied with drugs was five months ago (although the situation was much better for other councils visited). Most distribution problems are related to lack of transport at the district level. The CHMT is responsible for transporting the goods to the PHFs throughout the district, but when vehicles have broken down or there is no money for fuel, or roads are impassable due to rains, delay in delivery occurs.

Vertical Programmes

The Drug Tracking Study critically analyses the role of the vertical programmes vis-à-vis MSD as all of them use MSD for storage and distribution of their items. Nationally, the vertical programmes constitute the biggest part of total costs for drugs (FY 2006/07), due to the high costs of ARVs and Artemisinin-based Combination Therapy (ACT) for malaria. As the essential drugs programme is subsidizing the vertical programmes through the support given by MSD, the study recommends that the much better off vertical programmes should assist MSD so that its essential drugs programme is strengthened. The constant follow up from the field by the vertical programme district coordinators, in addition to a timely response from MSD, all result in a system which ensures that the vertical programme items are available in PHF, while at the same time MSD is consistently out of stock of up to 50% of essential drugs. The evaluation also observed in the field that the vertical programmes do not seem to have any drug supply problems, while the essential drugs programme has many.

Allocations and Payment Systems

The MOHSW transfers the budget for essential drugs and supplies to MSD in regular tranches. All public health facilities have an allocation with MSD specifying the budget they can use for drugs and supplies. When they order, the costs are subtracted from their allocation. When the allocation has been fully used, orders by HFs will not be processed. When MSD receives less money from the MOHSW (or receives the money late) it reduces the allocation for each facility. The fixed allocation for a dispensary is TSH 4 million per year and for a HC TSH 8 million. As this amount is not related to utilisation of the HF, busier HFs cannot order enough drugs, while the allocation for others is too abundant. In the latter case there is an incentive to order more drugs/supplies than needed.

MSD and the MOHSW do not agree on the cause or severity of shortfalls in shipments when allocations were apparently available. MSD staff claim that the MOHSW does not pay in full or pays late. MOHSW staff reply that they have paid the whole amount and that MSD is holding the money. The 2007 Drug Tracking Study was apparently unable to resolve these contradictory claims. Later in 2007 a Public Expenditure Accountability Review of MSD was done, but the results were not available to the evaluation team to be taken into account.

Faith-Based Organizations

The Drug Tracking Study and the district case studies both found that FBO hospitals normally have a higher availability of drugs than government hospitals because they have less complicated and more flexible procurement procedures. They can buy from MSD, MEMS (Mission for Essential Medical Supplies) and from private suppliers. MEMS also supports FBO hospitals with a computer, printer and access to the internet, and advises on drug use in relation to case mix. MEMS normally delivers orders to the hospitals within two weeks and is more reliable than MSD. The evaluation found that FBO health facilities generally also have better storage facilities and better-organised pharmacies.

MSD's Monopoly and Alternative Sources

The district self-assessments found that six out of 16 councils are dissatisfied with MSD and five out of 16 think that MSD's monopoly, as the sole provider to public facilities, should be ended. Many interviewees at national, regional and council level were of the same opinion. RMOs have officially requested elimination of the monopoly of MSD in providing drugs to the public sector. Public sector HFs can also order from MEMS, but only if they have cash available, rather than an MSD budget allocation. Mtwara and Lindi regions have considered alternative suppliers like Action Medeor. Mwanza City Council has plans to open its own medical store.

As a result of a MOF directive in the Budget Guidelines for FY 2007/08 the central drug budget was reduced by 30%, with the intention to include this amount in the Council budgets so that HFs, would receive 30% of their MSD allocation in cash, which would effectively mean the introduction of some competition for MSD. However, as of September 2007, no provision had yet been made in the Council budget for this 30%.

With the right efficiency incentives MSD should be able to operate at lower cost than private wholesalers, due their exemption from import duties and VAT and the sheer scale at which they are operating. MSD should thus be able to compete with private suppliers.

In summary, there has been some reported improvement in the availability of drugs at primary health facilities and hospitals during the evaluation, but the problems and disruptions in supply continue to impede efforts to improve the quality of service. The introduction of some element of competition and access to alternative sources of supply for HFs seems to be a clear necessity.

7.4 Transport

Public Transport

Transportation is directly correlated to access to health care services. If patients cannot reach a health facility, especially in emergency cases or for deliveries, they simply receive no care. Many of the rural areas visited have almost no public transportation, meaning that patients still need to travel long distances by foot or bicycle before they reach a HF. During the rainy season many roads are simply impassable. When patients need to take a taxi, the costs can be a many times higher than the costs of the medical services and become prohibitively expensive. Although public transport has improved in some places, it is still an important barrier to access to care.

Quote community member during CAST sessions:

"...if you are sick and you cant afford to pay, you just have to die".

Ambulances

The district case studies confirm that the availability of ambulances or other vehicles to transport emergency cases differs greatly from one council to the other. In some councils the use of an ambulance is free for certain groups, such as pregnant women and under

fives, while others have to pay. In other councils all patients pay for the use of an ambulance (the price of the fuel for example).

The overall picture for emergency and other transportation needs remains extremely difficult. Some councils (Kigoma Urban for example) have no functioning ambulances. Others that do have ambulances often do not maintain logs and don't seem to have any coherent policy on how and when they should be used and whether fees should be charged. In Same for example, one dispensary was able to request use of the ambulance located at a nearby HC while another, equally distant, was not aware that this practice was possible.

Transport for Outreach and Supervisory Activities

Transport is also necessary for carrying out routine health work. Health workers at dispensaries are supposed to do outreach activities, but many cannot because their catchment area is too large to be covered on foot or by bicycle. RHMTs are supposed to conduct quarterly supervisory visits to the districts, but there are often no funds for fuel and per diems. In some regions, RHMT members can supervise districts only when vertical programmes provide funding for transport.

Transport for People living with HIV/AIDS

For people on ARV medication, transport remains prohibitively costly. While diagnosis and counselling can be done in primary health facilities, patients must regularly travel to the nearest hospital for treatment. For residents of Same, for example, the trip from village to the council hospital, although as short as 40 kilometres, takes four to five hours and requires hiring a private four-wheel drive vehicle costing more than TSH 10,000. Many People Living with HIV/AIDS (PLWHA) simply do not come for treatment because they cannot afford the transport costs.

Thus the evaluation found little improvement in the transport situation in the health sector during the evaluation period, including improvement in the availability of emergency transport.

7.5 Communication and Information Technology

Communication between a peripheral HF and the CHMT is essential for patient care, referrals and administration. Moreover, facilities personnel feel less isolated if they can regularly communicate with the council headquarters. There are still many remote HFs without any form of communication or where equipment installed some years ago is not working due to lack of maintenance. In the case of an emergency, staff can sometimes use their private mobile telephones, but these costs are not reimbursable. The HERA Review of 2006 recommended two-way radio communication for all remote HFs. An alternative may be (where coverage warrants) to provide officers in charge of a HF with a mobile phone and an allowance for professional use.

Information technology is slowly being introduced into the health system, with some councils and HFs being more advanced than others, but Internet access and e-mail are not yet available in the public sector. Information technology requires a significant investment at regional and council levels initially, in order to open up the Internet for health workers and to facilitate communication with each other and higher levels of the administration.

7.6 Monitoring and Evaluation

As already noted, health services and related aspects of support services are routinely monitored through the HMIS, which still has major weaknesses, despite having improved over the evaluation period. Other major information sources for monitoring key indicators are the Census, the Household Budget Survey, the DHS and surveys or studies on specific topics. The limitation of these sources is their infrequency: they only provide reliable data once in five (DHS) or even 10 (Census) years. The HIRS at MOHSW is responsible for analysing all this information, but remains understaffed.

As already noted, MOHSW has recently established a monitoring and evaluation working group but the outputs of that initiative are not yet apparent in any aspects of the health service delivery system reviewed by the evaluation. Clearly, efforts to improve the HMIS system over time as well as efforts to strengthen monitoring of disease burden both have the potential to contribute to a strengthened M&E system.

Similarly, the annual Technical Reviews undertaken for the JAHSR process constitute elements of a regular M&E process and the CCHPs have the potential to support a more structured monitoring process at council level. Elements are in place to potentially support a coherent M&E framework and system for the health sector in Tanzania, but they would need further strengthening to operate coherently.

7.7 Detailed Recommendations

Infrastructure and Equipment

1. MOHSW in collaboration with other relevant ministries should, as a matter of urgency, find and implement methods to ensure more reliable electricity and water supply in all health facilities. Solar panels and water storage tanks can be installed where there is no grid or public water system. (2 and 3)
2. New public health facilities should not be constructed before necessary staff, equipment, drugs and supplies to provide the basic package of care in all already existing facilities are present. Only when budgeted funding ensures that new facilities can be equipped and staffed, should they be constructed, in underserved areas as a priority.
3. Health facility budgets should include an amount for (preventive) maintenance, so that maintenance contracts can be signed by HFs. Preventive maintenance costs should also be reflected in CCHPs. (2)
4. Regular inventories of medical and office equipment should be conducted in order to forecast demand and to allow for the time needed to procure these items. (1)

Health Management Information Systems (HMIS)

5. The MOHSW should encourage the University of Dar es Salaam to implement planned MSc course in Health Information as soon as possible in order to improve the supply of higher trained information managers to the system. (1)
6. The HMIS Unit in the MOHSW should be strengthened with more highly qualified staff. (1 and 2)
7. A staffing plan should be developed so that CHMTs would include a full time information officer, specifically trained in data management and analysis. (2 and 3)

8. In the mean time short refresher course in health information should be developed and offered to all present HMIS focal persons in regions and councils, focusing on skills in data collection, checking data correctness, analysis, feedback and utilisation of information. (2)
9. The CHMT should organise regular meetings for officers in charge of health facilities to discuss and compare HMIS data, thereby increasing their understanding and motivation to properly collect data and use information at facility level. (2)
10. Urgent discussions with all stakeholders are needed to reach a consensus on which indicators should and can be routinely collected through the HMIS and which are better collected through the Sentinel Surveillance system. (1)

Drugs and supplies

11. MOHSW should urgently proceed with its stated intention to allow health facilities to receive one third of their MSD allocation in cash, so that they can buy drugs and supplies in the market, and thereby introduce an element of competition to the process of drugs procurement and supply. Accompanying measures for ensuring procurement of quality drugs would be required. (1 and 2)
12. If the actions recommended immediately above produce positive results, MOHSW could increase the portion of the drugs allocation provided to councils as cash over time. (3)
13. MOHSW should assess the feasibility of linking drug allocations for primary health facilities (either in cash or as allocation with MSD) to actual utilisation, rather than all dispensaries and HCs receiving the same amount. (2)
14. Orders sent to MSD by PHFs should be rationalized so that approximately one third of PHFs send in orders in any four month period. (1)
15. The MSD should accelerate phasing in of ILS and decentralise full handling of orders to zonal stores. (2)
16. MSD should organise a training-of-trainers course for regional and council Pharmacists or Pharmaceutical Technicians/Assistants to train health facility staff in how to forecast and calculate their drugs and supplies orders. (2)
17. More attention should be given to ensuring quality standards of storage facilities for drugs in primary health facilities. (1)

Transport

18. Councils should develop a clear policy on ambulance use for transport of patients. Ambulances should not be used for administrative or representative purposes. Ambulance use in case of emergency could be included in the CHF package. (1)
19. In order to make outreach activities and home-based care a regular feature of primary health care, staff should be provided proper means of transport, such as motorcycles. (2 and 3)

Information Technology and Communication

20. Regional Secretariats and councils should accelerate investment in information technology. RHMT, CHMT and all hospitals should, over time, make better use of Internet and e-mail facilities, and make arrangements for reliable technical back-up, support and maintenance. (2)

21. In order to facilitate urgent patient-related and necessary administrative communication, such as calling the ambulance, councils should provide primary health facility staff with a mobile phone and a modest monthly allowance for professional use. (2)
22. For areas where there is no mobile network coverage (yet) radio communication should be installed. (2)

Monitoring and evaluation

23. In the HSSP3, in the operational regional plans and CCHPs, as well as in annual hospital plans, targets should be quantified and time-specific, with explanations for variances required in progress reports. (1)
24. GHIs and large bilateral programmes should plan their evaluations to be integrated into the evaluation schedule for the sector as a whole, as articulated by the GoT and development partners. (2)

8 Human Resources for Health

Conclusions: Human Resources for Health

1. By all estimates, Tanzania has faced a severe shortage of skilled health sector workers throughout the evaluation period and continues to do so, although this only became a priority policy and programme focus later in the period.
2. Staffing levels are not related to actual workload at facilities level and the productivity of staff could be much higher, resulting in increased efficiency of service provision.
3. Government and private training institutions have increased their output in recent years and there have been improvements in in-service training for public health workers, most recently through strengthening Zonal Training Centres (ZTC), resulting in higher qualified staff being available in health facilities, improving quality of care.
4. Efforts to recruit, deploy and retain public health workers, especially those assigned to remote or hardship areas councils, continue to be hampered by administrative problems, the absence of an effective incentive scheme, and by loss of professional staff to other jurisdictions, resulting in lack of quality care in large parts of the country, inequities and eventually in avoidable mortality and morbidity.
5. Recent improvements in pay and benefits for public health workers have had significantly negative effects for FBO and private service providers.

Issues Focus: This chapter examines the issue of how effectively the health sector has dealt with important issues in HRH during the evaluation period. It deals with the following elements in the sectors response to the situation:

- National goal setting in HRH;
- Planning and policy development (including assessing staff shortages);
- Staff training and development;
- Recruitment and deployment;
- Remuneration and retention;
- Managing the workforce.

8.1 Goal Setting in HRH: POW, Health Policy and HSSP2

At the beginning of the evaluation period the POW noted that the ongoing recruitment freeze,⁴⁴ in particular of medical doctors, nurses and other allied health personnel, had negatively impacted service delivery. Key informants note that, at the same time, the MOH adopted a policy to reduce the numbers of lower qualified staff in order to increase efficiency. However, this policy actually resulted in lower efficiency because staff were not replaced by more qualified workers.

44) *In 1994 structural adjustment requirements resulted in a freeze in public service recruitment, which lasted 10 years.*

They also report that the limited capacity to forecast staffing requirements contributed to lack of awareness of an imminent staff shortage in the health sector. Perhaps as a result, the human resource element of the POW did not focus on overall staff shortages. Instead it emphasized efforts to deal with inadequate management and deployment, poor distribution of staff in terms of skills mix and across geographical locations, low quality and poor performance, lack of management skills, and low morale.

The POW stated that MOH would determine the actual staffing levels in HFs, build a HRH database, develop staffing norms and competitive pay and benefits packages, and ensure fair geographical distribution and a better skills mix. A number of activities to support attainment of these objectives, such as updating the HRH plan, strengthening HRH management capacities, increase and improving training, were also included in the POW.

Four years later, the Health Policy (2003) called human resource “the most critical element in the health sector”. It advocated flexible planning of HRH, taking into consideration health needs, disease burden, workloads and available financial resources. The Health Policy identified quality pre-service training, continuing education (to be budgeted for by the employing agency) and adequate remuneration as pre-requisites for good performance by health workers. The Health Policy also envisioned ZTCs taking on the role of key training institutes. It did not raise issues of a severe staff shortage.

In addressing progress in HRH since 1999, the HSSP2 (2003) only noted that management and technical capacities at district level had improved and that training activities had been decentralized to the ZTCs. The list of constraints it identified is considerably longer and contains many of the same issues as mentioned in the POW: inadequate coordination of HRH at central level; unclear personnel management systems and absence of systematic incentive structures; understaffing; absence of rational deployment of existing staff; low capacity of training institutions; and a poor working environment.

As the current statement of strategies for the health sector, the HSSP2 includes the following four priority objectives for HRH in the Health Sector Strategic Framework:

- Long-term manpower planning and production system established;
- Distribution, motivation and retention of staff attained;
- Full network of ZTCs throughout the country set up and short-term capacity building and skills-based learning modules produced;
- ZTCs teamwork on continuing education including exploring how to increasingly apply distance learning completed.

8.2 HRH Planning and Policy Development

Planning

Overall human resources policies and the conditions of service for all public servants are determined and regulated by the Public Service Commission. The Human Resources Development department in the MOHSW is responsible for specific policy development in the health sector, as well as HRH planning and pre-service and in-service training.

The main achievements over the evaluation period in this area are that a HRH planning unit was established in the MOHSW in 1999 and in the same year national HF staffing

standards were set. On the negative side, the national HRH plan 1996-2001 has not been implemented, reportedly due to lack of funding.

The problem descriptions in sector strategy documents clearly demonstrate an understanding that HRH was an important limiting factor in achieving sector objectives. Indeed, the JAHSR report for 2004 uses the term crisis in relation to human resources. On the other hand, a review of JAHSR reports shows that well-known problems and potential solutions were repeatedly identified, with very little reported progress in implementing agreed activities.

Even in 2006, HRH planning is hampered by the weaknesses in the HRH information system. It is neither comprehensive nor reliable enough to guide planning and decision-making. Even information from the GoT payroll is not easily available to planners. Currently information is collected from multiple sources with associated difficulties in coordination and reliability. One aspect of this is the limited collection and sharing of HRH information from the private sector. Finally, there is limited technical capacity in the MOHSW for analyzing HRH demand and forecasting future needs.

As efforts were made to decentralize HRH functions during the evaluation period, a limited form of HRH planning was devolved to councils and carried out mainly through the staff strength analysis done annually in the CCHP. In the CCHPs, council planners compile available resources and compare them to the facilities staffing standards developed in 1999. Council health managers and workers regard these standards as seriously out-dated in that they do not reflect the present workload and disease burden. Moreover, staffing level norms are identical for each HF of the same type (hospital, health centre or dispensary), irrespective of utilization levels, resulting in very uneven workloads between HFs as observed during district case studies.

Policy Development

In the area of policy development, Gilson et al. (2005) in *Supporting retention of HRH: SADC policy context*⁴⁵ mention that HRH problems are influenced by the broader governance context of the country, because they require coordinated action between several ministries as well as LGAs. (p. 53) The paper brings up the possibility that slow implementation could be due to “the immense complexities of the Tanzanian governance structures”, a reason why the MOH (initially) might have emphasised continuous education through the ZTCs as a key response to the crisis. At least training is in their hands and does not need to be coordinated with other parts of government (p. 57-58). In contrast, other key policies to address the HRH problems, such as financial and non-financial incentive packages and changes in recruitment, require intensive and difficult negotiations with other ministries, one possible reason why it has taken so long to address them.

A key policy issue yet to be effectively addressed is the need for including FBO and private sector workforce in planning exercises. In the 1990s many public health workers moved to FBO and private facilities attracted by higher salaries, better benefit packages, working environments and training opportunities. However, in recent years a reverse movement has occurred, largely due to the same factors, with the GoT now offering

45) Gilson L, Erasmus E. *Supporting retention of HRH: SADC policy context; Annex 4: The Tanzanian experience. Centre for Health Policy, School of Public Health, University of Witwatersrand, September 2005.*

better employment conditions. The loss of trained personnel by FBOs and the private sector to the public health services is so significant that efforts to strengthen human resources in public health facilities may result in a weakening of those resources in the 40% of health facilities operated outside government.

Another area in which a policy is lacking is the fact that an unknown number of professional staff leave the country to find work in other African countries, in particular in Botswana and South Africa. Gilson and Erasmus (2005) suggest that the post-independence policy of developing allied health professions has served the country well, as their qualifications are not transferable internationally and such cadres are therefore much less likely to migrate (page 48). On the other hand, a policy to retain more highly qualified staff as MOs and registered nurses in Tanzania is now urgently needed.

Although during the JAHSR 2001 all partners agreed that HRH should be given higher priority, it was not until the end of the evaluation period that MOHSW was able to draft a new HRH plan (2007-2012). The new policy does attempt to address the main problems and recognizes both the political and economic context and was developed in a participatory manner. On the other hand key informants noted that it lacks adequate supply and demand projections.

Assessing Staff Shortages

Seven out of 16 district self-assessments indicate that the number of health staff has improved somewhat since 1999, but 12 out also reported that staff shortages are (still) a significant challenge. The self-assessments rated this constraint to improving service quality of highest significance among those they identified. District assessments by the external evaluation team also confirmed that staff shortages are still severe. Without exception, key informants mentioned lack of human resources as a serious constraint in the health sector.

The Human Resource Crisis Continues

The health sector in Tanzania is facing a serious human resources crisis that is negatively affecting its ability to deliver quality health services. Although qualifications of staff have improved and their numbers have increased, there are severe shortages at all levels, exacerbated by the expanded population, increased disease burden and the increased demand for staff for the large HIV/AIDS, malaria and TBL programmes. Although many people have been trained, few have been recruited and even less stay in post. Salaries have increased, but an incentive package to motivate staff to work in remote or hardship areas is not yet in place.

Data from the World Development Indicators 2003, quoted by Gilson and Erasmus (2005), show that Tanzania's nurse to population ratio was 8.5/10,000 between 1995-2000, while Kenya had 9, Botswana 22 and South Africa 47/10,000. The situation is even worse for MOs. Bryan, Garg et al. reported in 2006⁴⁶ that of the approximately

46) *Investing in Tanzanian Human Resources for Health. Bryan, Garge et.al. MiKinsey and Company for TOUCH Foundation Inc. July 2006. p. 16.*

25,000 skilled HRH in Tanzania, fewer than 1000 were physicians (another survey estimated 1,339). Using even the higher estimate, this is equivalent to one doctor per 25,000 persons, far below the WHO recommended ratio (1:10,000). Considering the fact that 300 doctors work in the Muhimbili National Hospital in Dar Es Salaam (website 2007), and that many MOs work in administrative positions as DMO, RMO or in the central MOHSW, the situation outside the capital becomes even more difficult with very few doctors in clinical practice.

Bryan and Garg (2006) combined the numbers for MO and AMO positions in an effort to estimate the size of the higher skilled cadre in Tanzania and compare that to Kenya and South Africa. They found that Tanzania and Kenya were comparable in terms of the percentage of all health staff who were higher skilled (seven%) but that the ratio of higher skilled staff to population was much lower in Tanzania (1.5:1000 in Tanzania, compared to 5.7:1000 in Kenya). On both measures, Kenya and Tanzania were very far behind South Africa.

8.3 Staff Training and Development

In recent years, the health sector has also been benefiting from increased private sector participation in training of health personnel. Universities currently offering medical training include: one government (Muhimbili University College of Health Sciences – MUCHS) and three private universities in Dar es Salaam, and two FBO Medical Colleges in Moshi and Mwanza, affiliated with Kilimanjaro Christian Medical Centre and BMC respectively.

Pre-service Training

Although Tanzania has a total of 116 public and private health training institutions, 21 approved institutions provide the bulk of pre-service training. The increased numbers of pre-service health training schools, and existing schools expanding and taking on more tutors has resulted in more health workers available on the HRH market. The Muhimbili University College of Health Sciences has reportedly increased its intake from 50 to 200 medical students per year and developed post-graduate programmes for medical personnel and support staff. In addition, MOHSW reports that more key medical staff have been sent for long-term overseas training in the later part of the evaluation period. There has also been an increase in the number of HRH auxiliary paramedical personnel training schools in recent years. The draft HRH plan 2007-2012 observes that, in the years 1995 to 2005, pre-service health training institutions produced an overall total of 23,474 health workers. However, this is still far below the requirements of the sector, as the overall deficit in 2001/02 stood at 34,755.⁴⁷

While the number of newly trained health personnel available for hiring increased throughout the evaluation period, there are continuing concerns about the quality of the training provided in relation to National Council for Technical Education and Tanzania Commission for University standards. The pre-service training institutions also face problems with shortages of classroom and hotel facilities, clinical preceptors, tutors and teaching aides, inadequate re-training of tutors and insufficient funding. Some pre-service training institutions have donor funding but there are continuing problems of

⁴⁷) *Based on own calculation using data provided by MOHSW.*

sustainability. The increase in the number of health personnel training schools has also created logistical problems for health personnel professional bodies in monitoring the quality of training across the country.

Quote from an upgraded Assistant Clinical Officer

“After two years of extra training, as a CO, I can now deal with almost every case presented to my dispensary. I have to refer less people to the hospital”.

In-service training

As Tanzania was faced with large numbers of staff with relatively low qualifications having clinical responsibilities in HFs, a policy was introduced to encourage existing staff to upgrade their skills and knowledge in order to improve performance. The upgrades being emphasized include from Maternal and Child Health (MCH) aid to Public Health Nurse (PHN), Assistant Clinical Officer (ACO) to Clinical Officer (CO), CO to AMO, Pharmacy Assistant to Pharmacy Technician, and Laboratory Assistant to Laboratory Technician among others. These in-service courses are usually undertaken at the initiative of the individual staff with support from the DMO, but have to be approved by the MOHSW. Costs are born by the Ministry and the member of staff together, but staff retain their salary and their post while in training.

The district case studies were not able to find an explicit link between training provided and training needs assessments and a training plan at council level. However, many public health facility staff did report being upgraded through in-service training. Perhaps more importantly, using the CAST tool, the district assessments illustrated that community members in five of the six districts studied perceived an improvement in the qualifications and capacity of the admittedly inadequate numbers of staff at health facility level. Further, they cite this improvement as one dimension of improved service quality.

Despite the positive aspects of the strategy of in-service training and skills upgrading for existing staff, there is one important negative side affect of this activity. Health facility staff interviewed during the district case studies often noted that the absence of staff members on in-service training courses represents a real burden of increased workloads for the staff who remain on site, as temporary replacements are never available.

Zonal Training Centres

During the evaluation period, the MOHSW has increased from six to eight (with the addition of Mbeya and Dodoma) the number of ZTCs which offer both basic and post basic training, in order to facilitate the upgrading of health workforce skills and structured monitoring of the various training institutions under their respective catchment areas.

In recent years the ZTC have helped to train all CHMTs and RHMTs in using the planning guidelines for the CCHP. Recently, ZTCs they have been offering short courses in Council Health Management, Integrated Management of Childhood Illnesses, and the use of PlanRep2 Guidelines for developing CCHPs, all under the national expansion of TEHIP tools programme. The programme also provides support to ZTCs in making business plans, attracting core staff, financing and marketing. However, at present ZTCs

still face serious problems of limited capacity in terms of skilled staff, organizational structure, financing, mandate and institutional linkages, as well as development of their infrastructure.

8.4 Recruitment and Deployment

The draft HRH plan 2007-2012 observes that, over the 10 year period ending in 2004, out of a total of 23,474 graduates produced, the government hired only 3,836 (16%). As trained health personnel could not be employed in the public sector during this period, many were employed by FBO or private sector HFs, or changed careers altogether. The hiring freeze also resulted in an age-gap in the public health workforce which, in years to come, will lead to a lack of senior officers.

Under the current decentralized system, regions and districts have the mandate to identify and fill existing staff vacancies. During the evaluation period the concept of a human resources market was introduced, whereby staff apply and have to compete for advertised posts.

However, it seems that councils lacked the knowledge of recruitment procedures and the professional capacity to identify and recruit potential candidates, in particular higher-level health cadres. It also proved to be very difficult to attract professional staff to remote areas, in contrast to the situation under the old centralised system when they were simply posted there. Recruitment of professional staff has therefore been (temporarily) recentralized again, a move which was supported by many CHMT personnel interviewed during the district case studies.

The current recruitment process for all council staff (not just the health sector) involves preparation of the establishment by the council in collaboration with President's Office-Public Service Management (PO-PSM). The Permanent Secretary of PO-PSM, after approval, gives employment permits to the employing authorities – the councils. For health professional staff, however, permits are channelled through MOHSW to facilitate national recruitment. This allows MOHSW to identify suitable candidates and subsequently post them to the employing authority where they are formally recruited and deployed.

However, recruitment of new staff by councils still faces major challenges, such as non-approval of proposed posts by PO-PSM and the imposed budget ceiling on personnel emoluments. And whether the MOHSW or the council recruits still does not solve the problem of severe understaffing. Nonetheless some achievements have been made. The MOHSW has posted some staff from national level to districts, and more importantly, secured 3,000 extra posts and is in the process of recruiting candidates to fill them. A donor-funded emergency hiring plan also adds another 300.

One major problem with recent emergency staffing efforts has been the relative lack of success in having the appointed professionals report to more rural or isolated areas and to retain them when they do. According to DMOs and CHMT members interviewed there are three important factors contributing to this problem: general attitudes to living in isolated areas with problems of water, electricity and other shortages and often poor schools for children; the problem of staff housing; and the problem of a standard three month period when staff are probationary and their salaries are not paid until they are on

the civil service rolls. This last point was also an issue with teachers but reportedly was resolved through an agreement between the Ministry of Education and Ministry of Finance allowing salaries to be advanced to teachers in this three-month period.

8.5 Remuneration and Retention

To counter the significant shortage of qualified professionals, the GoT raised salaries for health services staff effective in 2006. The increase decompressed salary ranges at the lower end, with significant increases for middle cadres. Some of those interviewed question whether the 15% increase for senior clinical officers will be enough to retain them in the system. Another significant increase was scheduled for July 2007. Public health personnel interviewed on this issue were reasonably happy with their increased income, although many felt that it was long overdue, and some indicated it was still not enough to cover basic living costs.

The inability of the health sector to arrive at some form of incentive package to meet basic personal needs of staff in under-serviced areas has contributed to the continuing problem of understaffing.

8.6 Managing the Workforce

Observations and interviews during the evaluation indicate that most staff at facility level do not have official job descriptions. An open performance review and appraisal system for the public service was introduced in 2004 for selected staff, with plans for roll out to cover all health workers. This system, whereby performance is discussed between the worker and his/her immediate superior, is clearly an improvement over the confidential reports, made by the superior alone. But without clear job descriptions and individual targets, there is no objective basis for assessment. Staff interviewed sometimes reported that promotion and career advancement was awarded without any externally verifiable link to actual performance. They feel strongly that this situation eliminates one important incentive for improved performance as it breaks the link between performance and promotion.

Workforce productivity could also be increased by more regular supervision among and between all health system levels using checklists. It could also be enhanced by organising regular meetings for officers in charge of facilities discuss problems encountered, new procedures, new insights etc. A study by Kurowski et al. (2003) suggests that improved management and optimising staffing levels in council hospitals, HCs and dispensaries could, on average, generate 30% productivity gains by reducing the time spent on unproductive activities.⁴⁸

48) Kurowski C., Wyss K., Abdullah S, Yemadji N and Mills A. *Human Resources for Health: Requirements and availability in the context of scaling up priority interventions in low income countries. Case studies from Tanzania and Chad: London: London School of Hygiene and Tropical Medicine, January 2003.*

8.7 Detailed Recommendations

Planning and policy development

1. Implementation of the draft HRH strategy should be started as soon as possible. (1, 2 and 3)
2. The capacity of the MOHSW and councils to forecast future demand and thus training needs, plan and manage the workforce (including FBO and private sector) needs to be strengthened. (2)
3. This could enable a decision, at some point in the future, to devolve the whole personal emolument budget to the councils. (3)
4. A review of the HRH information system should be undertaken with a view, in particular, to making more effective use of existing data by better linking currently separated data bases so that aggregate information can be made more comprehensive and reliable. (1)
5. Facility staffing standards should be revised in consultation with relevant bodies and facility staff to reflect changing needs and demand for services, but should also reflect potential higher efficiency through better management (see below). (1)
6. Within councils, actual staffing needs should be related to utilisation of facilities, rather than as standard allocations for all facilities at the same level. Councils should be encouraged to establish staffing levels per health facility, based on an analysis of workload and the availability of staff. (2)
7. MOHSW and representatives of FBOs and private service providers should nominate members to a task force to review pay and benefits for health workers in the system as a whole. They should identify practical measures to be taken by all three parties to reduce intra-health-system competition for staff and establish reasonable standards for pay. (1)
8. The MOHSW should investigate the magnitude of staff losses to foreign postings and identify measures that would be required to retain highly qualified staff in Tanzania. (1)

Training and development

9. Each council/CHMT should undertake a simple training needs assessment and make a general council-wide training plan. (1 and 2)
10. MOHSW and PMO-RALG should consider transferring a larger portion of the training budget to the councils, so that they can organise local workshops, seminars pay for refresher courses from the ZTC. The budget can also be used to contribute to costs of upgrading training of staff, as well as to pay for attendance at national level workshops. In that way each council can decide on their own training priorities. (3)
11. Current plans and programmes to upgrade the capacity of ZTCs should be accelerated based on verified improvements in performance. (1 and 2)
12. Regular supervision of clinical skills by the RHMT (which is problematic) should be replaced or augmented through provision of annual refresher courses organized by the ZTCs for different levels of staff. The content of these modules could be based on training needs assessments and new technical guidelines being issued. (2 and 3)
13. Health personnel professional bodies should be strengthened so that they can undertake their function of quality control of training institutes and courses. (2)

Recruitment and Deployment

14. Councils should be further capacitated to recruit professional staff and should regain the power to hire as soon as possible (in combination with power to decide on incentives to actually attract and retain qualified staff). (2)
15. Recruitment of trained health professionals to meet health personnel demands of the health system needs to be further accelerated. (1 and 2)
16. MOHSW should investigate the size of the pool of trained health workers, who have left the service, and under which conditions they would be willing to return with a view to actively recruit from this group and organize refresher courses where required. (1)
17. Large disease-specific programmes, in particular those dealing with HIV/AIDS, should assess the impact of their staffing requirements on other key areas such as maternal and child health and develop staff training and assignment support programmes which help offset any negative impacts. (2 and 3)

Retention and Remuneration

18. Incentive packages to attract and retain health personnel in rural and underserved areas should be developed and implemented on an urgent basis. Preferably on the basis of a rapid appraisal among staff and examples of what has worked in other countries. Remote and hardship areas should be financially supported to enable them to finance the necessary incentive package. (1 and 2)
19. The Directorate of Personnel and Administration and the Directorate of HRH should strengthen coordination to accelerate recruitment and salary payment for new recruits. (1)
20. MOHSW should urgently seek, and MOF, should allow an arrangement similar to the one granted to the Ministry of Education to allow newly recruited health personnel on postings to receive full pay during their probationary period.
21. Failing the above, councils could advance initial salary of new staff, in order to bridge the period until payment arrives from the centre. (1)
22. The grading and thus salary of staff should be adjusted to recognize upgrading and/or postgraduate training. (2)

Managing the Workforce

23. Staff should have clear job descriptions, including evaluable tasks and targets so that the Open Appraisal System (OPRAS) can operate effectively. (2)
24. Promotions and opportunities for career advancement should be awarded on the basis of merit and actual performance. (1)
25. A policy to increase the efficient use of time of staff already present should be developed in conjunction with the redefinition of standard staffing establishments. This could therefore decrease the need for training new staff, leaving more funds available to upgrade existing staff's knowledge and skills. (2)

9 Health Care Financing

Conclusions: Health Care Financing

1. Public expenditures in the health sector increased substantially during the evaluation period with both domestic and external sources of funds contributing to the rise measured both as per-capita spending and as a share of national public spending. GoT budget allocations to the sector and DP contributions to the HBF both added to this rise. The increase was not as sustained in most recent years and still falls short of national and international targets.
2. The allocation of on-budget resources over the evaluation period has been characterized by a gradual but steady decrease in the share allocated directly to LGAs, although their overall spending has risen significantly. Because the financial data available did not allow the evaluation to identify the proportion of MOHSW (and national vertical programme) expenditures occurring at the local level, it is difficult to determine the trend in health expenditures at local level as a share of total spending. Nonetheless, it would be useful to establish a target for the share of on-budget resources to be allocated to LGA level.
3. Despite some problems, the evaluation period has been characterized by improvements in the budget performance in the health sector. On-budget resources (both domestic and foreign) have been more predictable and achieved higher levels of budget execution than off-budget funds.
4. Cost-sharing mechanisms implemented during the evaluation have had limited success in achieving their stated goals of raising additional resources for health, improving the quality of services and improving the operation of the referral system. On the other hand, there is some evidence they have strengthened ownership and involvement by local communities.

Issues Focus: This chapter focuses on efforts during the evaluation period to improve the level, appropriateness and sustainability of health care financing in Tanzania. It provides an analysis of the sources of funding, the levels of financing achieved and their composition, the pattern of spending in health by organizational level and functional use, budget performance, and the appropriateness of efforts to introduce cost-sharing and risk pooling mechanisms.

9.1 Sources of Funding

Among sources of funds, a major distinction can be made between on-budget and off-budget resources. The budget in this context refers to the central government of Tanzania budget estimates as submitted annually to the Parliament. The budget estimates for health expenditure include specific votes and sub-votes for MOHSW, PMO-RALG, the Regional Administrations, and the councils.

On-budget sources include revenue of the GoT as well as grants and loans from development partners, notably the HBF and general budget support (GBS). Off-budget financial

resources include revenue raised through cost-sharing mechanisms and councils' own sources in addition to a large portfolio of foreign funded projects and programmes. Although cost-sharing funds are often included in CCHPs, they are not consolidated into the national budget estimates.

The table below identifies the main sources of financing for the Tanzanian health sector using these distinctions.

Table 2: Overview of Main Sources of Financing

Source	On-budget	Off-budget
Domestic	Central Government Funds National Health Insurance Fund	Health Services Fund (User fees) Community Health Fund/ TIKA Drug Revolving Fund Council Own-Sources
Foreign	General Budget Support Health Sector Basket Fund Foreign Funded Projects and Programmes	Foreign Funded Projects and Programmes

9.2 Achieved Levels of Health Financing

Overview

After a period of decline in the 1990s, there has been a steady and general increase in both nominal and real financial resources for the health sector during the period under evaluation.⁴⁹ Combined on-budget and off-budget estimates increased in real terms from approximately USD 140 million in FY 2000 to almost USD 430 million in FY 2006.⁵⁰

The public health sector in Tanzania receives significant funds from both domestic and external sources with external sources predominating in the early part of the period and domestic sources dominating slightly towards the end of the period. The domestic component increased to constitute 55% of total estimates by FY 2006. It should be noted however that this does not take account of the significant volume of external funding flowing to the HIV/AIDS sector. The domestic component also includes general budget support from DPs.

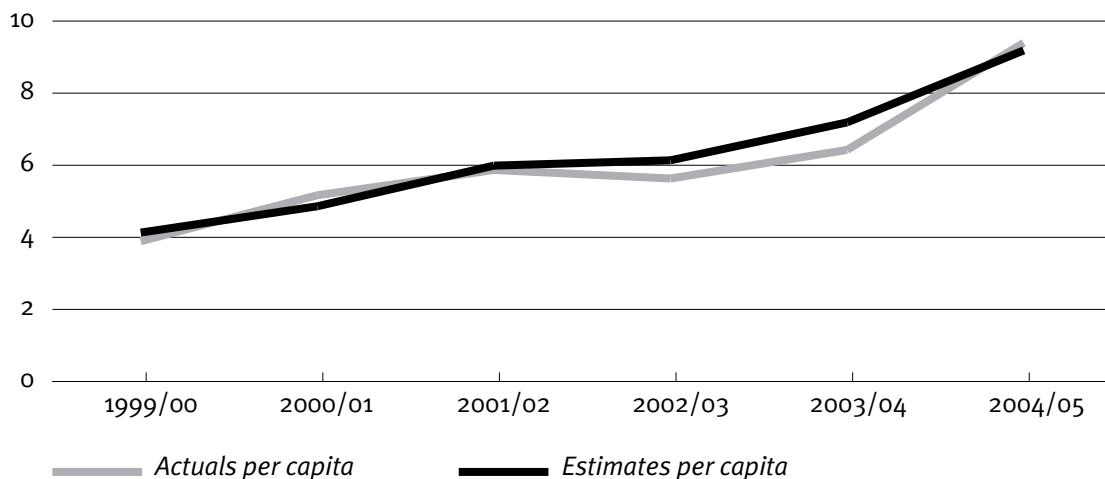
49) *In the interest of brevity, the tables and charts presenting financial data analysed in this section are presented in Annex 5. The data is mainly derived from the PERs for the health sector. As indicated in the PER, queries remain for some of the data and it may be revised with the release of the PER for FY 2007.*

50) *FY 2000 refers to the Fiscal Year 1999/2000, FY 2006 to Fiscal Year 2005/06 etc.*

Real per capita public health expenditures also increased over the period, but were flat from FY 2002 to 2003, mainly due to a decrease in the foreign component of off-budget financing. The level observed for FY 2005 (approximately USD 9) is still well below the USD 12 target established in the 1993 World Development Report and far below the USD 40 target for 2007 established by the Commission for Macroeconomics and Health for low-income countries in Sub-Saharan Africa.⁵¹

Chart 1: Allocation to Health Sector Per Capita, FY 1999/00-2004/05

Real expenditure USD per capita



Source: Own calculations based on PER FY 2004, FY 2005, FY 2006, IMF International Financial Statistics, and Bank of Tanzania

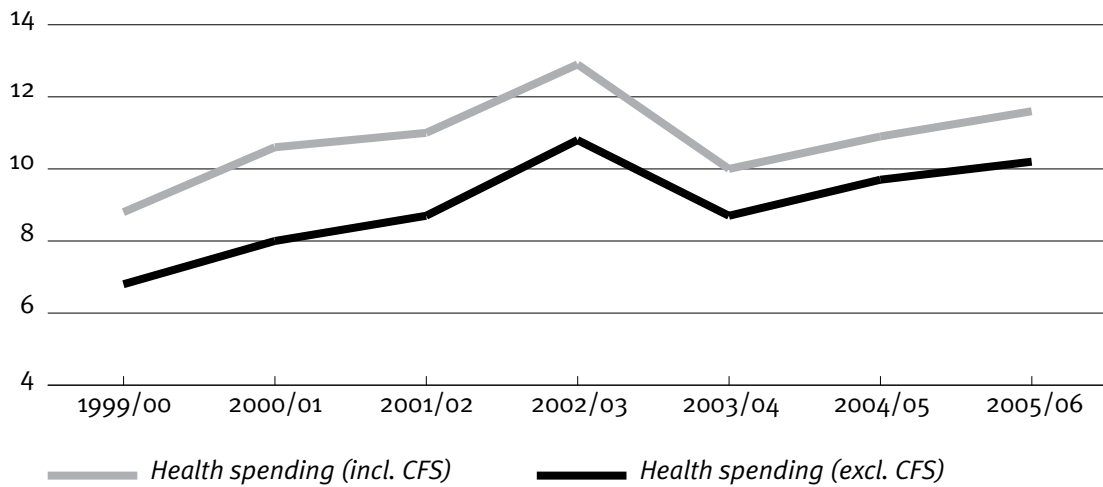
Note: 1999-2006 average exchange rate used

In 2001 in Abuja, the GoT, together with other countries, committed to reserving 15% of its national budget for health. In the first three years of the period under evaluation (2000-2003) health sector expenditures measured as a share of total Government spending increased from roughly 7 to 10.5% (including Consolidated Fund Service charges) and from roughly 9 to 12.5% (excl. CFS). Tanzania was apparently on track to meeting the 15% target under the Abuja Declaration. However, the following three years saw a decline followed by modest growth. The health sector's share of total GoT spending is yet to reach the level observed in FY 2003, let alone the Abuja target.

51) *Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health. WHO, Geneva, 2001. P.171.*

Chart 2: Budget Allocation to the Health Sector, 1999/00-2005/06

Spending as % of total GoT spending



Source: PER FY 2004, FY 2005, FY 2006

The table below demonstrates the development of on-budget and off-budget budget estimates for the evaluation period. The share of on-budget estimates of total estimates has increased from approximately 60 to 80% over the period of evaluation.

Table 4: Public Expenditure on Health: On- and Off Budget Estimates, Real Terms in USD million.

FY	2000	2001	2002	2003	2004	2005	2006
On-Budget	90.3	115.0	153.4	180.9	204.0	262.7	345.9
Off-Budget	53.3	57.5	63.4	45.6	66.5	89.4	81.7
Total	143.6	172.5	216.8	226.6	270.5	352.1	427.5

Source: Own calculations based on PER FY 2004-06, IMF International Financial Statistics, and Bank of Tanzania.

Note: 1999-2006 average exchange rate used. Figures rounded.

Increases in On-Budget Resources

The biggest single contributing factor to the rise in on-budget resources during the evaluation period has been a steady increase in Government of Tanzania financing from just over USD 50 million in FY 2000 to just under USD 200 million in FY 2005. GoT contributions accounted for between 65 and 75% of on-budget sector expenditure during the period.

A much smaller proportion of Government funding is channelled through the Accountant General's Office in the form of contributions to the National Health Insurance Fund (NHIF). While increasing over the period (FY 2006 saw a doubling of the budg-

eted contribution) it currently represents less than 5% of total budget estimates to the sector.

Defining On and Off-Budget Financial Resources

The FY 2006 PER for the health sector defined five different categories of financial resources.

- On Plan** Incorporated into planning documents, for health the MTEF and LGA plans.
- On Budget** Captured within the official budget estimates as submitted to the national assembly.
- On Treasury** Funding channeled through the exchequer and channeled fully in harmony with GoT systems. Domestic resources and general budget support are on treasury.
- On Account** Funding which, whether on treasury or not, is incorporated into financial reporting by the sector.
- On Report** Funding which is reported on in the regular monitoring documents of the sector.

There has also been a significant increase in DP on-budget funding of the health sector in Tanzania during the evaluation period, most significantly in the form of the HBF. The HBF increased steadily from FY 2000 before falling back in FY 2004 and rising again in FY 2005. Some key informants attributed the FY 2004 decline to DFID’s decision to move its contribution from the HBF to GBS. According to MOHSW staff, this resulted in only 50% of prior funding being allocated to the health sector.

Despite fluctuations over time, the HBF has become a key source of financing for the health sector in Tanzania, especially for development expenditure (less so for recurrent expenditure, where domestic financing is still the main source). Development partners also provide on-budget support in the form of financing for specific projects and programs. Except for FY 2004, this funding tracks well below HBF funding and has been very volatile over time.

Off-Budget Resources

In reviewing off-budget resources it is also useful to consider both domestic and foreign funding. Domestic off-budget resources are raised mainly through cost-sharing schemes. The combined contribution of the cost-sharing schemes is limited (estimated at USD 10.9 million in FY 2006) compared to the foreign financed component of off-budget health sector financing (USD 96 million in the same year). On the other hand, revenue raised through the cost-sharing schemes increased in nominal figures reaching its 2006 level from a base of USD 1.5 million in FY 2000. Data on these sources is not systematically reported and consolidated at a central level, so estimates provided in annual PER reports understate the amounts they contribute.

While significant, the volume of external off-budget expenditure has been highly volatile, increasing from a low of USD 40 million in FY 2004 to a peak for the period of over USD 120 million the following year. Generally speaking off-budget foreign financing consists of projects financed by development partners as captured in the external finance database maintained by the Ministry of Finance.⁵²

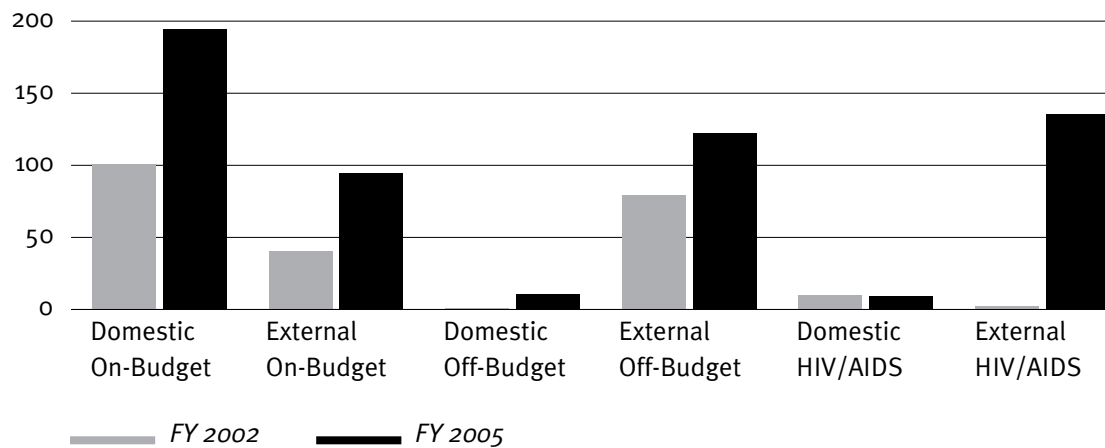
52) *The data on off-budget external financing is based on crude estimates carried out by the PER team on the basis of data from the MOF external finances database.*

HIV/AIDS Finances

According to the most recent PER on HIV/AIDS expenditure, the most significant funding mechanisms for HIV/AIDS activities are the Global Fund for AIDS Tuberculosis and Malaria (GFATM), the Presidents Emergency Programme for Aids Relief (PEPFAR),⁵³ and the World Bank financed Tanzania Multi-sector AIDS Programme (TMAP). These have seen a tremendous increase in the course of the evaluation period. PEPFAR funding for example increased from roughly USD 45 million in FY 2005 to close to USD 100 million for the current FY⁵⁴.

External HIV/AIDS support now exceed external on-budget resources for the health sector and is second only to domestic on-budget resources for health.

Chart 3: Combined Health and HIV/AIDS Expenditure by Source, FY 2002 and 2005
TSH Nominal (billions)



Source: *PER Health FY 2005, 2006 and PER Tanzania Public Expenditure Review Multi-Sectoral Review: HIV/AIDS, November 2003 and March 2007.*

Note: Both sources rely on data from MOF database on externally financed projects. It has not been possible to ascertain whether some HIV/AIDS financed activities are double-counted in the sense they are included in both external-off-budget and external HIV/AIDS.

Almost all of DP support to HIV/AIDS spending was managed outside the Government's accounts and systems in FY 2003 and 2004. The budgeted assistance for HIV/AIDS will according to projections in the most recent PER for HIV/AIDS amount to almost USD 350 million in FY 2007 with almost USD 300 million outside government accounts. Although the share managed outside government accounts has decreased slightly since FY 2004, it still accounts for the overwhelming majority.

53) *Clearly this classification mixes multilateral global health initiatives (GFATM), a single-country large bilateral program supporting HIV/AIDS work (PEPFAR) and a national program with IFI support (TMAP). The characteristic these three programmes share is their very large scale and the fact they remain essentially off-budget (and sometimes go unrecorded in annual PER reports).*

54) *PEPFAR funds in nominal USD figures as reported by the US Embassy to Tanzania.*

Even though funds such as the GFATM are managed outside the Government accounts, they are increasingly captured on the Government budget. Accordingly, the off-budget vs. on-budget debate is somewhat distorted by the fact that a significant proportion of on-budget funds are nevertheless managed through parallel DP-controlled systems.

Council Own Sources

As already noted, off-budget finances are also raised by Councils in the form of dues and taxes. No reliable aggregated data is available to estimate the total of these funds and the share allocated to health. However, based on the review of CCHPs in the six focus councils, it can be seen that revenue raised through own sources has constituted no more than 5% of total income for health in the councils for the period under evaluation. Councils are to a very large degree dependent on intergovernmental transfers and funding from development partners to operate health services.

Implications for Sustainability

The implications of all this for the sustainability of funding of the health sector are complex. On the one hand there are factors arguing for increased sustainability, including the increasing share of GoT funding for on-budget resources in the health sector and the growth (although limited) in the volume of funds from cost-sharing, the CHF and the NHIF. On the other hand, the very rapid rise in funding for HIV/AIDS, while apparently sustainable in the medium term given the commitments made by the programmes in question, may not be sustainable in the longer term given the relatively small proportion of overall HIV/AIDS expenditures provided from domestic sources.

9.3 The Pattern of Spending in Health

Overview

With regard to the share of health sector actual expenditure by administrative level, it is possible to track the relative share of on-budget financial resources accounted for by MOHSW, PMO-RALG, the Regions and Local Government Authorities.⁵⁵

The share of MOHSW (which also includes its expenditures on regional hospitals) has risen steadily over the evaluation period from a 57% share in FY 2001 to 62% in FY 2006. Councils have seen their share decline from 36% to 32% in the same period but have maintained their strong second place in the hierarchy. At the same time, PMO-RALG achieved an increase in its share of total expenditures from a very low base at the beginning of the period to 10% in 2006, as it took over responsibility for use of the HBF component for emergency rehabilitation of health facilities.

The overall pattern is one wherein the central level represented by MOHSW maintains and even slightly increases its share of expenditures while the Councils see a gradual but steady decline in their share which accelerates somewhat in the estimates for FY 2006,⁵⁶ and PMO-RALG sees significant growth in the same year (but some of the funds it receives are spent on rehabilitation of LGA facilities). Although their expenditure as a share of

55) *On-budget health finances include allocations to Vote 52 for MOHSW, Vote 56 for PMO-RALG, Vote 23 for NHIF subventions, sub-votes 3001 (curative) and 3002 (preventive) for Regions, and allocations to sub-votes 5010-5013 for Councils.*

56) *Data for FY 2006 based on estimates. Actual expenditure data not yet available.*

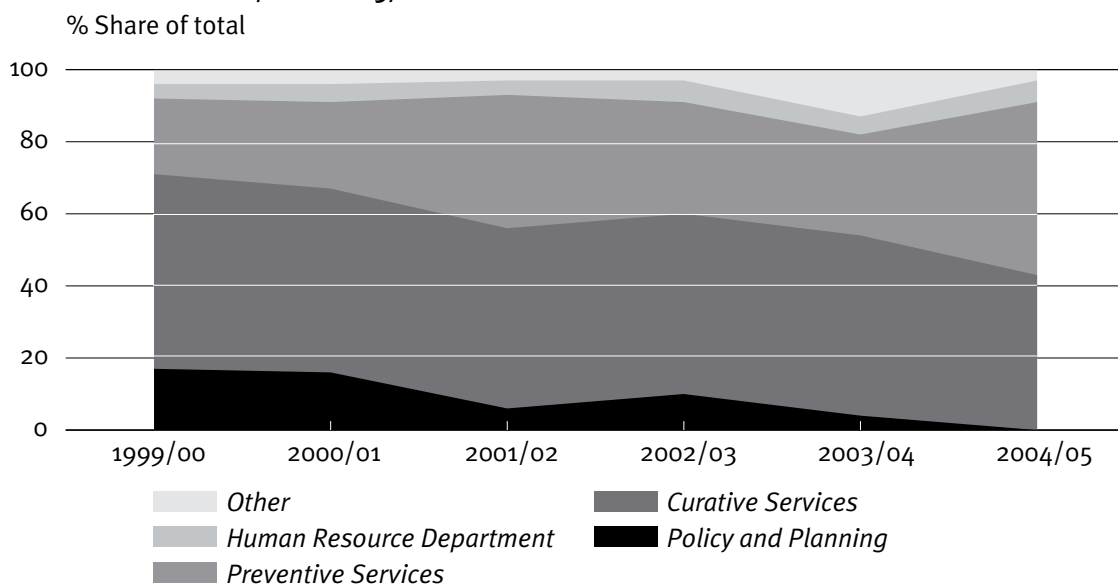
total expenditure has decreased marginally, the volume of Council expenditure on health has increased in absolute terms in each year under evaluation. The volume of health related expenditure in FY 2005 at LGA level was more than four times higher than in FY 2000.

Given the high priority assigned to strengthening district health services as a strategy in HSSP3, it is remarkably difficult to track the actual level of public health expenditures at district level (including both on and off budget expenditures and expenditures by MOHSW). If funds allocated for expenditure at local level can be tracked and reported more effectively, it should be possible to establish targets for increasing the share of resources allocated to the LGAs for health.

By reviewing the share of recurrent spending accounted for by preventive services/primary care, in comparison to the share for hospitals and for MOHSW administrative services, the evaluation was able to do some analysis of the functional allocation of on-budget health recurrent expenditures.

Since FY 2001 there has been a convergence of the share accounted for by hospitals and the share spent on preventive services/primary care with the former declining from 50% to under 45% and the latter rising from just over 40% to just over 45%. These changes over time may be indicative of a trend to increasingly favour PHFs and preventive care, but the evidence is far from convincing given the small size of the changes.

Chart 4: MOHSW Recurrent and Development Expenditure as Share of Total, FY2000/01-FY2005/06



MOHSW

The evaluation examined the trend in MOHSW combined recurrent and development expenditures in five different categories (policy and planning, curative services, preventive services, the human resource department and “other”)⁵⁷ using data from the Ministry of Finance Integrated Financial Management System.

57) The category encompasses administration and general, finance and accounts, chemist lab agency, chief medical officer, TFDA and social welfare expenditures.

Perhaps the most important pattern in MOHSW spending has been the increasing share of preventive relative to curative services, especially since FY 2004, although both increased in nominal terms. In contrast, the share of actual expenditure accounted for by policy and planning has decreased in both relative and nominal terms. Whereas roughly USD 13.2 million was spent in FY 2001, only USD 1.5 million was spent in FY 2006. The reason for this decline is not readily apparent in the accounts themselves.

Council Level Health Expenditures

Health is one of the largest cost centres for Councils, second only to education.⁵⁸ The share of total health finances going to the Councils has fluctuated quite significantly between a third and a quarter of total on-budget estimates for the evaluation period.⁵⁹ In absolute numbers there are indications that the HBF has played a key role in strengthening district level health services. For example, a notable increase of 28% in on-budget health finances to councils was reported from FY 2004 to FY 2005; the year in which the health basket increased significantly. The CCHPs of the Councils subject to district case studies can be analysed with a view to obtaining a rough estimate of the breakdown of council-level health expenditure.⁶⁰ In FY 2006 29% of total Council health spending went to the Health Department, increasing from a level of 25% in FY 2000. The share going to dispensary costs on the other hand has decreased from 45% in FY 2000 to 27% in FY 2006. Finally, the share going to rural health centres has decreased from 27% in FY 2000 to 16% in FY 2006.

A clearly positive development has been the use of more transparent and fair criteria for allocation of the HBF and block grants introduced in the course of the period under evaluation. The new formula approved by the BFC in October 2003 has been applied to components of block grants since July 2004. This has strengthened the equitable allocation of resources to the health sector and generally favoured rural councils, although the “hold harmless” principle continues to distort the picture somewhat since no council is permitted to experience a decline in resources as a result of the application of the formula. On the other hand, the Personal Emoluments (PE) component of the Block Grant is yet to be based on a similar type of allocation formula.⁶¹ According to data from the FY 2005 PER, roughly two-thirds of health related intergovernmental transfers were going to the PE component. The need for a more transparent allocation mechanism for this component seems clear.

58) *There are four sub-votes at the local government level, dealing with health expenditure: curatives services, preventive services, health centres, and dispensaries and clinics.*

59) *The Councils' FY was January-December until June 2004 after which it was harmonised to run from July to June in accordance with the FY of the central Government.*

60) *No aggregated data is available.*

61) *Recurrent public expenditures in Tanzania are commonly broken down into wages and wage-related expenditures such as pension and NSSF contributions (Personal Emoluments, or PE) and non-wage expenditure (Other Charges, or OC). Source: logintanzania.net and MoF Budget Preparation Guidelines, Forms for Budget Submission and Implementation.*

9.4 Budget Performance

Overview

A key aspect of both efficiency and effectiveness in the sector concerns how well financial budgets and plans are executed. One aspect of this can be termed budget performance. Budget performance can be measured by the degree of correspondence between budget estimates, budget releases and actual expenditure. For central Ministries, Departments and Agencies (MDAs), the evaluation analysed the relation between budget estimates and actual expenditures. For councils, the analysis compares the release of financial resources as compared to budget estimates. The decision to focus on these two different measures is based simply on questions of data availability.

The most striking distinction in budget performance is the extent to which on-budget resources are much more effectively executed. In the areas where data is available, budget performance for the off-budget component is poor in the sense that actual expenditure in some years is 20% over budget estimates and in other years 20% below. The poor performance of the off-budget component is arguably to some extent explained by funds from DPs not being made available as planned. This in turn can be explained by cash-flow problems on part of the DPs as well as inability of the beneficiaries to meet certain conditions for release of additional funds. Further down the process, it may also have to do with absorption capacity of the beneficiaries.

For the on-budget component, by contrast, performance has improved gradually over the period from roughly 80% in FY 2000 to close to 95% in FY 2005. Moreover with respect to on-budget expenditure, it is useful to distinguish between recurrent and development expenditure. On balance, budget implementation for recurrent expenditure has been between 95% and 101% in the period FY 2002 to FY 2004. Implementation of development expenditure by contrast was at only 66% in FY 2002, but has improved remarkably over the period and was close to 100% in FY 2004.

Despite the relatively good performance of the on-budget component, performance can still be further improved. Three major factors have a negative impact on-budget performance:

- Late Parliamentary approval of the national budget estimates is a consistent occurrence;
- The Medium Term Expenditure Framework (MTEF) is not yet consistently used in the medium term sense of the word, but is more of a one-year planning document; and,
- The abovementioned cash limitations have at times made it necessary for the Ministry of Finance to release less than estimated.

Central Level Budget Performance

MOHSW

After a period of consistent improvement from FY 2003 to FY 2004, budget performance by MOHSW deteriorated in FY 2005 for curative services, preventive services and policy and planning functions before rebounding somewhat in FY 2006.

Not surprisingly perhaps, the decline in budget performance observed in the MOHSW is mainly due to the development expenditure component. This component includes funds

from the Basket Fund and on-budget foreign funded projects. It is likely that part of the reason lies in procurement related delays. This has been cited continuously as a reason for low absorption capacity in the MOHSW for the development budget and was identified in the preliminary findings of the 2007 Public Expenditure and Financial Accountability Review exercise – with health finances among its focus areas. The procurement related capacity constraints are underlined by substantial delays incurred by the MOHSW in recruiting a procurement audit team.

MOHSW plans to scale up the current supplies unit to a procurement management unit – and training through the Public Procurement Regulatory Authority is reportedly being organised to support this.

Health Sector Basket Fund

Budget implementation of Basket Fund has improved significantly over the period from a low of 20% in fiscal year 2000 to well over 90% in 2004. From FY 2001 to FY 2003, the budget performance of the Basket Fund was far superior to the same measure for other foreign funds. On the other hand, the Basket Fund remains short of the 100% target.

The latter is likely to be a result of the still relatively weak procurement capacity of MOHSW, PMO-RALG and the councils (considering that a relatively large proportion of the HBF goes to development expenditure). Another possible contributing factor may be delays by the beneficiaries in preparing and submitting reports, work plans and other documentation in time for the BFC to approve new releases. In this context it should be noted that the decision to have only semi-annual BFC meetings (in place of quarterly) has, according to MOHSW officials, provided for a more expedient process.

Council Level Budget Performance

At the level of individual councils, budget performance can be examined in relation to both on and off-budget resources. Turning first to on-budget financial resources, around 90% of council revenue comes from intergovernmental transfers generally composed of recurrent block grants, the HBF and development grants. Refer to Annex 5 for a diagram showing the flow of Basket funds to the councils.

In the PER FY 2003, based on a sample of release figures for selected councils, releases were assessed as satisfactory with 93% of councils receiving their budgeted allocation, although the timelines of receiving these payments was not assessed. For FY 2004, performance was even better with releases to urban councils constituting 102.8% of estimate and for rural councils just over 100% of estimates. For both rural and urban councils it is mainly the Personal Emolument components that boost the statistics, while Operating Cost releases were slightly below target at close to 92% for both for the years in question.

More recent analysis suggests that release performance has been less than satisfactory. Nyaywa and Petersen (2007), point out that two thirds of the councils assessed reported delays or non-disbursements of funds from either the HBF or block grant as a main challenge. Similarly, in the joint (MOHSW and PMO-RALG) assessment of 113 CCHP implementation reports for the FY 2005/06, all councils reported late release of funds.

9.5 Cost-Sharing and Risk Pooling

This section examines whether mechanism for cost-sharing and risk pooling established or expanded during the evaluation period have reached their stated objectives. The objectives of cost-sharing and risk pooling mechanisms, including user fees, the CHF, and the NHIF are stated as generate additional revenues, improve quality of services, improve equity and access by pooling financial risk and cross-subsidizing costs, strengthen the referral system, and strengthen community voice and provide accountability.

The mechanisms themselves are described below.

Cost-sharing and Risk Pooling Arrangements⁶²

Cost-sharing has existed in the health sector in Tanzania for decades as most FBOs asked for a fee for their services and public facilities sometimes charged for drugs or were sought illicit payments (Abel-Smith, 1992).⁶³ Cost-sharing was introduced in the public health sector in 1993, after the GoT decided it could not provide free essential health services of acceptable quality free for all citizens.

User fees (to be paid at the point of service when sick) were introduced in 1993, initially for hospital services only. An exemption and waiver policy was agreed to ensure access for those not able to pay, for all maternal and child health services, for all services provided to children under six, elderly over 60, students and disabled people, as well as for specified communicable and chronic diseases. User fees in primary facilities are being introduced gradually, usually in parallel with the CHF (for non-members). Hospitals keep revenues in their own accounts and can use it at their own discretion (HSF), while health centres and dispensaries deposit the collected fees into an account held by the council.

The **CHF** was piloted in one district in 1996 and nine more in 1998. Following an evaluation in 2000, a decision was made to roll out the CHF nationally. It now covers 72 out of 92 rural districts. The CHF operates as a voluntary pre-paid scheme for rural households, who pay between TSH 5,000-10,000 per year. They are covered for preventive and curative services in PHFs. The CHF is conceived as a partnership between the government, represented by the council, and the community, represented by the CHSB. A CHF Matching Grant contract with the central government, stipulates that the government will match all contributions by members (on the condition that at least TSH 5 million have been collected). Contributions are collected by the officer in charge of the PHF and regularly deposited in a separate CHF account, held by the council. The council reports on the amount collected to PMO-RALG and the MOHSW, as well as back to the HFs. The Health Facility governing committee can propose how to use the money in the account, to be approved by the CHSB. The scheme is regularly audited. A separate scheme for urban areas, called TIKA, is starting in 2007. Other organisations also run micro-health insurance schemes.

62) *This information has been compiled using multiple sources, among which official documents of the MoH, studies, interviews etc.*

63) *Abel-Smith B, Rawal P. Can the poor afford 'free' health services? A case study of Tanzania. Health Policy and Planning; 7 (4): 329-341 – 1992.*

The **NHIF**, a parastatal organisation responsible to the Minister of Health, is a mandatory health insurance scheme for public servants, their spouse and a maximum of four dependents. It effectively started in July 2001. Member contribution is 3% of basic salary, matched with 3% by the employer, the GoT. On average this translates into TSH 96,000 per year for about 5-6 people, 10-20 times as much as the CHF contribution. Members have free choice of provider. All public health facilities were accredited at the start of the scheme. FBO and private facilities were accredited later against quality criteria. Benefits include both primary and hospital care. Hospitals claim expenses monthly according to an agreed fee schedule, based on actual costs plus a mark-up. Dispensaries and HCs claim through the DMO office. They also pay the HF's when the patients or services are exempt. More recently the National Social Security Fund also introduced a health care benefit package.

Generating Additional Revenues

According to the PERs, information on how much revenues are raised through cost-sharing is consistently incomplete over the years, as not all HF's report the amount they collect to the council and not all councils report to the central level. Furthermore only a few councils provide a breakdown by type of cost-sharing (user fees, NHIF and CHF – very little information is available on the DRF). An investigation reported in the PER FY 2005 estimates the total to be around 3% of the available resource envelope (range 0.2%-11%), which is lower than that reported in many other Low Income Countries.

The Health Service Fund Balance Sheet for selected years of the Bank of Tanzania shows an increase in collected user fees at hospital level from around USD 1 million in FY 1999 to USD 2.75 million in FY 2006. As membership in both the NHIF and CHF has increased over the years, the contributions have also increased. NHIF contributions rose from USD 11.6 million in FY 2002 to USD 20.7 million in FY 2004,⁶⁴ but in 2007 only two-thirds of eligible civil servants were included in the scheme and large groups of civil servants are not eligible yet (police, army and others). As long as councils do not request CHF matching funds, the central level has incomplete information on the CHF revenues, but from interviews with the CHF team in the MOHSW it is clear that uptake has lagged behind expectations, as in 2007 only 10% of rural households (range 4-40%) were covered in districts enrolled in the CHF.

Different studies, cited in a literature review of the CHF by Mtei and Mulligan⁶⁵ suggest a multitude of potential explanations behind the slow roll out of the CHF. These include: poor understanding of insurance concepts amongst community members; lack of capital for initiation of the scheme; lack of uniformity on premiums; inadequate mechanisms for continuation of membership; low income and income un-reliability; non-coverage of referral care; perceived poor quality of health care services at public facilities; poor staff attitudes; low user fees; and broad exemption policies. So many groups, services and specific diseases are exempt, and user fees for non-exempted services are so low, that some see very little incentive to join the CHF. Community members ask why should they pay if some family members (particularly children, pregnant women and the aged) receive most services for free.

64) Source: NHIF Actuarial and Stat Bulletin as at 30th June 2004.

65) Gemini Mtei, Jo-Ann Mulligan. *Community Health Funds in Tanzania: A literature review*. Ifakara Health Research and Development Centre. January 2007.

Districts and regions also lack full-time, capable, well-trained CHF coordinators, who can organise advocacy events, explain procedures and ensure that collected funds are properly used. Current coordinators are most often co-opted members of the CHMT, who have received very little training, have other regular duties and are not sufficiently equipped for their task.

Improving the Quality of Services

Because hospitals collect substantial user fees (partly because many do not adhere to the exemption policy in all cases) and NHIF payments, and have easier access to them and more freedom in deciding how to utilise them (compared to PHFs), they have been able to use the revenues for off-setting the shortage of drugs caused by supply problems of MSD. User fees have also been used for the maintenance and procurement of equipment, both of which may contribute to quality improvement.

On the other hand, cost-sharing has so far brought limited improvement in quality of services at primary health facilities, for three reasons: *first*, the amounts collected have been limited; *second*, the most effective efforts to boost quality, such as higher qualifications and salary of staff, renovation of buildings, offering more diversified services etc. have been financed from other sources; *third*, the district case studies found considerable confusion in the field about how to access the user fees and CHF contributions collected. Substantial amounts of funds are accumulating in the Council accounts without being used to improve services. Where the CHSB, which has to approve proposals to utilise the funds, is not functional, the money will not be spent. This presents a considerable risk to the CHF, as people's willingness to pay is linked to visible improvements in service. This was the case for the CHF in Masasi district, where the very high initial CHF enrolment was not matched by quality improvements and many did not continue their membership.

Improving Equity and Access

Without some mechanism for subsidizing the poor, cost-sharing in the form of flat rate user fees collected at the point of service when ill is in essence inequitable. It is therefore important that an exemption system was introduced, which in theory guarantees access for essential services to all who need them, as well as granting waivers to those who are unable to pay. Exemptions were not posted in the facilities visited during the evaluation, resulting in not everybody being informed of their right to receive services for free. While PHF staff frequently inform patients about exemptions, hospitals visited only did so when patients would indicate they could not pay.

The introduction of the NHIF has increased equity among civil servants, due to a progressive contribution system and pooling of financial risk, resulting in cross-subsidization between the better-off and the less well-off, as well as between the healthy and the sick. It has improved access for civil servants, as they have free choice of provider and an ever-increasing benefit package. However, the NHIF only caters to an already reasonably well-off part of the population, and is heavily subsidised by the GoT. Although the GoT fully matches both the CHF and the NHIF member contributions, the amount per capita spent on the NHIF is 10-20 times as high as on the CHF, because of the difference in member contributions. The NHIF runs a large surplus,⁶⁶ which could be used to finance services for the poor.

66) *In FY 2004, NHIF contributions rose to USD 20.7 million, while claims were USD 3.9 million, leaving a large surplus, even after allowing for administrative costs, reserve building and 'under-claiming' by providers.*

CHF contributions are assessed at a flat rate within a given council (although they vary across councils), and are therefore regressive, which can compromise equity where the waiver system is not functioning. The fact that payment in instalments is not possible makes it difficult for the very poor to join the CHF. Moreover, poor communities benefit less from the matching grant (because fewer households may enrol) while they may need the subsidy most. Although councils can provide free membership cards to the indigent, few are implementing these arrangements due to resource constraints and lack of awareness among councillors. A creative example, however, is presented by Kigoma rural council, who managed to mobilise TSH 54 million from the Catholic church and another amount from TACARE (Jane Goodall Foundation), matched by government to provide free CHF cards to the poor.

Compared to the NHIF, the CHF benefit package is very small as hospital costs are not (yet) included and the CHF therefore cannot increase access to hospital services. On the other hand, although 57% of community members during the CAST sessions rated the increase in costs to make use of the PHFs as (very) negative, these charges did not deter most people from using the services, in particular when additional costs were off-set by quality improvements.

In summary, in order to effectively promote access and equity, cost-sharing and risk pooling arrangements such as the CHF would need to have much improved waiver mechanisms to ensure that those who cannot pay have access to services at participating health facilities.

Strengthening the Referral System

Theoretically, user fees at hospital level (while PHF services were free) should deter people from bypassing lower levels of care. On the other hand, now that people in many councils also have to pay for PHF services (either in the form of CHF membership contributions or in the form of user fees) bypass fees are much less of a deterrent to referral. One solution may be to include hospital benefits in the CHF but have their use linked to a referral from a PHF. This would deter patients from bypassing the PHF and, at the same time, provide access to hospital care when needed.

The NHIF does not require their members to be referred from a PHF to a hospital, except in the case of the four national referral hospitals. This actually weakens the referral system and encourages bypassing because some patients will be treated at a higher, more costly, level for ailments that could have been dealt with at the PHF. As long as the NHIF has a large surplus, it has little incentive to enforce efficiency.

Strengthening Community Voice and Provider Accountability

From the district case studies, it seems evident that cost-sharing is increasing people's sense of ownership of the PHFs and their influence on their management. This is due to the establishment of HF committees with the ability (in principle) to decide how to use the collected fees and contributions to improve the quality of services. The community's involvement was clearly noticeable among those members that took part in the CAST discussion groups. This is obviously much less the case for the hospital level, because of the distance between the communities and the hospital and the lower frequency with which people make use of the services. People refer to *their* dispensary, but to *the* hospital.

During the CHF pilot the communities were charged with collection of funds, but it was found that funds were misused. Therefore it was decided that the officer in charge of the

HF would collect the contributions. The evaluation did not assess whether the HF committee has any way of establishing that the officer in charge actually transfers all the collected fees and contributions to the Council account. Once the revenues are in the Council account, the communities often have no idea how much is at their disposal.

9.6 Detailed Recommendations

Basket Fund

1. The HBF should be retained and strengthened as an important element in supporting LGA health services. Over time, it should be possible to merge the HBF and the Block Grant into a single mechanism for providing GoT and DP support to Councils for financing health services. (1, 2 and 3)
2. Councils should retain access to some project-mode financial support as the HBF is less conducive to fast-track funding, provided project support is in alignment with national policies and the SWAP. (2 and 3)
3. Councils should be allowed more flexibility in the use of the HBF, this can be achieved either by changing the conditions attached to the HBF or in the context of merging the HBF and the Block Grant. (2)

Budget and Expenditures

4. The MOHSW should investigate the possibility of tracking MOHSW and LGA budget and expenditure data to EHIP priorities, which can, for example, be graded as first, second or third degree priorities, each with a decreasing percentage of the PHC and hospital budget allocated to it. The result would be a financial monitoring system linking funding to priority health interventions. (2)
5. MOHSW, together with development partners, and GHIs and other large bilateral programmes, should study how the budget performance of off-budget resources can be improved. (1)
6. The reason for the reported low absorption capacity for development funds in the MOHSW and the councils should be clarified and addressed. (1)

Cost-sharing

7. MOHSW and PMO-RALG should develop and implement more reliable systems for tracking and estimating cost-sharing revenues. (1 and 2)
8. Management of cost-sharing revenues should be further decentralised to HF level, greatly facilitating their use for quality improvement of services. This should, however be linked to requirements for improved reporting of the volume and use of these revenues by the HF. (2)
9. The many lessons learned through several studies and the CHF workshop in 2007 should be translated into a plan of action on how CHF uptake could be improved and implementation procedures could be simplified. (1)
10. A pilot to replace the user fee waiver system with free CHF cards to reduce barriers for the poor and vulnerable to access health care should be conducted in order to establish whether this would increase CHF uptake. In this study different methods for means testing also need to be piloted. (2)

11. At the same time, the feasibility of adopting a system of graduated contributions to CHF by income levels (creating a more equitable system), as well as the payment of CHF contribution in instalments, should also be piloted in a separate study. (2)
12. A renewed awareness raising campaign should be organised along with updated training for HF staff and committees, CHSB and CHMT on CHF procedures. (2)
13. On a pilot test basis, the plan to include hospital services in the CHF should be implemented (at a higher membership contribution) but use of the benefits should be linked to referral by a lower level health facility. (2)
14. The NHIF should accelerate expansion of membership to include all public servants, as well as interested other agencies and private companies. (2)
15. The NHIF should act to support the referral system by linking payments for services to evidence of referral. (1)
16. The MOHSW should discuss with the NHIF Board how (part of) their surplus can be used to co-finance costs to provide essential health services to the poor, especially in light of plans to merge CHF and NHIF in the future. (2)

10 Public Private Partnership

Conclusions: Public Private Partnership

1. There is little evidence of progress or even sustained commitment to the strategy of Public Private Partnership during the evaluation period. Concrete measures will be required to retain the interest and cooperation of FBO and private sector health service providers if this strategy is to be made effective.
2. Lack of action and progress on PPP could have serious consequences for the provision of health services in Tanzania in the future.

Issues Focus: This chapter deals with the issue of what progress has been made in promoting Public Private Partnership (PPP) in the effort to promote a more effective mix of service delivery providers. It examines overall progress in promoting PPP and identifies some of the most important constraints to progress under the strategy.

10.1 Progress in Public Private Partnership

Tanzania has had a mixed system of health services for decades. FBOs have operated hospitals, health centres and dispensaries literally as long as there has been a functioning health system. During the evaluation period they have been supported by the GoT through the provision of grants both on a per-bed basis and for the cost of some staff. Some NGOs have also provided community health services. The Government's relationship with private (for-profit) service providers has been a different matter, as private provision of health services was outlawed from 1977 until 1991 and has, in the view of many key informants, been tolerated rather than encouraged ever since.

Both the POW and HSSP2 identified strategies to promote private public partnerships. The POW in 1999 laid out the vision that the “public private mix will be promoted in the delivery of health services,⁶⁷” and included a specific Public/Private Mix Strategy to develop new ways of promoting private sector participation, contracting out services and adopting the required legislation. In short, according to the POW, the government “adopted a policy of complementation rather than confrontation with the private sector,⁶⁸” and the Government was “to be more of a facilitator than the main provider of health services.⁶⁹”

Four years after the POW was published, the HSSP2 noted that “the only significant achievement reported [within the area of PPP] is the registration of new facilities.⁷⁰”

67) POW, p.1.

68) POW, p.6.

69) POW, p.12.

70) HSSP2, p.12.

Furthermore, HSSP2 stated that there was generally poor collaboration between the private sector and government, and that an atmosphere of mistrust between the public and the private sector continued to prevail. HSSP2 indicated that the way forward was to support the formation of networks for interaction between the private and public sectors. In 2005 the MKUKUTA repeated the political commitment to PPP. It called for “forging partnership with all other stakeholders, including CSOs, private sector, and FBOs, in the provision of quality social services.”⁷¹

Recurring reference to PPP in all JAHSR reports is indicative of the importance attached to PPP and the distance still to be covered in this area. The following table highlights what the reports from the JAHSR have noted on PPP.

Table 5: Highlights on PPP from reports of the JAHSR

Year	Extracts from JAHSR reports
2000	PPP was a priority issue for discussion.
2002	It was resolved that private sector representatives were to become part of the CHMTs.
2003	FBOs were complaining that they were not integrated into the health planning process at district level, and that they were losing large numbers of staff to the government because of the better pay and benefits offered in the public sector. It was also made clear that mutual suspicion persisted in the partnership between government and the private service providers.
2004	It was acknowledged that increases had been made in the bed-grant subvention and that a draft “service agreement” for contracting with non-government providers had been drawn up.
2005	The need was emphasised to replace the current government subsidy (i.e. grant subventions) to FBO-providers by a service agreement linked to outputs. Another resonating theme was the need to expand the opportunity for non-state actors to participate in health planning and management at district level.
2006	Many participants voiced dissatisfaction with the lack of progress during the year. Service agreements were still not implemented, and staff continued to emigrate from non-profit to government employment because of the recent salary improvements in the latter.

Source: Reports from the JAHSRs.

As the highlights from the JAHSR reports show, some critical aspects of PPP have not progressed much over the evaluation period and the same issues appear to be on the agenda year after year.

In 2005, the independent Technical Review focused specifically on the promotion of PPP.⁷² As these reviews are meant to feed into the JAHSR, this, in itself, was a manifestation of the importance attached to the issue by the major stakeholders. The review

71) *MKUKUTA, p.49.*

72) *HERA. 2005. Technical Review 2005: Public Private Partnership for Equitable Provision of Quality Health Services.*

described the variety of non-state actors in the health sector. It pointed out that roughly 40% of health services in Tanzania (more in urban areas) are delivered by non-state providers. Furthermore, it stated that FBOs made a large contribution and some of the FBO hospitals had been assigned district responsibilities (so-called District Designated Hospitals). The not-for-profit services by FBOs were complemented by a range of activities by NGOs, often with external funding and increasingly HIV/AIDS related. The private (for profit) side had even greater variety, with a range of private hospitals, pharmacies, laboratories, maternity homes etc.⁷³

The Technical Review presented the key elements of PPP in Tanzania's health sector. It stated that the Government provided funds for recurrent expenditure of 21 FBO hospitals (19 DDH and 2 Consultant Hospitals) and bed and staff grants to 62 FBO owned hospitals. However, it also pointed out that the Medical (grants-in-aid to voluntary agencies) Regulations started as early as 1952 and the practice of using DDH agreements began in 1972. According to one centrally placed observer, "these are the only means that have so far been used to foster the public private partnership in the country."⁷⁴ While this statement may reflect the principal government effort to promote PPP, it should be added that the Government also provides student grants for training schools run by FBO hospitals, and that Voluntary Agency Hospitals in the districts are entitled to receive 10%-15% of the HBF and Block Grants.

Apart from the above, NGOs and CBOs make important contributions to the health sector and they may be regarded in the context of PPP. Community-based health promotion and prevention services, which are mostly done by NGOs and CBOs, are not as well documented as mainstream health service delivery since this is not routinely captured by the HMIS and more often reported in project reports. Partly due to their large numbers and diversity, juridical arrangements, objectives, etc., health NGOs have not been sufficiently well organised. As a result, the NGO sector is somewhat excluded from policy discussions and strategic planning, especially at central level. At the local level, collaboration with CHMTs seems to be more effective, but varies from district to district depending on pro-active attitudes of NGOs and CHMTs.

The Technical Review produced a list of about 20 specific recommendations to promote PPP. To date, almost none of these have been implemented. However, the evaluation noted that in all of the six case study districts public funds were allocated to Voluntary Agency Hospitals (FBO operated). Furthermore, it was ascertained that in each of the six districts the CHMTs engage in supervision of FBO and private health facilities. These findings corroborate some of the changes highlighted by the District Self -Assessment (Synthesis Report, April 2007, p. 25).

In contrast with the district self-assessment (p. 25), the evaluation did not find that: "there is recognisable public private partnership mainly in the areas of planning and training." First, the individual reports from the 16 districts covered by the District Self Assessment show a more nuanced picture. While several of the individual reports mention that there has been participation in planning, they also contain many qualifiers in this respect. For example, the extent of participation has in many districts been restricted

73) *The Association of Private Health Facilities in Tanzania (APHFTA) currently has around 250 members.*

74) *Technical Review 2005, p.22.*

(to e.g. one large FBO), there has been poor attendance, or it has not gone beyond co-ordination, inputs or information sharing.

Reviewing a number of CCHPs, the lists of members on the council planning teams indicate that some FBO participation was generally the rule. But, based on the interviews done, the district case studies found that real FBO and private sector participation in the preparation of CCHPs was very limited in the six districts visited. Simply having a member on the planning team is no guarantee of participation or influence. While some FBO participants (in Same and Njombe for example) did indicate that they participated meaningfully in the CCHP process, others noted that their participation was minimal. Private service providers on the other hand, were largely unaware of the CCHP.

Training and seminars may be one of the areas where there have been some improvements in PPP. Again, several of the district self-assessments reports refer to achievements in this area. But the limitations are also pointed out: unequal access to training (in some cases) by public and non-public health professionals. Training and seminar activities are not planned in response to the needs of both of these target groups. On the other hand, in most cases non-public health professionals may be invited to participate in training events designed for public sector staff.

The district self-assessment reports highlight joint vaccination and community sensitisation programmes and preventive services as areas of PPP achievement. While this is an area of PPP that has undoubtedly contributed to increase coverage and accessibility to essential health services, the process is designed with a bias in favour of the public sector. Many non-state actors appreciated the opportunity to take part in such campaigns, but the evaluation also heard complaints that they were obliged to participate in e.g. nationwide vaccination campaigns without being compensated for staff time or the use of their facilities. In such cases, private HFs only receive the drugs and supplies required to implement the activities.

In a few of the six districts visited, both public and non-state actors mentioned that they benefited from a technical dialogue with colleagues “on the other side.” Key informants also noted that some FBOs and private sector providers have been certified to provide health services to public servants who are covered under the NHIF.

Some of the individual district self-assessment reports make reference to a practice of exchanging professionals and secondment from public health providers to private health providers and vice versa, which is reported to have strengthened the collaboration between the public and private sectors. The report for Mkuranga District Council, for example, states that staff from the public hospital is sent to work in a private clinic in order to improve the quality of health service. This practice was also observed in the district case study of Kigoma Municipal Council.

It is also worth pointing out that councils do provide financial support to FBO hospitals working in their district and the district case studies regularly found a reasonably high level of cooperation between the CHMT and at least the larger FBO hospitals.

The evaluation found only a few PPP co-ordination mechanisms in the six districts, despite the fact that these had been singled out in the POW and HSSP2 as holding particular promise. A Lake Zone PPP Forum has been established (with DP support) and two years ago council quarterly meetings had been institutionalised in Mwanza in order

to bring together all the actors in the health sector, public and private. Both of these were reported to have increased transparency and the degree of information sharing.

10.2 Constraints to Greater Progress

Some of the factors that limit the development of PPP have already been implied in the section above. The Technical Review in 2005 pointed to the following challenges:

- PPP is a reality in Tanzania, but its concept and practice are still limited;
- Mistrust persists between the public and private sectors;
- The ownership of the providers rather than the health services provided and utilised are seen as the centre of gravity;
- Funding and resource sharing arrangements at the council level are not sufficiently equitable.

One of the factors that hinder further development of PPP is a fairly pervasive lack of understanding of what is meant by PPP, or rather, what role PPP is really intended to play in the Tanzanian health sector. This was apparent in many of the interviews done in connection with the evaluation, and the district self-assessments made the same point in at least some of the district reports. One reason this arises is the apparent lack of clarity and concreteness in the policy and strategy documents on PPP.

Generally speaking, a public private partnership is a long-term contractually based arrangement between the government and one or more private sector operators, where the private sector delivers a public service but the government retains the overall responsibility. In some types of PPP the government uses tax revenue to provide capital for investment, and operations are subsequently run jointly with or contracted out to the private sector. In other types, capital investments are made by the private sector based on a contract with government to provide agreed services. Government contributions to a PPP may also be in kind (notably the transfer of existing assets).

The district self-assessments and district case studies and other key informant interviews demonstrated that in most districts there has been a positive change in the perception of the role of especially the private (for profit) service providers, but also that mistrust persists by the district officials in some places. Varying degrees of this are also discernible at the regional and central levels of government. On balance, it seems clear that mutual understanding between the parties has become the rule, but genuine partnership is still to be achieved.

The evaluation was not able to probe deeply into the reasons for this continuing mistrust. The explanation for the insufficient progress on PPP is presumably rooted in the historically tense relationship between the Government and the private sector in Tanzania. The legacy of having private provision of health services outlawed from 1977 to 1991 cannot easily be turned around with the advent of the notion of PPP. Moreover, while the government may be more prone to embrace the private sector as a partner in other areas, the health sector in most countries is pre-eminently within the public sphere and thus PPP in this area may be more difficult to foster.

As the Technical Review pointed out (p. 6): “there are not three separate [health] sectors in Tanzania; there is one sector in which different actors provide complementary serv-

ices.” Unfortunately, this reality is neither fully acknowledged or appreciated in all circles. As a result, as mentioned above, planning at the council level is not really comprehensive or concerted in the sense of allocating the available resources (human, financial, medical supplies and equipments) in accordance with the status of the institutions and their share in the provision of essential services. The importance ascribed to the ownership of health service providers has led to a differentiation in registration, quality assurance, resource sharing etc. If the stated national policy on PPP is to be implemented, there is clearly a need to effectively address and to reduce or eliminate this bias in favour of just one of the main actors in the health system: the public sector. The tendency to see the private sector as supplement or gap fillers should be discouraged.

In five of the six case study districts, the salary increases and improvements in employment conditions in general in the public health sector represented a serious challenge to faith-based and private health providers (as already noted in Chapter Eight above). In fact, looking at the six district case study reports this emerges as the most serious constraint to further development of PPP. In several cases, especially faith-based (but also some private) health facilities have lost professional staff who have recently been recruited into public sector employment based on the better salaries and conditions offered. In addition to this, members of the Lake Zone PPP Forum told the evaluation that some FBO health facilities had been forced to close down due to a lack of funds. They reported that donor funding to FBOs had dwindled as donor resources were shifted from FBOs involved in health service delivery to Basket Funding, budget support and advocacy-oriented NGOs. Funding has also diminished because Western churches and their members from abroad are reported to have reduced their levels of direct funding of FBOs in Tanzania.

Against the above background, some faith-based and private health facilities find it unfair that they are required to provide free services for pregnant women, infants, under fives and the recognised poor in order to comply with the public health policies. A government subsidy to cover at least the costs associated with this would address one important financial challenge for FBOs. While it is true that most public facilities are not reimbursed for exemptions and waivers, MOHSW points out that they are compensated somewhat through their drug allocations with MSD, a benefit not available to FBOs.

Similarly, the existing regulation that 10%-15% of Block and Basket Grants have to be allocated to Voluntary Agency Hospitals, and not to VA facilities like HCs or dispensaries, seems too rigid at this point. Members of the Lake Zone PPP Forum argued that the allocation range of 10%-15% should be revised upwards.

Given the challenges facing the health sector in Tanzania, PPP presents an opportunity to make the most of the available health resources. It is logical that effective co-operation between the public and non-public health service providers can produce better results than just letting the two co-exist. The time may have come for the stakeholders to seek external advice and guidance from specialists in the area of PPP.

10.3 Detailed Recommendations

1. The preparation of HSSP3 offers the opportunity to develop a new policy on public private partnerships, together with all stakeholders. (1)
2. MOHSW and PMO-RALG should ratify and implement the draft service agreement with non-public providers on an urgent basis. Fee levels for services under these agreements should be sufficient to support more competitive salaries. (1 and 2)
3. Depending on the activity level of non-profit, non-state health service providers in their area, councils should have more flexibility, provided a minimum level is met, to decide on the magnitude of allocation from the basket fund to voluntary agencies, and be allowed to also let PHFs and NGOs benefit from the transfer. (2)

11 HIV/AIDS Programming

Conclusions: HIV/AIDS

1. Including HIV/AIDS as a specific strategy in HSSP2 has contributed (along with other factors) to a more effective national response through increased resources, infrastructure improvements and improved coverage of testing and treatment.
2. Important constraints to more effective HIV/AIDS programming include staff shortages, limited rural coverage, service bottlenecks, low participation by males, limited availability of Prevention of Mother to Child Transmission (PMTCT), continuing stigma for patients, and relatively weak home-based care and workplace programmes.
3. The large increase in external funding for HIV/AIDS sometimes distorts priorities and draws staff away from, for example, maternal and child health.
4. Prevention efforts require increased attention and priority in comparison to recently strengthened care and treatment programmes.

Issues Focus: This chapter addresses the issue of the extent the incorporation of HIV/AIDS into the HSSP2 as an explicit strategy contributed to an effective national response. It examines the context of HIV/AIDS programming during the evaluation period and presents an analysis of achievements and constraints and continuing challenges to integrating HIV/AIDS programmes.

Context

HIV/AIDS is a key development and health issue given priority in poverty reduction, health and development documents including MKUKUTA, the Health Policy, the POW and the HSSP2. Among the operational targets of the MKUKUTA are to “Reduce the HIV prevalence from 11% in 2004 to 10% in 2010 between ages of 15-24 years” and to “protect rights of vulnerable people, including people affected by AIDS”.⁷⁵ The evaluation period has also seen an expanded response to HIV/AIDS, both in and outside the health sector. Key events include preparing the National AIDS Policy (2001), establishing the Tanzania Commission for AIDS (TACAIDS) 2001, and developing the third National Multi-Sectoral Strategic Framework (NMSF 2003).

While a multi-sectoral response to HIV/AIDS is emphasised (with TACAIDS, and the council HIV/AIDS Coordinator position at district level), the health sector remains the central actor in the national AIDS response. Four of the nine goals of the NMSF (2003) are directly linked to the health sector. High priority attention to HIV/AIDS remains relevant considering HIV/AIDS is a major cause of morbidity and mortality. AIDS is the second most common cause of death among persons five years and older and the sixth cause for children under five years of age.⁷⁶

75) *National Strategy for Growth and Reduction of Poverty (NSGRP)/MKUKUTA. Vice President's Office, United Republic of Tanzania. 2005.*

76) *MOHSW Annual Health Statistical Abstract April 2006 (using 2004 and 2005 data).*

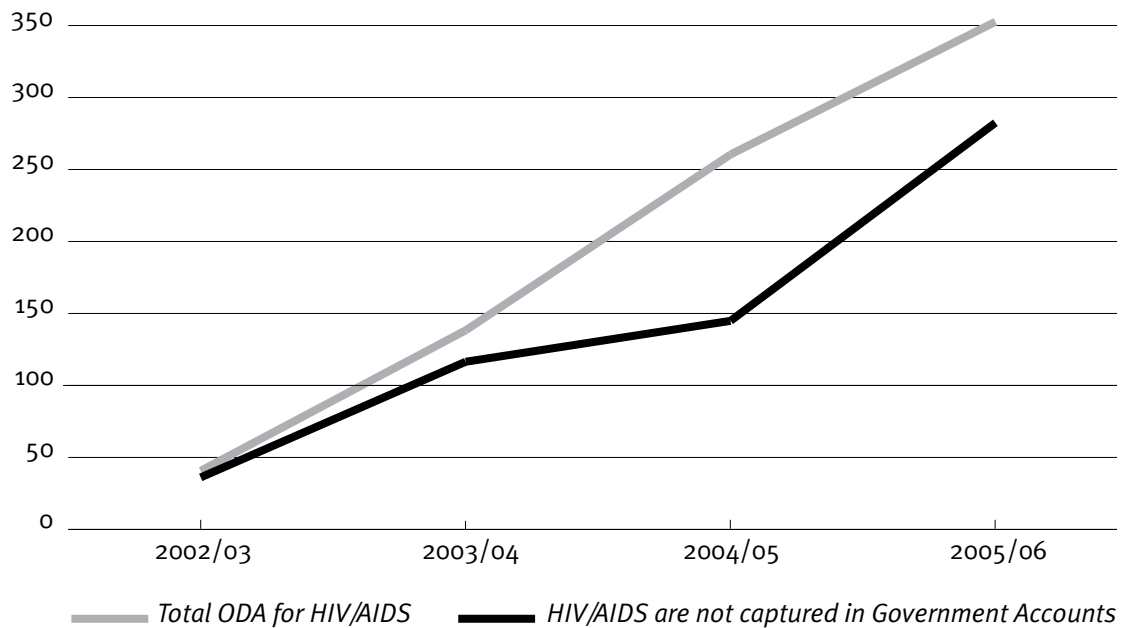
11.1 Achievements in Extending HIV/AIDS Programming

The emphasis on HIV/AIDS in past years has resulted in many positive developments and achievements. Attention to HIV/AIDS at international and national levels contributed to increased funding for AIDS from both government and external sources. Financing of HIV/AIDS programmes almost doubled between FY 2002 and FY 2003. This rise has included a significant and ongoing increase in the volume and share of health sector resources devoted to HIV/AIDS by the government. The GoT increased its share of total funding from 20% in FY 2002 to 33% in FY 2003. An increase in HIV/AIDS spending by local government authorities was also documented during the same time period.⁷⁷ Greater amounts of external financial and technical support have also been earmarked for many different aspects of AIDS prevention and treatment.

One feature of HIV/AIDS funding already noted in Chapter Nine is that it is often off-account (not channelled through the exchequer and not incorporated into financial reporting).

Chart 5: HIV/AIDS Financing Aid Not Captured in GoT Accounts, 2002/03 - 2005/06

USD Nominal (USD billions)



Source: Tanzania PER Multi-Sectoral Review: HIV/AIDS, November 2006 (first draft prepared by Foster and Smythe)

At least partly in response to increasing HIV/AIDS funding and activity, the MoH originally decided to place NACP directly under the CMO within the MOHSW structure, in order to better manage the health sector HIV/AIDS response.⁷⁸ After one year this

77) MOH (2003). *Health Sector PER Update FY 2003 First Draft Report February 2003* cited in Lake, S.; *Public Expenditure Review 2002/2003*.

78) MOH HSSP 2 2003.

decision was reversed and responsibility for NACP returned to the preventive services department of the Ministry.

NACP/MOHSW has developed a *Health Sector HIV/AIDS Strategy 2003-2006*, which contains over 20 clear targets for care and support, prevention and cross-cutting issues, a National Care and Treatment Plan (2003-2008) (supported by the Clinton Foundation) and a number of other guidelines related to HIV/AIDS prevention and care. A Care and Treatment Unit was established (in 2003) for coordination and management of the National HIV/AIDS Care and Treatment programme.⁷⁹

Civil society is also an active partner in the national HIV/AIDS response. FBOs have engaged in HIV/AIDS interventions since the beginning of the epidemic, though often in ways not linked to the national coordination plans. The Christian Social Services Commission (CSSC) has now developed an HIV/AIDS strategic plan for a comprehensive response by Church institutions against HIV/AIDS (2006)⁸⁰ especially in health and education services, but the effect of this development remains to be seen. Beyond the FBOs and CSOs, the role of the private sector still lacks internal organisation and representation in the AIDS response.⁸¹

The evaluation identified a number of achievements in HIV/AIDS programming⁸² including:

- 200 clinics providing Anti-Retroviral Therapy (ART), 1,427 health care workers were trained on ART management, and 125,139 People Living with HIV/AIDS (PLWHAs) enrolled in care programmes, of which 60,341 are receiving ARV drugs;
- 1,027 Volunteer Counselling and Testing (VCT) sites have been established, such that each district has a minimum of three VCT sites, which is 50% of the target of six sites per district; and numbers of clients seeking VCT service is increasing;
- 60% of all dispensaries offer reasonable quality Sexually Transmitted Infection (STI) services;
- 7,926 health care providers have been trained in STI syndromic case management;
- According to the recent HIV/AIDS Indicator Survey 2003-04, 41.7% of youth aged 15-24 years had used a condom at their last higher risk sexual encounter.

Most of the above achievements cannot be compared to targets, mentioned in the Strategy, the treatment plan or the NMSF, as these are differently formulated.

According to the treatment plan, the target was to have at least 150,000 people on treatment by the end of 2006 (the 3rd year of the plan) and at least 600,000 HIV+ persons enrolled. The targeted number of treatment sites has been exceeded, but the number of patients on treatment falls far short of the target in the plan leading some to question the realism of treatment targets.⁸³

79) MOH NACP Annual report 2003.

80) CSSC (2006) *HIV/AIDS Strategic Plan for Church Institutions*.

81) NMSF (2003).

82) MOH NACP Paper on Situation Analysis on Health Sector HIV/AIDS Strategy 2007.

83) 6th JAHSR (2005).

Antiretroviral treatment is now available within the public health care system, at FBOs at hospital level and at some private hospitals. In contrast to other drugs and supplies, ARVs are regularly available in sufficient amounts and stock outs are not happening. The availability and regular supply of drugs for opportunistic infections and STIs is reportedly also satisfactory.

Additional achievements in the health sector response include:

- A national monitoring framework for Prevention of Mother to Child Transmission (PMTCT) has been developed. Some districts are implementing paediatric HIV/AIDS services;
- A national HIV surveillance system is now functional in the NACP, including guidelines for second-generation surveillance and protocols for Antenatal Clinic (ANC) surveillance. ANC and behavioural surveillance (including youth) is underway in six regions;
- Post-exposure prophylaxis for health workers exposed while at work was reportedly present but not accompanied by “full workplace programmes” in health services.

At council level, HIV/AIDS activities are integrated into the CCHP. There are HIV/AIDS committees established at council, ward and village level, though their functioning and effectiveness was not assessed during the evaluation.

The driving impetus for many positive developments in the health sector response to HIV/AIDS during the 2003-2005 period is difficult to clearly ascertain. Some of may be due to specifying HIV/AIDS as a separate strategy in the HSSP, but there are a number of other concurrent events that have also affected the trend. HIV/AIDS has been recognised as a national emergency; it is included in numerous national strategy documents and plans, and there have been continued international interests contributing substantial resources for HIV/AIDS-related activities. In this regard, the evaluation observed that the newer and better-equipped infrastructure at health facilities including labs, wards, VCT centres and pharmacies were related to HIV/AIDS funding. District respondents felt that having HIV/AIDS as a separate strategic area in HSSP2 was positive as it supplemented funding for HIV/AIDS activities available from council funds.

11.2 Constraints in HIV/AIDS Programming

Despite impressive achievements over a relatively short period of time, the HIV/AIDS health sector response is plagued by the usual constraints found in the health sector, as well as some specific to HIV/AIDS services. The key constraints in HIV/AIDS programming are documented in a number of reports including HSSP2, NMSF for HIV/AIDS, the GFATM tracking study, a situation analysis of GHIs in HIV/AIDS in Tanzania and a number of the MOH annual reviews. These constraints were also evident in the six district case studies carried out by the external evaluation team.

Among the key constraints are:

- Coverage of HIV/AIDS services is low compared to population needs. Despite service increases, remote areas remain largely un-reached by prevention and care services due to a combination of limited service delivery points and transportation constraints (while it is true that HIV prevalence rates are higher in urban areas, this does not negate the fact that relatively lower prevalence areas also require due attention);
- Skilled human resources to deliver all the interventions needed are in short supply;
- Poor health infrastructure plus management and planning constraints result in service bottlenecks for laboratory, logistics, coordination and patient referrals.
- Low participation of male users in HIV/AIDS services; in one health centre visited for example, the ratio was 400 women to less than 30 men attending HIV testing;
- Stigma and discrimination also prevent the uptake of available testing and treatment services; and public opinion still sometimes opposes prevention methods like condoms;
- Further scale-up of current interventions will pose a major capacity challenge.

Beyond the health facility, community based HIV/AIDS care efforts to back up the health facility services are not very well developed and community participation in Home-Based Care (HBC) services has been low. There has been insufficient support to HBC providers from hospitals and district health teams. Health facility attempts to offer HBC are limited by staff numbers, transport and lack of HBC kits. HBC kits are not routinely provided from MSD or CHMT top up for drugs and supplies. Care interventions outside the health facility that need community inputs, like nutrition for those on ARVs and HBC for PLWHAs, are lagging.

The MOH care and treatment plan (2003-2008) acknowledges the complexity of ensuring services beyond the health facility but is less specific on community based care and treatment activities including home based care. Strategies to ensure basic support such as food, secondary support for adherence, and community education in ART are also not elaborated. This suggests weak linkages and/or inequitable emphasis between the health and social welfare components of MOHSW's response to HIV/AIDS.

Other than post-exposure prophylaxis, HIV/AIDS workplace activities are in their infancy, especially in public sector work places including the MOHSW itself. For example, in Mwanza the few medium to large scale workplace sites with functional HIV/AIDS programmes were all private corporations. Whereas civil service workplace programmes on HIV/AIDS are also planned, these receive very little attention and a much smaller proportion of the funds to be disbursed. In the 2004 NACP budget, for example, a sum of USD 200,000 is set aside for fighting stigma and discrimination, but only USD 85,590 is earmarked for workplace interventions.⁸⁴

Paediatric AIDS, most of which comes from MTCT, totalled about 5% of reported AIDS cases in 2004.⁸⁵ PMTCT services have been started, but coverage is low and uptake is vulnerable to low rates of hospital deliveries. Even when mothers deliver in

84) Beckmann, S., Rai, P.; *HIV/AIDS+ Work HIV/AIDS, Work and development in the United Republic of Tanzania ILO, GTZ 2004.*

85) *MOH NACP Surveillance report Jan to Dec 2004 (2005).*

PHFs, the PMTCT opportunities are not fully utilized. Only a fraction of facilities doing ANC and deliveries are offering PMTCT because staff have not been trained and/or needed drugs are not provided. By October 2006, only 66% of hospitals, 38% of health centres and 7% of dispensaries doing deliveries were providing PMTCT services.⁸⁶ More integration of HIV/AIDS is needed in anti-natal care and delivery services to reduce the number of missed opportunities.

Training is a major component of HIV/AIDS interventions. During district visits for this evaluation, it was found that zonal training centres (ZTCs), including ones like the PHC Institute in Iringa,⁸⁷ have not been much involved in HIV/AIDS related training.

Synchronization of modalities for coordination and harmonization of donor supported HIV/AIDS activities remains a constraint.⁸⁸ An assessment of the GHI in Tanzania⁸⁹ found that the HIV/AIDS situation is moving very fast and coordination mechanisms for HIV/AIDS are quickly outdated or superseded, making coordination difficult. Coordination above MOHSW and below the central MOHSW level, at sub-national level, e.g., council Multi-sectoral AIDS Committees are being destabilized by new GHIs, funding pledges and new frameworks.

11.3 The Challenges of Integrating HIV/AIDS Programming

The national HIV/AIDS response faces many challenges in the future. Chief among these are: providing adequate and sustained attention to cost-effective prevention, integration and coordination of activities; the sustainability over time of resource intensive CTC services; and addressing HIV/AIDS in the context of other health and development priorities. The best way of addressing HIV/AIDS is still prevention, and more emphasis needs to be placed there in future. Prevention activities also need to address difficult social issues like gender relations, sexual behaviour, cultural values and stigma.

At district level, the CHMT budget ceiling is 20% for communicable diseases, which includes HIV/AIDS. For the district council, 20-30% of the social sector budget is intended for HIV/AIDS, including the multi-sectoral response. Meanwhile, the district level costs for HIV/AIDS prevention, care and support are often way beyond the amounts available in these ceilings. Because of this limitation, district funded HIV/AIDS activities often have to be carried over beyond a single financial year. In fact, many, if not most, of the HIV/AIDS activities in the district are funded outside the basket fund and block grant. However, similar to the national level, extra funding for HIV/AIDS including non-monetary support is not always captured in the CCHP, so it is hard to gauge or quantify the adequacy of funding at the council level.

86) *MOH NACP Situation Analysis 2007.*

87) *Iringa PHC Institute has been doing health sector reforms related training for districts and CSOs.*

88) *TACAIDS Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS) Reporting period: January 2003-December 2005.*

89) *Hutton, G.; Global Health Initiatives in HIV/AIDS in Tanzania: Situation analysis and review of key issues A briefing paper established in the frame of the SDC-STI SWAp Mandate 2003-4 Swiss Centre for International Health 2004.*

This limitation aside, HIV/AIDS interventions at district level continue to get special attention and efforts relative to other disease specific interventions. In some districts, HIV/AIDS is one of the better funded areas due to significant external support via donors and the visible presence of HIV/AIDS programming. In regional and district hospitals, the better equipped labs, newer and better infrastructure, dedicated rooms and more reliable drugs, up to date reporting are directly linked to HIV/AIDS funding.

Health staff and some community members agree that care and treatment of HIV/AIDS patients has considerably improved, but at the same time, they acknowledge that not all persons who need care are getting it. Even though the roll out of care and treatment programmes is impressive, increase in service utilisation has not met the level of demand and neither have the treatment targets been attained. The treatment plan aimed to have 400,000 people (with an estimated cost of USD 539 million) on antiretroviral treatment within a period of five years (by 2008); but by December 2006 only 60,341 were receiving ARV drugs.

Another challenge is cost and eventual affordability of HIV/AIDS treatment and care. Although the annual cost per individual on treatment is projected to reduce over a 5-year period, these costs are many times the per capita expenditure in health.⁹⁰ In fact, the budget for ARVs has increased so dramatically that it is almost as large as the MOHSW budget for drugs in general. The projected number of health staff needed in the 5-year period of the treatment plan is more than the numbers for medical officers, pharmacists, medical lab technicians, registered nurses produced in a 5-year period (1999 to 2003).

While the national treatment plan includes estimates of the total cost of treatment, it does not identify full funding for such activities and acknowledges that the proposal is a tool to mobilise additional funding. Even with offsetting costs by the GoT covering human resource and the Global Fund taking the bigger share of the treatment and care plan, the largest proportion of the budget (USD 445 million) has to be raised from other sources.

The significant inflow of funds, drug supplies, testing equipment, training, improvement of infrastructure and technical assistance to combat HIV/AIDS in recent years has had a number of negative impacts on the general health system. While the seriousness of the problem of HIV/AIDS is acknowledged, some identifiable negative effects include:

- Increased HIV/AIDS funding has increased activities without necessarily increasing HR available.⁹¹ In an already overburdened health system, key personnel are being diverted from priority activities, e.g., malaria control and maternal health;
- Government of Tanzania budgetary resources are being diverted away from agreed priorities, such as maternal and reproductive health;
- Efforts to transfer responsibility for health services planning, management, delivery and accountability to district level may be weakened when most AIDS programmes are centrally or donor managed;

90) *Tanzania HIV/AIDS care and treatment plan, 2003 to 2008.*

91) *HERA Technical Review of Health Service Delivery at District Level, March 2003.*

- The HMIS may be overburdened with demands for specialized data (or the creation of a parallel system of data management) although interviews with HF staff at district level indicate that HIV/AIDS programmes have worked to keep the forms simple and the burden of extra reporting manageable;
- As a life-sustaining drug, ARVs will need to be provided to patients for decades and international funding may not be maintained for such long periods.

In HSSP2, the roles of the MOHSW and NACP are specific and linkages to other line departments and institutions are emphasized for purposes of integrating HIV/AIDS activities.⁹² However, the coordination and integration of HIV/AIDS services within the health sector and between health and other sectors,⁹³ between GoT and GHI and within GHI and the different donor partners remains challenging.⁹⁴ The GFATM has acknowledged that it cannot successfully address HIV/AIDS in Tanzania without addressing health systems strengthening issues in general. In its last round, the GFATM provided a proportion of its budget for health systems strengthening.

Home-based HIV/AIDS care is part of an effective health sector response to HIV and AIDS, but it has not received the same attention as other forms of treatment. By December 2005, 66 out of 121 districts were providing HBC services, mostly with donor support.⁹⁵ Many independent groups are working at both national, regional, district and community levels but there is no proper coordination and referral system. Interventions for VCT, ART and HBC need to grow together to ensure a continuum of care for those with HIV and AIDS.

11.4 Detailed Recommendations

1. VCT should be more actively promoted among men. (1, 2 and 3)
2. Prevention of HIV infection needs renewed attention. (1, 2 and 3)
3. Councils should consider reserving a budget for nutrition support for HIV positive persons receiving ARVs. (1, 2 and 3)
4. Workplace policies to protect health workers from HIV infection should be developed and implemented. (2)
5. Drugs for the prevention of mother-to-child-transmission for HIV infection should be made available in all health facilities that do deliveries. (2)
6. Support for transport costs to hospital and/or an expansion of home-based care should be provided to HIV positive persons enlisted for anti-retroviral treatment. (2)
7. MOHSW and partners should focus increased attention on strengthening coordination of HIV/AIDS prevention and care out to the decentralized community care and support systems. This entails the development of a well coordinated and integrated home-based HIV/AIDS care programme allowing for a continuum of care from the health unit to the family in collaboration with CSOs. (2)

92) *MOH CCHP Guidelines, February 2007.*

93) *MOH HIV/AIDS HS Strategy.*

94) *Hutton, G. Global Health Initiatives in HIV/AIDS in Tanzania, 2004.*

95) *Chipfakacha, V.G. Report on the Evaluation Mission of the Belgian Government Supported Home Based Care Project in Tanzania. 2006.*

12 Service Quality, Access and Equity

Conclusions: Service Quality, Access and Equity

1. The evaluation identified evidence of improvements in service quality in the areas of improved ability of health facilities to deal with malaria and HIV/AIDS, improved vitamin supplement programmes, improved cleanliness of facilities and improved attitude and capacities of those staff who are available. At the same time there remain critical challenges in improving service quality further and, other than local initiatives, there is little evidence of improvement in services aimed at preventing maternal mortality and promoting maternal health.
2. Tanzanians who are able to use the health system on a regular basis did report to the evaluation that there has been an improvement in the quality and value of the services they receive, including those requiring fees for service.
3. On the other hand, equity of access continues to be hindered by geographic isolation and poor transport links, by weaknesses in emergency obstetric care, and by cost-sharing and risk pooling mechanisms which are unable to effectively implement systems of waivers for those who cannot pay.
4. There has also been no apparent systematic attention to issues of gender equity during the evaluation period.

Issues Focus: This chapter deals with the issue of whether or not the evaluation period has seen improvements in quality of care and equitable access to health services in Tanzania.

12.1 Quality of Health Services

Quality in health services can be roughly divided into two categories: technical quality of diagnosis and treatment, usually assessed by the profession itself, and other quality aspects, such as friendliness and respectful attitude to patients, cleanliness of facilities, waiting time etc., the assessment of which can perhaps best be undertaken by the users of the services. Both the POW and the HSSP2 include a strategic objective to improve quality of district health services. To this end, the MOHSW produced many guidelines for specific diseases and numerous training courses were given.

Central Initiatives on Quality

In 1998, the Health Services Inspectorate Unit was established in the MOHSW. While the legal mandate for the inspection function is still under study, the Unit developed a quality improvement framework,⁹⁶ a (pocket) guide for infection prevention and control,⁹⁷ and a strategic plan and guiding principles to enhance integration of vertical programmes

96) *Tanzania Quality Improvement Framework – delivering quality health services.* MoH, 2004.

97) *National Infection Prevention and Control Guidelines for Healthcare Services in Tanzania.* MOH, November 2004. A pocket guide is in press.

into general health services.^{98,99} All these documents were developed through wide consultations with stakeholders and distributed to all RHMTs and CHMTs. It is planned that each health worker will soon receive a copy of the pocket guide. How far clinical staff have actually been exposed to these quality improvement tools and whether the ideas therein are followed in the district is not known, as monitoring of quality in the HMIS is still limited and health inspectors do not (yet) exist. With only three staff, the Health Services Inspectorate Unit remains understaffed and under-funded. Appointment of a health inspector in every region could be a powerful tool (among others) to assure and improve quality of care.¹⁰⁰

As one way to increase quality of service in hospitals, the POW contained an objective to establish therapeutic committees. During the regional and district level interviews, health service staff noted that these have been established in hospitals, are meeting regularly and are functioning well. More generally, there are also institutions, including professional councils, the Tanzania Food and Drug Agency (TFDA), Government Chemist, and the Bureau of Standards that play a role in regulating standards and conducting quality improvement activities.

While clinical examination suffices for correct diagnosis of certain diseases or symptoms, correct treatment for others is ideally based upon laboratory-supported diagnosis. At the PHF level laboratory services are either absent altogether or only able to do the most basic tests. Although WHO supports syndromic treatment for LICs,¹⁰¹ recent developments in malaria treatment for example challenge its cost-effectiveness, due to the high cost of ACT. The presence of basic laboratory facilities at dispensary level could prevent unnecessary treatment of many patients with this expensive drug if tests are properly used and interpreted.

In line with current developments in health financing, the HSSP2 also mentions the introduction of performance-based incentives linked to service delivery as a way to improve quality of care. Reportedly there are no pilots to test this approach in public health services in Tanzania, although PBF has been very successful in other countries, such as Rwanda, where the approach is now being implemented nationwide.¹⁰² However, a Dutch NGO is presently piloting a Performance-Based Funding (PBF) arrangement in Catholic Dioceses in Arusha, Bukoba, Kigoma, Rulenge, and Sumbawanga.¹⁰³ If the pilot proves to be successful, it could provide a model for wider implementation.

Assessing Changes in Quality of Care

Perhaps the most important method used by the evaluation to assess changes in quality of health services at community level was the use of the CAST tool in focus group discussions with community members as it included indicators of changes in quality over

98) *Enhancing integration of health services in Tanzania-guiding principles*. MoH, March 2003.

99) *Strategic Plan for Integration of Health Services in Tanzania*. MoH, April 2003.

100) *The education sector has an inspector in every district*.

101) *Syndromic treatment is often more cost-effective, but has the disadvantage that a substantial number of people will be treated without having the disease (false positives)*.

102) *Maria Paalman, Médard Nyandekwe. PHC Support Programme in Cyangugu Province Rwanda 2003-2005. External evaluation of a performance-based financing programme*. Cordaid, April 2007

103) *Pay for Performance. Briefing note*. Cordaid, January 2006.

time as perceived by users of the health services.¹⁰⁴ Of the groups participating, more than 75% responded that the capacity of HFs to deal with malaria and HIV/AIDS has (much) improved and that availability of drugs and cleanliness of the HF has become (much) better. Across all 16 indicators used in the CAST focus groups, 58% of all responses are either positive or very positive and only 17% are either negative or very negative, while 26% of the responses indicate that no change is perceived. No significant differences in men's and women's responses are apparent on the 16 indicators, with the exception of change in waiting time, to which men responded much more negatively than women.

On balance, the perception of community members about changes in service quality over the period 1999-2007 is positive.

These findings correspond to the results of the district self assessments where 16 of the 16 reports scored the quality of health services as improved, mostly relating to improved infrastructure and improved supply of equipment and drugs, as well as to the availability of more qualified staff. Further, the staff of facilities visited for the district case studies gave concrete examples of improvements in staff training and capacity as well as improved (although still intermittent) supplies of drugs.

Change Assessment Scoring Tool (CAST)

The CAST was developed in the mid-1990s as a special focus group technique to capture people's perceptions of change (see reference below). The CAST applied by the evaluation addressed villagers' perceived changes on a simple 5-point scale from very positive change, through no change, to very negative change. Each focus group addressed 16 indicators in the areas of access to and quality of health services, capacity to deal with specific health issues (child delivery, malaria and HIV/AIDS) and the community's overall health situation. Villagers either reached consensus or a majority vote determined how to score change in a given area. A total of 21 focus groups were conducted in six different districts. The results of this exercise reflect the perceived changes of nearly 300 villagers who participated, mostly in separate groups for men and women.

Mikkelsen, Britha. 2005. Methods for Development Work and Research: A New Guide for Practitioners. London : SAGE Publications.

The Tanzania Service Provision Assessment Survey (TSPA 2006)¹⁰⁵ makes the following relatively positive observations on service quality (although it does not compare them to earlier survey results);

104) *For a complete list of the CAST indicators see Annex 6.*

105) *Tanzania Service Provision Assessment Survey 2006. National Bureau of Statistics, and ORC Macro, January 2007.*

- Almost all hospitals and health centres have at least one qualified provider assigned;
- Over 90% of government run and 80% of FBO run health facilities provide all basic child health services;
- Curative care for sick children, measles vaccines and vitamin A, as well as STI services and malaria treatment are available in almost all facilities;
- Modern family planning and antenatal care services, and all vaccines required for immunizations are provided in over 75% of facilities.

Generally in these areas of care, hospitals scored better than other facilities and government run and FBO facilities had higher overall scores than private facilities. The survey also points to areas of continuing weakness;

- Different dimensions of infection control, such as waste disposal systems and running water were available in only 38% of facilities;
- IMCI clinical assessment was of variable quality, even when conducted by an MO or CO;
- Signal functions in emergency obstetric care as defined for the Averting Maternal Death and Disability (AMDD) project are present in only two thirds of hospitals and less than 10% of all facilities (hospitals, health centres and dispensaries).

Clearly, the improvements in services cited by community members and reported in both the district self-assessments and district case studies (improved treatment of malaria, immunization, staff qualifications – although not overall numbers – and improved availability of supplies of drugs and vaccines) are not directly contradicted by the TSPA 2006.

At the same time, continuing constraints and weaknesses in quality of care around infection control (evidenced in the district assessments in the form of lack of running water and insufficient sterilisation facilities) and, especially, adequacy of services in emergency obstetric care were noted by almost all key informants and reported in the district case studies as well as the TSPA. This is especially important given the findings on maternal mortality reported in Chapter Thirteen.

12.2 Access and Equity

Equity of access to quality health services in Tanzania continues to be constrained by a number of factors, some of which can be influenced directly by the capacities, policies and services provided by the health sector and some which cannot. Current factors hindering access and limiting equity in the health system as identified during the evaluation include:

- Geographic isolation and both poor and expensive transport links which (in terms of frequency of mention by users and the relative magnitude of the expense) remain probably the largest single barrier to access by both women and men to health services and which, in cost terms alone, often outweigh the impact of cost-sharing and fee requirements. This combined with poor and poorly organized ambulance services disadvantages rural Tanzanians in comparison to their urban counterparts;
- Relative under-investment over the evaluation period in some areas of care such as emergency obstetric care and family planning with a subsequent negative effect on maternal mortality and on disability. This was the subject of a major MOHSW programme proposal in 2006 which was reportedly not funded as a result of problems encountered in the supplemental estimates process;

- Cost-sharing and risk sharing mechanism unable to effectively manage special exemptions and waivers for those who cannot pay. Community members were very clear on this point. While they found user fees expensive, if able to pay they saw value in the relatively improved services they have been receiving. At the same time, almost every focus group discussion pointed to many serious examples of the persons who could not pay, for whatever reason, being denied the mechanisms established to provide them free access. If the CHF and cost-sharing are to be retained, it is essential that the systems for providing free access to those who cannot pay are made to function;
- Finally, of course, all of the continuing constraints in the health system tend to limit access, especially human resource constraints which are felt most urgently in rural and isolated regions and districts.

These barriers were noted in all six district case studies carried out by the external evaluation team.

Equity Issues and MOHSW

The issue of equity, especially as it is impacted by user fees and the introduction of the CHF, has been a regular subject in deliberations during the JAHSRs. One study in 2004¹⁰⁶ concluded that “*presently, the user fees in Tanzania are regressive and contribute to substantial exclusion, self exclusion and increased marginalisation. A functional exemption and waiver system is actually non-existent, putting vulnerable and poor people at risk by practically denying them access to public health services*”. For many years the JAHSRs have also noted that the waiver system for the poor and vulnerable does not work properly.

The change in the resource allocation formula to include a poverty measure is an important effort to increase resources available for less prosperous councils, but there is no readily available information on how the councils, who benefited from this, used these additional funds to ensure that the poor receive services. The fact that few districts have used funds to provide free CHF cards to those who are entitled to them suggests that these funds may not be reaching their intended use.

In light of the importance of the equity issue over the evaluation period, and the many reviews pointing to weaknesses in the waiver system, the level of attention given to the issue by MOHSW seems low. Some key informants suggested that a post should be created in the Health Sector Reform Secretariat (HSRS) to act as a focal point for equity issues in the sector.

Gender Equity

A particular feature of almost all of the strategies, policies, plans, guidelines, reports and review documents available throughout the evaluation period has been the absence of an analysis of issues in gender equity and approaches to addressing them. Similarly, a systematic screening of JAHSR reports and minutes of the SWAP committee indicate that gender equity issues have not featured prominently in these discussion forums.

106) *Equity implications of health sector user fees in Tanzania. ETC Crystal, July 2004.*

Interviews with staff in health facilities at all levels also indicated that gender equity as an issue is not regularly discussed or considered relevant to efforts to improve service quality. Interestingly, this perspective seems also to hold at community level. Focus group discussions carried out with separate groups of men and women regarding changes in service quality produced almost no significant differences in response, with the sole exception that men were more negative on the issue of waiting times at facilities.

One recent positive step has been the reported decision by MOHSW to collect and analyse gender-disaggregated data through the HMIS system. When available, this data should help analysts inside and outside the ministry as they assess the gender equity effects of the health sector. It will also offer the basis for policies to address specific health needs of men and women.

In keeping with the evaluation ToR, the evaluation did not conduct a systematic gender analysis of the sector and cannot comment on the extent that women's strategic gender interests are met. On the other hand, it is clear that at least one area of women's practical gender needs is not being effectively addressed at the present time, the need for effective measures to improve safe delivery and reduce maternal mortality.

Detailed Recommendations

Detailed recommendations made at the end of Chapters Four through Eleven include many aimed at improving access to quality health services in an equitable manner. They have not been repeated at this point in the interests of saving space. In addition, major recommendations on improving equity of access are provide at the end of Chapter Fifteen.

13 Health Outcomes

Conclusions: Health Outcomes and Achieving Targets

1. Tanzania has made significant progress towards achieving goals in reducing infant and child mortality and some progress in aspects of child malnutrition. However, no measurable progress has been made in reducing maternal mortality or improving maternal health. There has also been little progress in reducing neonatal mortality.
2. The information gathered by the evaluation at both the national and local levels strongly suggests that positive contributing factors have included, among others: continued strengths in immunization and improved micronutrient supplementation; improved diagnosis and treatment of malaria, especially among children; improved availability of drugs; and increased use of Insecticide Treated Nets (ITN).
3. Factors limiting further progress towards achieving MKUKUTA and MDG targets in health include continued shortages of health workers, poor infrastructure, intermittent shortages of drugs (despite the noted improvements), shortages of other medical supplies, and poor and inefficient use of transport.

Issues Focus: This chapter compares the available data on health outcomes in Tanzania during the evaluation period with national health related goals and targets. It also analyses the factors apparently contributing to and impeding progress in reaching health sector goals.

13.1 Assessing Progress Against Targets and Goals

There are three sets of key goals and targets which are most relevant to the evaluation period: The health related goals of the first Poverty Reduction Strategy to be achieved by 2003, the goals of the MKUKUTA to be achieved by 2010 and the Millennium Development Goals in health to be achieved by 2015.

The table below presents an overview of key indicators for the Tanzania Mainland as they relate to PRS, MKUKUTA and MDG goals in health.

The overall picture presented in the table is one of significant progress toward goals in the area of reducing child mortality, having essentially achieved those goals in Mainland Tanzania for the PRS (2003), and trending downward toward the goals for MKUKUTA and the MDGs, although with considerable progress still needed.

Table 6: Progress Against Targets

Indicator	1996	1999	2004/5	PRS Goals (2003)	MKUKUTA Goals 2010 ¹⁰⁷	MDG Goals (2015) ¹⁰⁸
Infant Mortality Rate ¹⁰⁹	88	99	68	85	50	40
Under Five Mortality Rate ¹¹⁰	137	147	112	127	79	47
Prevalence of stunting in under five year olds	44	44	38		20	23.3
Prevalence of moderate or severely underweight (wasting) in under five year olds		29.5	21.9			14.4
Proportion of Children Vaccinated Against Measles ¹¹¹	81	78	80	85	85	90
Coverage of Diphtheria, Tetanus and Polio Vaccine among 12-23 months ¹¹²	85	81	86	85	85	
Maternal Mortality Rate	529 ¹¹³		578		265	133
Percentage of births attended by trained personnel		36	46		80	90
% HIV/AIDS Prevalence among Adults		9.4 (2000) ¹¹⁴	7			<5.5
Number of People Living With HIV/AIDS Receiving Anti-Retro-Viral Drugs (ARV)			125,312 in AIDS Care and Treatment and 60,341 on ARVs ¹¹⁵		100,000 by Dec 2006	

107) MKUKUTA Status Report 2006

108) Millennium Development Goals Implementation Report 2006 (2nd Draft)

109) Using DHS data

110) Using DHS data

111) Using TRCHS/DHS data, which does not coincide 100% with EPI data of Ministry of Health

112) Using TRCHS/DHS data, which does not coincide 100% with EPI data of Ministry of Health

113) A number of key informants point out that this estimate for maternal mortality is contested with some analysts and agencies suggesting it may have been much higher in 1996.

114) As reported in the MDG Implementation Report 2006.

115) Presentation by NACP, January 2006.

Similarly, immunisation coverage is close to the targets set for 2003, 2010 and 2015 (although it has not increased significantly since 1996). This coincides with the findings of the district case studies where health staff and community members reported a reduction in measles cases and where facilities were generally well stocked with vaccines.

Given diminishing returns on investment, it may still prove difficult to achieve the set goals for IMR and U5MR. As mentioned by key informants, most infant mortality occurs very early after birth (neonatal mortality), and interventions targeting neonatal will therefore have the biggest impact on IMR.

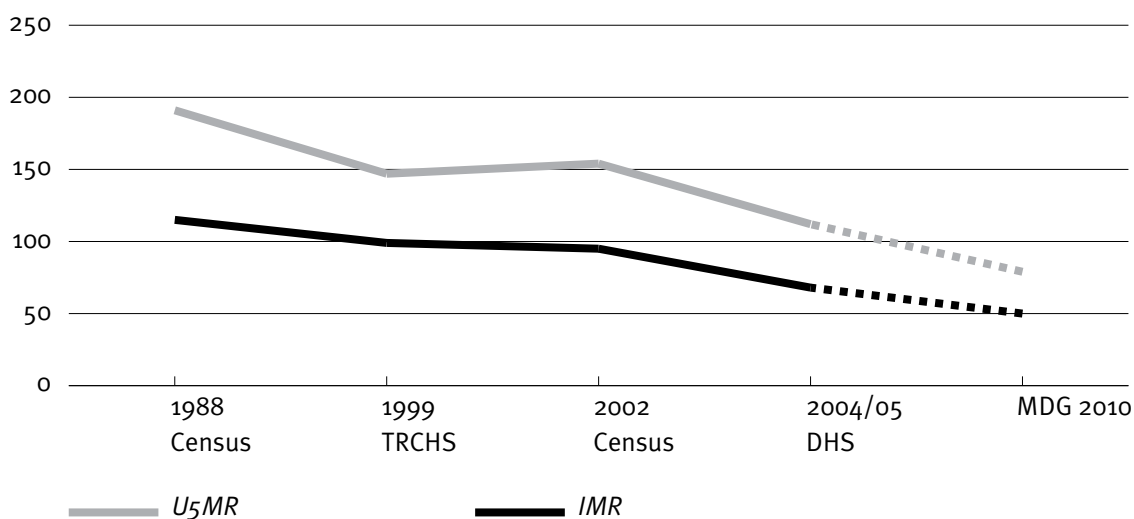
At the same time, there has been no progress in the reduction of maternal mortality, although the number of births attended by trained personnel increased considerably. This goal is clearly not on track to be met in either 2010 or 2015 unless very significant action is taken.

It is clear that finding an effective solution to the problem of Tanzania's maternal mortality rate will not be easy given the link between this indicator and effective emergency obstetric care and to issues relating to infrastructure and transport.

On the other hand, the district level case studies found little evidence of a concerted effort to address this problem within the health sector as a whole. The Tanzania Service Provision Assessment Survey 2006 points out the severe shortage of health facilities with capacity to undertake caesarean sections and blood transfusions. It also notes that less than 10% of facilities report ever offering the "signal functions" developed by the AMDD project in an effort to track progress in the area of facility preparedness to deal with maternal complications.

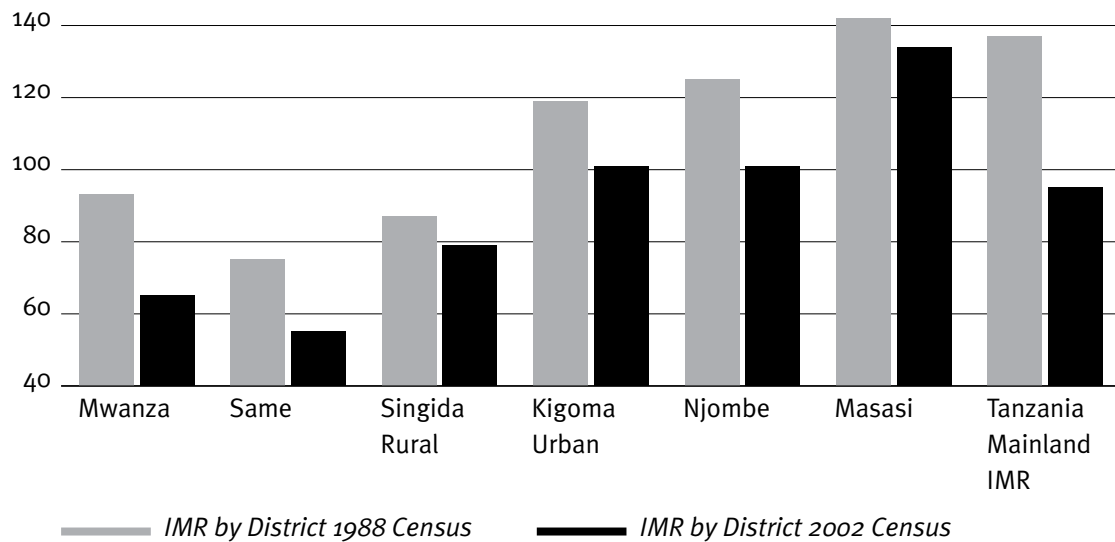
As one indicator of progress in health outcomes, Chart 6 below provides an overview of progress towards the MDG goals in IMR and U5MR.

Chart 6: National Trends in IMR and U5MR as Reported in Census and DHS Data
Trends in IMR and U5MR



The six districts chosen for case studies during the evaluation also experienced declines in IMR and U5MR during the evaluation period. The most reliable data at council level is found in reports of the national census. Chart 7 illustrates the change in IMR in the six case study districts, and in mainland Tanzania as measured in the two 1988 and 2002 census. A very similar pattern is evident in changes in U5MR for the six districts.

Chart 7: Changes in IMR in the Six Case Study Districts.



While HMIS data at council or district level is not reliable enough to track trends in health outcomes over time, the census data suggests that the case study districts are experiencing similar improvements in at least IMR and U5MR as those reported for the country as a whole.

HIV/AIDS

Regarding progress in addressing HIV/AIDS, the THIS 2003/04 is the first comprehensive study on HIV/AIDS in Tanzania. Its most positive result was finding the overall prevalence rate at 7%, which is lower than had previously been estimated. The most important findings of the THIS are the following. The overall prevalence rate is higher among women (7.7%) than men (6.3%). About 1,070,000 people aged 15-59 years are HIV positive. The average prevalence among pregnant women is 6.8%. The overall prevalence rate for blood donors is 8.8%, again showing a difference between males and females (8.2% male and 11.9% female). There are also great regional variations. For example, in Manyara and Kigoma, the overall prevalence is 2.0%, while in Dar es Salaam it is 10.9%, and in Iringa and Mbeya it is over 13%. The risk of being HIV positive is twice as high for residents of urban areas as for rural residents (the overall urban infection rate is 12.0% and overall rural infection rate is 5.8%). More than 50% of tuberculosis patients are HIV positive.

Malaria and Tuberculosis

With regard to malaria, the 2004 Demographic Health Survey (DHS) indicates that the percentage of under-fives reported to have had fever in the two weeks prior to the survey, a proxy indicator for malaria, declined from 35% in 1999 to 23% in 2004, which is significant. Ifakara data indicate a decline in child deaths due to malaria or acute febrile ill-

ness from 10.4 per 1,000 person years in 2000 to 3.7 per 1,000 person years in 2003. The decline may be due to an increased usage of bed nets and more effective anti-malarial drugs. For example, UNICEF data shows that the percentage of under-fives who have slept under a bed net the night before the survey went from 21% in 1999 to 31% in 2004/05. Likewise, the percentage of under-fives with fever who were given anti-malarial drugs in the two weeks before the survey rose from 53% in 1999 to 58% in 2004/05. Similarly, MOHSW reports that the 2005 Roll Back Malaria survey for Tanzania confirms a significant increase in the use of insecticide treated nets and further points out that the case fatality rate for severe malaria among under fives was now ranked much lower (5th) than previously among the 10 leading causes of death on the Tanzania mainland. They also point to a TEHIP study reporting a significant decline in malaria specific under-five mortality between 1999 and 2003.

With regard to tuberculosis, MOHSW reports a dramatic increase in the number of tuberculosis cases reported over the last two decades, although the number was reasonably constant from 2001 to 2005 when it fluctuated in a range from a low of 61,246 cases in 2001 to a high of 64,298 cases in 2003 before dropping back to 63,780 cases in 2005. The steady rise in TB cases during the 1990s is attributed to the precursor rise in HIV/AIDS cases.

13.2 Contributing and Constraining Factors

A key question for the evaluation is the plausibility of a link between the positive (and negative) developments in health outcomes in Tanzania and the features of health sector programming and service delivery.

One possible interpretation suggests that those indicators addressable through large-scale vertical program interventions have shown the most positive change. For example, U5MR and IMR could be responding to national scale programmes of immunization, malaria treatment, increased use of ITNs, and micro nutrient supplementation. To reduce MMR it is of major importance to find out which mothers die in childbirth and why,¹¹⁶ before embarking on scaling up certain interventions. That said, it would likely require system wide improvements in availability of contraceptives, emergency transport and emergency obstetric care services, including improved availability of fully functioning operating theatres and qualified staff trained in caesarean section and other procedures as well as a major improvement in infection control.

In its draft report on progress toward the MDGs, the MOHSW attempts to identify those factors contributing to improvements in child health. At a management and finance level it includes in that list the advent of the SWAP, the advent of the HBF, and increased public and private per-capita expenditures in health.

MOHSW also lists increases in the coverage of a number of health interventions as important positive contributing factors. These include: Vitamin A supplementation; the number of districts implementing Integrated Management of Childhood Illnesses

116) *In Uganda for example researchers reported that 80% of maternal deaths occurred in girls 18 or younger, a finding which changed their approach to reducing MMR. Oral information from WB representative to the JAHSR 2007.*

(IMCI); households with at least one mosquito net; malaria preventive treatment during pregnancy; children sleeping under a recently treated bed net; iron supplementation; breast feeding and measles immunization.

The evaluation was not able to locate a model or study able to mathematically link changes in health outcomes to specific changes or interventions in the health sector. On the other hand, the district case studies along with key informant interviews and a review of research documents strongly suggest that the following factors contribute to or limit positive changes in health outcomes. Only factors within the influence of health service providers (public, FBO and private) are included.

Potential Contributing Factors

- Strengthened micronutrient services;
- Increased numbers of skilled birth attendance;
- Improved diagnosis and treatment of malaria, especially among children;
- Improved availability of drugs, especially for treatment of malaria and HIV/AIDS;
- Increased use of ITNs; and,
- Some reported improvement in the use of modern contraceptive methods.

Potential Constraints and Limiting Factors

- Continuing severe shortages of trained health workers;
- Deficiencies in infection control and poor infrastructure, especially the lack of running water as reported in the Tanzania Service Provision Assessment Survey and directly observed during all six district case studies;
- Continuing intermittent shortages of essential drugs at HF level;
- Shortages of other medical supplies (syringes, gloves, x-ray film, reagents) at facilities level;
- Poor and/or expensive transport infrastructure, especially as it relates to emergency transport and the use of ambulances.

These factors, both positive and negative were cited by many of the key informants interviewed during the evaluation study, especially health care workers and managers at central, regional and local levels. Their relation to trends in outcomes seems plausible. On the other hand, they have not been subject to a rigorous impact analysis based on random sampling and econometric analysis techniques. Such an analysis was clearly outside the scope of this evaluation. It must be recognized that there are also a other factors which could contribute to changing health outcomes in Tanzania including general trends in economic development and initiatives from other sectors. Nonetheless, based on the data gathered from all sources during the evaluation and from the perspective of the health sector, these seem to be the most readily identifiable factors contributing to or impeding progress.

Detailed Recommendations

Detailed recommendations made at the end of Chapters Four through Eleven have included many aimed at improving health outcomes in Tanzania. They have not been repeated at this point in the interests of saving space. In addition, major recommendations on improving health outcomes are provide at the end of Chapter Fifteen.

14 Development Partnership

Conclusions: Development Partnership

1. Within the context of the SWAP, the evaluation period has been characterized by a more harmonised and aligned system of development cooperation in the health sector, partly through the development of structures for formal dialogue.
2. While these formal structures help to maintain a common sense of direction and foster alignment, they have been cumbersome and each has varied in effectiveness over time. There is an opportunity to streamline these structures and processes.
3. Informal policy and technical dialogue between the GoT and DPs has been effective as a means of exchanging views and information during the evaluation period, but FBOs, CSOs and private service providers have tended to be relatively excluded from planning and coordination, especially at council level.
4. While all available project and programme aid modalities are in use, the HBF has played a particularly important role in supporting the meaningful implementation of decentralization of responsibility for health services to the local level.
5. National ownership has been strengthened during the evaluation period but the increasing importance of GHIs and large bilateral programmes tends to threaten this as they remain largely outside the established coordination and alignment mechanisms.

Issue Focus: This chapter deals with the issue of the changing nature of development partnership in the health sector from 1999 to 2006. It examines the changing nature and quality of dialogue among and between DPs and the GoT and examines different aid modalities and funding mechanisms. It also addresses the effect of the development partnership in the health sector on national ownership.

In March 1998 the MOH and DPs collectively issued a *Joint Statement of Intent for the Further Development and Implementation of Health Sector Reform in the Context of a Sector-Wide Approach*. This committed MOH and Partners to develop and establish joint cycles and systems for appraisal, programming, reviews, monitoring and evaluation.

14.1 Dialogue

All the stakeholders in Tanzania's health sector interact in numerous ways to discuss and reflect on overall sector objectives and goals, policies, strategies, programmes, budgets, mechanisms, etc. For the last eight years, a sector-wide approach (SWAP) has shaped this dialogue and gradually fostered a more harmonised and aligned co-operation in the health sector. The adoption of the SWAP has led to the creation of a series of fairly formal structures for dialogue, including: the SWAP Committee, BFC, JAHSR and DPG Health. In addition, informal dialogue has continued but changed considerably between the Government and a number of the DPs (both DPs that adhere to the SWAP and others that do not), CSOs and the private sector.

Formal Dialogue Structures

SWAP Committee: The implementation of HSSP2 (and POW before it), the MTEF, and CCHPs has been monitored jointly by GoT, DPs and CSOs through the SWAP Committee (policy level) and Technical Committee (technical level) meetings.¹¹⁷ Two SWAP Committee meetings have been held annually: one in September to assess progress against milestones, and one in March that (until 2007) coincided with the JAHSR.

The September SWAP Committee meetings have covered a broad range of mainly policy issues relating to the annual work plans, progress on milestones, budget and PERs, ToR for the joint Technical Reviews and the JAHSRs. The number of participants in the September meetings has been around 50, rising to 90 in 2007.

When the SWAP began, these meetings reportedly reflected an “us and them” situation, rather than a genuine partnership. Changes in government and the continuous change (every 3-4 years) of DP staff in Tanzania have created inevitable bumps in the evolution of the partnership. Likewise, personalities and the chemistry between individuals appear to have had a lot to do with the effectiveness of the dialogue. Despite these limitations, over the years, especially from the perspective of the GoT, the quality of dialogue in the SWAP Committee has improved considerably. Several MOHSW officials now refer to the dialogue as trusting and flexible, and one called it an example of “real partnership in practice.”

SWAP Technical Committee: This started off as a technical sub-committee of the BFC. Later it grew to include non-basket fund DPs and, gradually, became the overall technical committee of the SWAP. Over the years, various task forces, working groups and technical working groups have emerged to facilitate dialogue around sub-sector issues.

To date, the Technical Committee and its sub-groups have worked in a somewhat ad-hoc fashion, organising, inter alia, the JAHSR. Several respondents reported that there have been productive meetings and activities in the Technical Committee and its various sub-groups, but their potential influence may have been constrained by the irregular participation of the MOHSW.

New ToR for the SWAP Technical Committee were discussed at the SWAP Committee meeting in January 2007. The new ToR are a reflection of a perceived need to make the role of this committee more systematic and strategic. Essentially, the proposed new Technical Committee would become a better-organised and smaller sub-set of the SWAP Committee. The Technical Committee is to serve a critical coordination role and eventually help to focus the work of the much larger SWAP Committee.

Basket Financing Committee: In 2000 the GoT and six DPs agreed to pool resources in a joint Basket Fund for supporting the Health Sector Programme based on the health sector MTEF.¹¹⁸ This led to the establishment of the BFC, which has had two main

117) *Details on this are listed in the Code of Practice (Working Arrangements) for Health Sector Wide Approaches (2003) and proposed ToR for Technical Committee of SWAP Committee (January 2007).*

118) *The Netherlands joined the first six DPs (SDC, Danida, DFID, Ireland Aid, Norad and World Bank) when a MoU was entered concerning the Joint Funding of the GoT Health Sector Programme based on the Health Sector MTEF 2000/2001-2002/3.*

functions: 1) approve the annual and quarterly sector plans for pooled funding and approve the release of resources against these plans and budgets; and 2) oversee that the use of resources to support the priority action plans and agreed council health plans follows set financial, administrative and management procedures. Initially, the BFC had a core of active and hard working members who, to some extent, succeeded in moving the agenda. Thus, the BFC was seen as a powerful centre of activity.

More recently, the MOHSW has been asserting its leadership of the BFC and exercises a degree of control over the basket funds disbursed by the DPs. This has strengthened the ownership of GoT, at least of those financial resources. There is a caveat to this, however. Fairly strict guidelines have been established to regulate the distribution of basket funds between all the districts of Tanzania and within each of these (six different cost centres are established for the use of funds within the districts, each with a certain percentage allocation range provided).¹¹⁹ Moreover, while the basket funds provided by the DPs are managed in parallel with the Government's own Health Block Grants, the DPs still require a separate audit of their pooled funds.

JAHSR: This joint monitoring and review mechanism has been conducted each year in March since 2000 by the GoT with representation from all key stakeholders. Only as of 2007 has a decision been made to hold the JAHSR in September, which will allow it to input into the Budget Guidelines that are released in November/December each year. While this will clearly align the JAHSR more operationally with the Tanzanian budget process, it also means that it has not been synchronised with it over the past seven years. It is puzzling why this decision took so long to make, inasmuch as the JASHR in 2002 stated that "to date the Annual Joint Review has been perceived primarily as a meeting between the Health Sector and its Donors. This year an attempt will be made to embed the review more solidly in government processes (link with PER, PRSP, MTEF and the Budget)."

The JAHSR represents the culmination of a series of recurrent events and reports: it builds on a Technical Review Report, the Report of the Technical Preparatory Meeting, the Milestones Report, the draft Public Expenditure Review, and the Health Sector Performance Profile. Usually, the JAHSR itself spans three days and draws an increasing number of participants (Government, DPs, NGOs, CSOs, private providers of health services, etc).¹²⁰ Several stakeholders interviewed by the evaluation argued that JAHSR has grown so large as to inhibit meaningful interaction on the health sector reform process or for identifying concrete goals for the upcoming year. Other studies have made the same observation.¹²¹

One of the main purposes of the JAHSR is to assess progress against the milestones set at last year's review. Apparently, milestones were often developed before the MTEF and not linked to this. Indeed, it seems the milestones have a life of their own, as they do not

119) *Joint Ministry of Health and PORALG. 12 March 2004. Health Basket and Health Block Grants Guidelines for the Disbursement of Funds, Preparation of Comprehensive Council Health Plans, Financial and Technical Reports and Rehabilitation of PHC Facilities by Councils. Pp. 16-20*

120) *According to the lists of participants, the JAHSR had the following number of participants (excluding support staff): 130 in 2002, 160 in 2003, 251 in 2004 and 247 in 2005.*

121) *Catherine Paul. 2005. Tanzania's Health SWAp: Achievements, Challenges and Lessons Learnt. p. 22.*

reflect consensus or endorsement by all government stakeholders.¹²² In the report from JAHSR in 2002, DPs expressed concern regarding the rescheduling of several milestones by MoH and PORALG. But, apparently, this was not sufficiently dealt with. The *Technical Review 2006* (p. vii) pointed out that there has been a repetition in the technical and joint reviews of many of the same observations, milestones and recommendations, which is followed up by too little action. The evaluation's review of the reports from JAHSR points in the same direction. The table below illustrates that some of the most serious constraints, although they receive plenty of attention, have remained on the agenda year-after-year.

Table 7: Extracts from JAHSR reports on the need for special incentives for hardship postings

Year	Reported observation on the need for special incentives for hardship postings
2000	"New schemes of service and remuneration and incentive packages are being finalised."
2001	"Key concern is incentive schemes."
2003	"Innovative solutions should be found to the problem of understaffing in remote areas."
2004	"Additional incentives will be needed to fill posts in hardship areas."
2005	"Hardship posting incentives need to be tackled."
2006	"Incentives package for hardship postings will be essential to attract and retain staff."

The report from the JAHSR in 2005 shows that nine of 25 milestones on performance over the last year were achieved, and the report from the following year's JAHSR shows that only four of 14 milestones were achieved.

In sum the JAHSR, as a collaboration instrument, has not been sufficiently effective in promoting the desired results. On the other hand, there are limits to what this kind of forum can be expected to achieve. Defining more concrete and more realistic milestones (or other monitoring tools) would help. As it is, the milestones have very limited utility as a management tool.

DPG Health: Currently, with 21 active partners formally part of the structure, the DPG Health is one of the largest of all DP sector groups in Tanzania. DPG Health is a donor-only coordination forum. On average, DPG members have met every two or three months in order to coordinate their views and activities. WHO provides the secretariat of the DPG Health, but not its leadership, which is exercised by the Troika.¹²³ The DPG mechanism has created a more concerted way for DPs to exercise their influence, and it has helped foster a convergence of donor policies on many aspects of sector reform, although some issues escape reform.

122) *The report from the 7th JAHSR (27-29 April 2006: 9) stated that "the milestones were too ambitious, some were poorly specified, and others did not have strategies and resources to address them."*

123) *The current Troika consists of the Tanzania-based DPs from Ireland (chair), World Bank, and Switzerland.*

The Troika reflects an intention of the DPs to “speak with one voice.” However, there are DPs that still seek individual dialogue and some high-ranking officials of MOHSW have expressed a preference for this. The Troika, in particular, works in close liaison with the HSRS, and less with the various departments of the Ministry. This can be seen as a positive effort to reduce the burden of interaction and dialogue on MOHSW by concentrating contact with the group charged with steering health sector reform.

Given the above, while the Troika is a clear manifestation of DP commitment to harmonise their dialogue with the Government, it is impossible to ascertain the extent to which the Troika has increased the effectiveness of the dialogue.

Some DPs take the view that dialogue is overly confined to the Troika, at least among the agencies that work diligently in the spirit of the SWAP. There is also a sense among a number of DP representatives that access to GoT, including access by members of the Troika, has diminished recently.

The DPG Health meetings have addressed a very broad range of issues reflecting the topics of the time.¹²⁴ In the early part of the period, some of the recorded statements are aimed at what could be called micro level sector developments. Over time, this tendency has diminished and given way to an endeavour to promote and safeguard government ownership. For example, the minutes from the May 2006 meeting, in which there was a reflection on the JAHSR a few months earlier, stated that: “preparations of the review with a bigger push from DPs risked the review to be orchestrated. Fortunately that was not the case but in future we need to avoid an excessive role of DPs participation in the preparatory meetings.” Furthermore, the minutes of the November 2006 meeting, where a proposed meeting structure to facilitate health sector dialogue was discussed, stated: “The most important element should be the demand and usefulness of these forums by MOHSW.”

Informal Dialogue

Until the late 1990s, most DPs were accustomed to having relatively easy and frequent access to decision makers in government. While much of the dialogue took place in formalised structures such as annual negotiations and programme reviews, a substantial part of the interaction with the MOH and local government officials was informal. Numerous projects and programmes funded by individual DPs and the presence of a large number of advisers often linked directly to these provided opportunities for frequent contact. As DPs in the health sector agreed to harmonise and rationalise their dialogue with the authorities in line with the SWAP and the Code of Practice,¹²⁵ this has changed.

However, as Chapter Nine (Health Care Financing) has demonstrated, project and programme funding outside of the Basket Fund, notably HIV/AIDS financing, has continued to grow over the evaluation period. Thus, to some extent, project related dialogue has continued to take place between some of the DPs who have funded their “own” projects and programmes and, in particular, by those who have had heavy technical

124) *The Evaluation reviewed the minutes of 17 meetings of DPG health (September 2003-April 2007) that were kindly availed to it by the DPG Health Secretariat.*

125) *The Code of Practice (Working Arrangements) for Health Sector Wide Approaches (2003, p.3) states that: “partners will seek to avoid unscheduled multiple TA visits / ad-hoc meetings and missions.”*

funding, potential new donors to the sector or new initiatives taken by individual DPs assistance investments. Furthermore, as the MOHSW is keen to secure additional have sometimes captured the attention of high-level staff in the Ministry and laid claim on their time. At times, DPs making a stronger effort to adhere to the Code of Practice have found this to be unfair.

As the funding through GHIs and large bilateral programmes especially in the area of HIV/AIDS has grown dramatically over the evaluation period, so have their demands for dialogue with, and reporting from, MOHSW, PMO-RALG and MOF. The extent of this dialogue, and the relative burden it imposes on the authorities in comparison with the formalised dialogue linked to the SWAP, is difficult to quantify but has been acknowledged as substantial by almost all key informants interviewed.

Of course there has also been dialogue between the government authorities and the national stakeholders in the health sector. Given the historically important role played by the faith-based health facilities, one would expect that this segment constituted an important dialogue partner to the Government. This evaluation was not designed to explore this issue in depth, but it is apparent from the document review and interviews conducted that the dialogue between the Government and the FBOs is not commensurate with the significant role played by the latter. MOHSW has had separate dialogues with some representatives of the FBOs, but FBOs have not until recently been invited into the formal dialogue structures of the SWAP. In fact, civil society and NGO representatives did not participate in the JAHSRs in a significant manner until 2005. Representatives of private health providers have been included in the dialogue to an even lesser extent.

Generally speaking, FBOs, civil society and private health providers feel relatively excluded from the planning and co-ordinating mechanisms at council level. Certainly, their involvement does not match the important role of these in many areas. For example, although the *Guidelines for the Preparation of Comprehensive Council Health Plans* state that the Planning Teams, which prepare the CCHPs, should include a representative each from the private sector, NGOs and faith-based service providers, this does not always happen in practice. According to the HSRS's own assessment of CCHPs for 2006/07 from 60 districts, the following percentages of non-state actors had participated: FBO/VA/CSO 53%, private 12%, community 3%. The 25 CCHPs reviewed by the evaluation in the six case study districts corroborate this finding. Moreover, the evaluation found that despite the significant presence of private providers in, for example, Same and Kigoma, they were not consulted in the development of the CCHP.

14.2 Aid Modalities and Funding Mechanisms

The aid modalities in the Tanzanian health sector can be seen in light of the dialogue that has taken place among the stakeholders. The mix of aid modalities over time has both influenced the dialogue and been influenced by it. Aid modalities are the tools through which official development assistance (money, goods and knowledge) is transferred to developing countries. Consequently, aid modalities include the funding mechanisms involved in the transfer of development assistance, but encompass other aspects as well. Funding mechanisms refer to the way financial resources are raised, allocated and used.

A sector-wide approach is not itself an aid instrument: a SWAp is a way of working, and the sector development programme on which it focuses can be supported by a variety of

aid instruments.¹²⁶ This section discusses the effectiveness of the different aid modalities used in the health sector.

Table 8: Characteristics of Main Aid Modalities

Modality	Conditionality	Earmarking	Accountability
General budget support	Macro and budget	None or nominal	Government systems
Sector budget support	Sectoral	On-budget to sector	Government systems
Sector earmarked	Sectoral	Off-budget within Sector – usually basket funding	Blend of government and donor systems
Projects using Govt. systems	Sector and project	Project	Blend of govt. and and donor systems
Projects using parallel systems	Limited: low govt ownership	Total	Donor
Technical Assistance	Limited: low govt ownership	Total	Government/donor

Source: adapted from Foster and Leavy (2001)

Over the evaluation period, all of the aid modalities listed in the table above, except sector budget support, have been employed in the health SWAP.¹²⁷ As noted in Chapter 9, according to the PERs for the health sector there has been an overall increase in the proportion of on-budget expenditure (from approx. 60% to 80%) over the period of evaluation. However, substantial resources have also been channelled through off-budget expenditures, and the health sector still encompasses an extraordinary number of projects.¹²⁸ Off-budget expenditure on health actually increased in real terms between 2000 and 2006; comparing the first three years of the period with the last three years, average annual expenditure increased by approx. one third (see Table 4, Chapter 9 above). In addition to this, HIV/AIDS project financing not fully captured in GoT accounts has greatly exceeded the volume of financing through other aid modalities. External off-budget HIV/AIDS expenditure rose by nearly 50% between 2002 and 2005 (see Chart 1, Chapter 9 above). In other words, despite the Rome Declaration on Harmonisation (2003) and the Paris Declaration on Aid Effectiveness (2005) that committed the signing parties to implement these agendas, funding through the project modality has persisted and even grown. Generally, one would expect the SWAP, if it is successful over time, to be accompanied by a diminishing amount and share of off-

126) OECD. 2006. *Harmonising Donor Practices for Effective Aid Delivery, Vol.2. DAC Guidelines and Reference Series*. OECD: Paris, page 36.

127) Budget support (general and sector budget support) is defined as donor funds being channelled to the partner government's national treasury, and thereafter managed in accordance with the partner's own budgetary procedures. This definition explicitly excludes funds transferred to the national treasury with the aim of financing programmes that apply budgetary procedures different from those of the partner country with the intention of earmarking the resources for specific uses. Thus, donor funding of the Health Basket Fund cannot be regarded as sector budget support. See OECD, 2006, page 26.

128) DPG Tanzania. 2006. *Tanzania Joint Program Document*, page 30.

budget and off-accounts financing. In the Tanzanian health sector (when including HIV/AIDS financing), this has not been the case.

Several stakeholders and observers of the health sector in Tanzania would like this evaluation to assess the relative effectiveness of the different aid modalities. Such an assessment is desirable and could help to enhance aid effectiveness in the future. While some observations can be made, the realities of the situation do not permit a definitive assessment. As a mix of aid modalities has been used throughout the evaluation period, it is difficult to establish causal relationships between any one aid modality and the broad health outcomes achieved. Moreover, changes in the health situation typically occur as a result of many different factors, of which the externally funded input is only one contributing part. Furthermore, disbursement patterns and the mix of aid modalities have been highly volatile, and there is no counterfactual against which assessments can be made. Nevertheless, based on the evaluation's interactions at district level and interviews with many stakeholders, it is possible to make the following observations:

Projects: are valued for their timeliness and flexibility; in short, their ability to “get things done.” That is, if a DP is available and interested, a given problem can be addressed quickly and without a large planning and coordination burden on either the GoT or DPs not directly involved in the project. From the perspective of the individual problem-solver in the health sector, it is also an advantage that projects can be planned and implemented with limited political involvement. On the other hand, government authorities are sometimes unaware of projects within their area and it is a disadvantage that it is not possible to predict what comes where and when. Moreover, projects tend to be more supply-driven than demand-driven and this produces limitations in terms of local ownership.¹²⁹

GHIs and large bilateral projects/programmes: the most significant funding schemes in Tanzania's health sector have been GFATM, PEPFAR and TMAP. These initiatives, which are rather unique to the health sector – but not limited in their scope to a single sector in the case of TMAP – are not an aid modality on their own but rather a mixture of projects using government and parallel systems. As such these funding schemes share many of the advantages and disadvantages listed above under “projects.” However, given the vast amounts of funding involved, these activities have more profound ramifications. The Minister of Health alluded to this in his opening comments to the 7th JAHSR. Speaking about the financial constraints of the health sector, he stated that “complementary support will be required from donors, but this should support the system rather than vertical interventions.” Whether these funding schemes contribute to the development of the health system or whether they have the opposite effect is a subject of frequent discussion among stakeholders in Tanzania. The evaluation does not have sufficient evidence to make an assessment of this, but it is clear that there are elements of both.¹³⁰ Similarly

129) *The OECD's 2006 Survey on Monitoring the Paris Declaration: Tanzania states that the main challenge in the area of harmonisation is the continued use of poorly co-ordinated project modalities.*

130) *The literature on the impact of disease- and intervention-specific programmes on health care systems mentions that they have significantly increased the resources available in their areas of focus, introduced new technologies, and they seem to be more effective than general government programmes in delivering services to the targeted populations. On the negative side, the GHIs and large bilateral programmes potentially disrupt the country's health system. The expenditures they generate may not be sustainable within the recipient country's budget constraints, and they are not accountable to the recipient country. See Gottred, Pablo and George Schieber (2006) *A Practitioner's Guide: Health Financing Revisited*, Washington: World Bank.*

important questions concern whether the balance of funding and effort in the health sector is appropriate to the overall health needs of the population, and whether the endeavour is sustainable. And here, from the perspective of the sector-wide approach, it is problematic that the GoT has only limited ownership of these funding schemes.

Sector support programmes: several DPs support programmatic activities that package a range of aid modalities into one sector support programme. Essentially, to follow the categorisation of the table above, such programmes are mostly project aid using government systems. The biggest advantage of these programmes is their predictability. MOHSW and PMO-RALG know what support is coming and some of the sector support programmes included mechanisms that have allowed fast and flexible response in the face of specific (and unforeseen) needs. The dilemma of some DPs using this support modality is that their influence has diminished as “their” funding has been processed through the governmental mechanisms.

Basket Fund: the most significant source of DP financing to the (non-HIV/AIDS) health sector has been the HBF. Due to the earmarking of the funds it holds and the parallel budgetary, monitoring and audit processes associated with the HBF this assistance would not normally be characterised as not sector budget support (though it has clear traits of this), but rather sector earmarked programme support. As with sector support programmes, the biggest advantage of this aid modality has been its predictability in terms of the councils knowing precisely how much funding is coming. The planning of the use of basket funds has been largely in the hands of the councils (though specific guidelines have established the overall direction of spending) and fully integrated into their planning procedures. While the procedures have been complicated (with changing requirements) and this has caused delays in disbursements, the Basket Fund has fostered a high degree of ownership of this resource.

GBS: many of the DPs who finance the HBF, and faithfully adhere to the SWAP principles, also provide general budget support to Tanzania. As government funds have constituted a growing share of total on-budget sector financing, some of the GBS resources clearly have been a part of this. Taken as a whole, the GoT has clear and strong ownership of the GBS. However, this is not uniform across different government authorities. Growing development assistance in the form of GBS has increased the overall allocative efficiency (strategic resource allocation) and ownership of the Ministry of Finance. The effect on MOHSW and PMO-RALG has been the opposite as their room to manoeuvre (working directly with the DPs) has diminished. Similarly, representatives of local governments often told the evaluation that they preferred more support through the Basket Fund (over more funding through GBS) because they believe this will ensure continued access to resources.

Technical Assistance: in tandem with the development of the SWAP the use of international advisers has reportedly diminished slightly or remained more or less stable over the period of the evaluation. Stakeholders consulted by the evaluation made surprisingly little reference to the effectiveness and impact of technical assistance. At this time only a few of the DPs in the health sector provide traditional technical assistance. In the current context of harmonised SWAP processes, this has generated the unexpected effect that some of the DPs, who do not provide technical assistance, feel that it offers privileged access to the those who do. Moreover, several informants felt that the presence of international advisers tends to diminish ownership by the organizational units where they work.

The following table provides an overview of the different strengths and weakness of the principal aid modalities used in Tanzania's health sector.

Table 9: Summary of Aid Modalities

Aid Modality	Predictability	Timeliness	Freedom from Political Interference	Ownership	Transaction Costs
Projects	Disadvantage	Advantage	Advantage	Disadvantage	Both Ways
GHIs*	Disadvantage	Advantage	Advantage	Disadvantage	Both ways
Sector Support	Advantage	Advantage	Disadvantage	Both ways	Both ways
Basket Fund	Advantage	Disadvantage	Both ways	Advantage	Both ways
GBS	Disadvantage**	Disadvantage	Disadvantage	Advantage	Advantage
TA	Both ways	Both ways	Disadvantage	Disadvantage	Advantage

*Notes: the scores are not absolute; they merely indicate that e.g. advantages outweigh disadvantages. Bold scores represent the most salient feature (positive or negative) of each aid modality. *) In the table, GHIs also include large bilateral programmes. **) GBS is listed as having a disadvantage in terms of predictability to the MOHSW and local government authorities.*

14.3 National Ownership

Throughout the period under evaluation, it has been a primary concern of the GoT and most of the DPs to ensure that the aid modalities used in the health sector, including both the dialogue and funding mechanisms, promote the highest degree of national ownership of the health sector reform and its implementation. Tanzania's first Poverty Reduction Strategy (2000), the MKUKUTA (2005) and the Paris Declaration on Aid Effectiveness (2005) all have one thing in common: they strive to widen the space for country ownership of the development process. They have provided a formal platform for the GoT to assert its sovereign rights. This section assesses how the different trends have affected national ownership.

Evolution of dialogue

Ideally, the MOHSW should be reporting and accountable to the general public of Tanzania, not (as it seems at present) mainly to its various DPs. There are indications that the GoT has felt that they have had to organise e.g. the SWAP Committee meetings for DPs, not for the sector as a whole.

The complex JAHSR is reported to require three months of preparation by MOHSW and other stakeholders. It has not, until 2007, been dovetailed with the Tanzania budget process and has been seen by some as largely an add-on, rather than an integral part of government procedures. Some key informants rightly question whether it is necessary to hold the JAHSR, or at least a full-sized one, each year.

On the other hand, MOHSW staff point out that the decisions of the JAHSR reflect an important process of consensus building and contested options being worked out among key stakeholders at a national level. As such, it may well be worth the relatively high costs if the exchange is rich enough and the consensus represents a durable basis for action.

The bottom line is that there has been relative stability in terms of strategies for the health sector: the POW and HSSP2 have more in common than differences. This suggests that while they engage in dialogue in various forums, the GoT has been able to maintain a relatively high degree of ownership throughout the evaluation period.

Role of aid modalities

On average, roughly USD 40 million has been disbursed each year through the HBF in the period FY 2001-05, peaking at roughly USD 82 million in FY 2005. By comparison, total foreign disbursements averaged more than USD 316 million in FY 2005 up from USD134 million in FY 2002, mainly due to an increase in the funding (not least through the GHIs and large bilateral programmes) going to HIV/AIDS, for which the GoT feels it has little ownership. In other words, the basket funding has constituted roughly 20-25% of total annual funding from external sources in the two years in question. Considering that the Basket Fund (apart from GBS) is the aid modality that is most harmonised, aligned and in accordance with the principles of the SWAP, it is expected that national ownership would have been further strengthened if a larger share of total disbursements was taken up by the Basket.

The above is all the more striking since the *Joint Statement of Intent for the Further Development and Implementation of Health Sector Reform in the Context of a SWAP* from 1998 committed all Partners (including the main funders of the GHIs and large bilateral programmes) to work through the SWAP. It stated that “all activities in the sector will be under one common sector-wide program.” The current composition of external funding to the health sector (HIV/AIDS domination) does not match that commitment.

Transaction costs

It was expected that the SWAP would reduce transaction costs. Despite impressive achievements in harmonisation and alignment, in particular with regard to the SWAP processes and the Basket Fund, a number of DP and GoT representatives felt that there is still a significant process overload in the interaction between government and the DPs. Thus, while gains have clearly been achieved in some areas, other developments (mainly outside the SWAP itself) might have offset the gains. On balance, it is questionable whether the net effect has been a reduction of the burden on the MOHSW.¹³¹

There is no doubt that it is demanding for the GoT to be work with the various DPs in the health sector. The MOHSW today has to deal not only with the DPs that are organised behind the SWAP (through the Troika, BFC, SWAP Committee, etc), they also must accommodate the needs of the large externally supported vertical programme initiatives. These are integrated into the collaborative SWAP processes to varying degrees (some to a very limited extent), but they require separate reporting and management attention from the MOHSW. In addition to this, as some of the previous main providers of pooled funds have withdrawn from the Basket Fund and moved into GBS, the MOHSW increasingly also has to engage with the Ministry of Finance in the political (budgetary) contest to access public funds for the health sector.

131) Catherine Paul found that “the SWAp has somewhat reduced overall government transaction costs in the health sector – but definitely not in a spectacular way. The nature of transaction costs may have changed more than the overall burden.” Catherine Paul. 2005. *Tanzania’s Health SWAp: Achievements, Challenges and Lessons Learnt*. p.53.

The MOHSW must still pay attention to a large number of projects and programmes that receive direct funding from DPs and NGOs. Despite efforts to the contrary, the SWAP is still only part of the picture and the main governmental stakeholder, the MOHSW, is now forced to engage with its partners simultaneously on many different fronts.

Opposite trends

Seen from a distance, it seems there are two trends working in opposite directions. One is characterised by increased effectiveness of MOHSW and more assertiveness by PMO-RALG. This trend leads to increased ownership as the political and bureaucratic system in Tanzania gets stronger in dealing with the health sector. The opposite trend is characterised by GHIs and large bilateral programmes exerting influence over the shape of national vertical programmes. As already indicated, this raises profound questions about national long-term sustainability and national ownership.

14.4 Trends and the Way Forward

In several ways, the health sector in Tanzania is at a crossroads. This evaluation marks the end of HSSP2 and it is appropriate to take stock before the future strategy (HSSP3) is finalised and launched: is the co-operation process between the Government, DPs and other stakeholders on the right track? What lessons can be learnt regarding the partnership dialogue and use of aid modalities, and what changes, if any, are necessary?

One question frequently heard is whether a larger proportion of the external funding of the health sector should be provided in the form of general budget support or sector budget support. There is no simple answer to this. Most respondents consulted by the evaluation have argued against it. Officials from MOHSW and PMO-RALG tend to believe that a transfer of resources into GBS will result in lesser or unchanged funding for the health sector. The perspective from the Councils is similar; most actually prefer the current earmarking of the HBF to the alternative of no earmarking at all (GBS). Council authorities advance the view that the current earmarking works as a guarantee (ring-fencing) that funds set aside for priority health purposes will not be spent on other needs. Some DPs argue that more GBS will increase the overall allocative efficiency of public finance. Other DPs, while agreeing with the logic of GBS, are concerned with accountability issues and feel it might be premature to channel more resources through GBS.

Related to this, many observers of the health sector in Tanzania are keen to know whether the chosen sector-wide approach has produced the best value for money and whether the same results could have been achieved by budget support. Again, it is most difficult to provide a categorical answer. First, shifting all the external funding under the health SWAP into GBS has not been, and is not at present, a realistic option. Not all development partners have the necessary political will to do this, or they are not convinced it will yield better results. Other DPs are barred from providing GBS because it conflicts with their founding statutes.

Whatever the reasons, changing all the external funding of the health sector into budget support is a purely theoretical option. The absence of a counterfactual prevents the evaluation from making a clear-cut assessment on the merits of the sector-wide approach that has been pursued in Tanzania's health sector. Nevertheless, respondents across the board have pointed to a broad range of improvements that have accompanied the cooperation in the health sector over the period of evaluation.¹³² In view of this, and comparing with

the situation of loosely or non-coordinated projects and programmes before the health SWAP was launched in Tanzania, there is little doubt that the SWAP has delivered real improvements. But, as further streamlining of the co-operation and dialogue mechanisms is still required, the current approach is not yet delivering optimal value for money.

In all likelihood, a mix of aid modalities will continue to be used in the health sector. Many DPs already provide both GBS and funding to various SWAP aligned aid modalities. In general, there seems to be hesitancy in many quarters about increased GBS spending. It is more constructive to ask how the current SWAP mechanisms can be streamlined for greater effectiveness and efficiency.

The number of active DPs in the health sector is an important factor. Over the evaluation period, the number of DPs in the health sector has grown steadily. The current situation, with 21 active partners in DPG Health and 25 in DPG HIV/AIDS, is not ideal. Moreover, there is ample scope for a better division of labour among these DPs. Only two DPs (DFID and EC) have taken on the role of delegating partner.¹³³

The *Joint Assistance Strategy for Tanzania* states that: “DPs will rationalise the number of sectors and thematic areas in which each agency is engaged in order to reduce transaction costs that Government agencies incur in dealing with multiple DPs and achieve a more even engagement of DPs in sector or thematic dialogue.”¹³⁴ It goes on to state that a new division of labour will be agreed and organised around “lead,” “active” and “delegating” partnerships. The time has come to implement the aspirations of the JAST.

Attempts have already been made to streamline the mechanisms within DPG Health. In recognition that the environment for co-operation has changed, a revised draft *Code of Conduct for the Tanzania Health SWAP* was presented at the SWAP Committee meeting in January 2007. Priority should be given to the finalisation and approval of the Code of Conduct and full adherence to this.

All the emphasis on harmonisation has a consequence that is readily recognised by most DPs, but which could undermine DP support to the sector if not addressed. As the *Technical Review 2006* pointed out, on both the Government and DP side, people are very busy with fully legitimate activities, but these tend to be restricted too much to the central level and in fact impede engagement in understanding the actual dynamics of district health service provision. Several informants indicated that the SWAP led to a reduction in the use of technical assistance, certainly in the way these were used previously by DPs as conveyers of information. As a result, many DP representatives in Dar es Salaam today feel much less informed about what is really happening on the ground away from the capital. The question is whether the changes in the use of aid modalities have also affected officials at the MOHSW in the same manner? It is necessary to explore how decision makers in the capital can maintain an adequate level of awareness about the health situation in the districts.

132) Many of these have been discussed in the preceding sections of this report.

133) DPG Tanzania. 2006. *Tanzania Joint Programme Document, Annex B: Division of Labour Matrix*, page 30.

134) *The MoU on the Joint Assistance Strategy for Tanzania between the Government of the United Republic of Tanzania and Development Partners was signed in December 2006.*

Similarly, the GoT and the DPs need to consider the appropriateness of the level of detail involved in goal setting, targeting and monitoring. Can they agree more on the need for “big picture” monitoring and spend less time on the details? Currently, the HBF and the planning mechanisms at district level, in particular the CCHP, require very detailed planning, monitoring and even separate auditing. These processes demand significant resources from all parties involved and, it could be argued, divert capacity away from delivering services. At this juncture, it is reasonable to consider whether the same, or better, results could be achieved with different, leaner approaches.

Finally, the GoT and DPs in the health sector need to come to grips with the dichotomy between the efforts to develop the health system as a whole and the trend towards an overshadowing emphasis on national vertical programmes. Given the magnitude of this issue and its general relevance beyond the borders of Tanzania, perhaps it also needs to be addressed in an appropriate international forum on health issues.

14.5 Detailed Recommendations

1. DPs in the health sector should continue to operate within SWAP arrangements, though some adjustments should be introduced to make this more effective (see below). (1, 2 and 3)
2. The number of active DPs in the health sector should be rationalized through a more rigorous application of the principles of “lead,” “active” and “delegating” partnerships as outlined in the JAST. (2 and 3)
3. The revised draft *Code of Conduct for the Tanzania Health SWAp* should be finalised, approved and fully adhered to by all parties. (1, 2 and 3)
4. Joint Health Sector Reviews should be organised every second year, with for example, topical technical reviews in the years in between, and fewer participants should be invited in order to promote real dialogue. (2 and 3)
5. Overall, future streamlining of the structures for formal dialogue should give priority to the needs of MOHSW and PMO-RALG. It is essential to focus on what is needed by the national stakeholders, rather than just carrying on with the legacies of past practices. (2 and 3)
6. In recognition of the movement that has already been made towards a real sector-wide approach, better balance can be achieved in the set-up and use of the structures for formal dialogue to ensure that the respective roles of the governmental stakeholders, DPs and FBOs/CSOs/private service providers are adequately reflected. (2 and 3)
7. In tandem with the recommended simplification of the CCHPs, the guidelines for the HBF should be changed to put less emphasis on detail and more on monitoring higher level targets. (2 and 3)
8. National auditing mechanisms should be relied upon for the HBF. (1, 2 and 3)
9. The rationales for the funding of new phases of current sector support programmes, other programmes, and projects should be carefully considered. Specifically, DPs and the GoT should consider whether the funding available for such programmes and projects should instead (in full or in part) be allocated to the HBF. (1, 2 and 3)
10. Technical Assistance should in future be procured through more harmonised and aligned mechanisms such as a new, separate window of the HBF. (2 and 3)

11. The Government of Tanzania and DPs in the health sector need to come to grips with the dichotomy between the efforts to develop the health system as a whole and the trend towards an over-emphasis on national vertical programmes. Given the magnitude of this issue and its general relevance beyond the borders of Tanzania, perhaps it also needs to be addressed in an appropriate international forum on health issues. (1, 2 and 3)

15 Conclusions and Recommendations

Chapter Focus: This chapter presents the major conclusions of the evaluation as they relate directly to the objectives detailed in the ToR. It also presents the major recommendations resulting from the evaluation, particularly those which have implications throughout the health system in Tanzania.

15.1 Main Conclusions

1. The joint entry of the Government of Tanzania and the Development Partners into a Sector Wide Approach to collaborative development work in the health sector has resulted in greater sector coherence and consistency. In turn, this has secured higher levels of both domestic and external financial resources for health throughout the evaluation period. Comparing the situation in 2006 with the set of loosely or non-coordinated projects and programmes in place before the health SWAP was launched in Tanzania, there is little doubt that the SWAP has delivered real improvement. But, as further streamlining of the co-operation and dialogue mechanisms is still required, the current approach is not yet delivering optimal value for money.
2. Under the general framework of the SWAP, Development Partners have used a wide range of funding mechanisms to support the health sector, ranging from direct project funding to general budget support. Given the importance of the strategy of supporting Local Government Authorities in their efforts to strengthen council and district health services, the Health Basket Fund has been a particularly effective mechanism, alongside of the system of Health Block Grants instituted by the Government of Tanzania.
3. While Global Health Initiatives and large, multi-country bilateral, disease specific programmes have provided very significant financial (and material and technical) resources during the evaluation period, they have remained largely outside the planning and priority setting structures in place at national and local level. These programmes need to be more integrated into common funding, planning and programming systems if they are to avoid distorting local priorities.
4. The programmes, projects and activities implemented under the SWAP have contributed to improvements in health outcomes and to some improvements in the quality of health services at community level. These improvements can, in turn, be plausibly linked to progress toward MDG and PRSP/MKUKUTA goals, especially relating to infant and child mortality.
5. There has not, however, been significant progress towards achieving goals and targets relating to maternal mortality and maternal health (and to neonatal mortality) during the evaluation period. This should be a key area of emphasis for HSSP3.

6. What has worked and what has made a difference in the health sector in Tanzania has been the devolution of responsibilities for health facilities and health planning to Local Government Authorities – supported by financial resources (through the Health Basket Fund and Block Grants). Many of the organizational elements have also been established to allow the councils and their health management teams to undertake meaningful budgeting through the CCHP and to supervise and operate local health facilities. This strengthening of council level health services, supported by the upgrading of staff skills, and coupled with some improvements in centrally provided services (and the contribution of strengthened national vertical programmes) has contributed to improvements in service quality at health facility level.
7. Despite these notable gains, further progress towards achieving some of the most important MDG and MKUKUTA goals can be expected to be inadequate unless actions are taken to overcome the important constraints identified in repeated studies and noted by the evaluation. In particular, more effective management of human resources is an urgent requirement. Tanzania needs to employ more of the trained health sector staff it produces and to ensure those working in the system are managed more effectively.
8. While the evaluation has identified progress in strengthening local health services, it has also noted that several strategic priorities set for the health sector during the evaluation period met with relatively little progress. Most evident has been the relative lack of progress in hospital reform and in the implementation of an effective public private partnership.
9. While the evaluation period has seen an improvement in some health services, the benefits of these improvements have not been shared equitably. Some of the constraints to equitable access to service are outside the direct control of the health sector as they are based on geographic isolation and high transport costs. Nevertheless, the sector has not responded effectively to address some sources of unequal access.
10. Efforts to make the sector more sustainable and improve quality through the use of cost-sharing mechanisms, user fees, and risk pooling arrangements have not been accompanied by effective measures to provide any reasonable expectation that those who cannot pay will be provided access to essential health services. Finally, problems related to recruiting, posting and retaining staff at geographically isolated hospitals, health centres and dispensaries have not been effectively addressed by the sector. This further disadvantages patients outside urban areas.

15.2 Major Recommendations

1. The Government of Tanzania and Development Partners should maintain the SWAP programming format to structure their cooperation in the health sector in Tanzania during HSSP3 along with detailed adjustments and improvement aimed at streamlining review and decision making structures and processes as specified in later recommendations. (1,2 and 3)

2. The Government of Tanzania and Development Partners should make every effort to provide increased funding so that the goals of increasing per capita expenditure and of ensuring that at least 15% of national public expenditures are allocated to health can be achieved as soon as possible during HSSP 3. (1 and 2)
3. MOHSW and the Prime Minister's Office-Regional and Local Government should agree on a target for the percentage of public health budget estimates (and expenditures) to be allocated to Local Government Authorities. This should be accompanied by improvements in systems and procedures for tracking budget allocations and expenditures. (1 and 2)
4. A Health Basket Fund and direct GoT grants to councils for the operation of health services based on a transparent resource allocation formula should remain a feature of the sector during HSSP3. Over the course of HSSP3, the Health Basket Fund may be merged with the Health Block Grant. (1 and 2)
5. HSSP3 should be used to consolidate the achievements of HSSP2 and to address identified constraints related to already agreed reforms, rather than embarking on new reforms (although some ideas for long term system changes will be offered below). (1,2 and 3)
6. HSSP3 should retain the strategic priorities of HSSP2, but should also include concrete steps to considerably accelerate progress in both hospital reform and public private partnership as set out in the detailed recommendations below. (2 and 3)
7. Effective action to reduce maternal mortality and improve delivery services, including emergency obstetric care, should be a stated strategic priority of HSSP3. (1, 2 and 3)
8. Improving equity of access should be a cross-cutting theme of HSSP3. MOHSW should strengthen its capacity to review and modify policies and programmes with a view to improving equity and taking action to remove barriers to access. This should include the development of a strategy for improving access and establishing a focal point within the Ministry whose mandate will include all aspects of equity, including gender equity. (2 and 3)
9. HSSP3 should include specific strategies to improve efficiency of service delivery both in Primary Health Facilities and hospitals, by increasing the productivity of health sector personnel and better matching staffing levels to work loads (including piloting and, where appropriate, scaling the introduction of performance based pay). (2)
10. A health inspectorate (for which legislation has been prepared) should be established. The Health Services Inspectorate Unit in the MOHSW should be strengthened and regional offices should be established. The MOHSW should consider the option of transforming the RHMT into regional health inspectorate units. (2 and 3)
11. HSSP3 should include the development and implementation of an overall monitoring and evaluation framework for the health sector which incorporates existing data collection and analysis systems and which encompasses both regular performance monitoring and periodic effectiveness evaluation.

16 OECD/DAC Evaluation Criteria

The following table briefly summarizes the conclusions of the evaluation in relation to the main evaluation criteria of the OECD/DAC and the relevant chapters in the report.

Table 9: Evaluation Findings/Conclusions in Relation to OECD/DAC Criteria

OECD/DAC Criteria	Most Important Evaluation Findings/Conclusions	Relevant Chapters
Relevance	<ul style="list-style-type: none"> Sector priorities, plans, budgets and programmes are relevant to national goals and targets. 	
	<ul style="list-style-type: none"> Priorities are not linked to an integrated framework for monitoring and evaluation. 	
	<ul style="list-style-type: none"> The SWAP has helped maintain the relevance of external support to national goals, but GHIs and large bilateral programmes remain outside local health planning and management systems. 	Chapter 3
Efficiency	<ul style="list-style-type: none"> Important efficiency gains can be made by matching human resources to facilities workloads and by linking resources (including pay) to performance. 	
	<ul style="list-style-type: none"> The structures and processes for sector coordination and dialogue can be streamlined to improve both efficiency and effectiveness. 	
	<ul style="list-style-type: none"> There needs to be a more effective prioritisation of the elements of publicly financed health care as summarized in the Essential Health Interventions Package. 	Chapters 4, 8, 9 and 14
Effectiveness	<ul style="list-style-type: none"> Entry into the SWAP has resulted in greater sector coherence and the use of effective financing instruments, especially the Health Basket Fund. 	
	<ul style="list-style-type: none"> Programmes, projects and activities implemented under the SWAP have contributed to improvements in the quality of health services and to improved health outcomes (except in relation to maternal mortality and maternal health). 	
	<ul style="list-style-type: none"> While some strategic priorities (including strengthening district health services) have been effectively implemented, others have not, especially hospital reform and public private partnership. 	

	<ul style="list-style-type: none"> The benefits of improved health services need to be shared more equitably. 	Chapters 3 to 14
Impact	<ul style="list-style-type: none"> Key positive impacts on services have been felt in the areas of continued strengths in immunization and improved micronutrient supplementation; improved diagnosis and treatment of malaria, especially among children; improved availability of drugs; and increased use of Insecticide Treated Nets. 	
	<ul style="list-style-type: none"> Significant progress towards achieving goals in reducing infant and child mortality and some progress in aspects of child malnutrition. 	
	<ul style="list-style-type: none"> Little progress in reducing maternal and neonatal mortality. 	Chapter 13
Sustainability	<ul style="list-style-type: none"> Problems in pre-service training, recruitment, fielding, and retention of health sector staff represent a major challenge to sustainability of health programmes and services. 	
	<ul style="list-style-type: none"> The increased share of GoT finances in the on-budget component of health sector financial resources during the evaluation period is a positive indicator of sustainability. 	
	<ul style="list-style-type: none"> The GHIs and large bilateral programmes represent an important medium and long-term challenge to sustainability of strategies and programmes. 	Chapters 4, 8, 9 and 14

Annex 1: Terms of Reference

1. Introduction

The development partners (DPs) have supported Tanzania's health sector for several decades, the last eight years as sector programme support through a sector-wide approach (SWAP). A large proportion of funds are channelled via sector basket arrangements. Most of the DPs joining the SWAP had agreed on a joint monitoring and evaluation system replacing individual and separate review and evaluation activities in order to reduce transaction costs, to gain comprehensiveness and the validity of lessons learned and thus to achieve a greater credibility and broader ownership of the results.

The Joint Annual Health Sector Review (JAHSR) is regarded as the major monitoring instrument. The review is an excellent tool to measure the progress of the operationalization of the health sector programme reform and its achievements. The Public Expenditure Review, also carried out annually, monitors the fund allocations as well as the expenditures on the basis of the Medium Term Expenditure Framework (MTEF) and feeds into the JAHSR. In addition, several studies and research activities are carried out on an irregular basis focusing on jointly defined specific needs/questions.

Plans to conduct an external evaluation of the Health Sector have been on the table for some time. As there is a very close partnership and joint support of and pooled funding to the health sector within the SWAP, the evaluation has been proposed as a joint evaluation. At the recent JAHSR (April 2006) the Ministry of Health and Social Welfare (MOHSW) pointed out that input from an external sector evaluation would need to be coordinated with the national health sector planning process to feed into the Third Health Sector Strategic Plan (HSSP 3) covering 2008-15.

2. Background

2.1 Health Situation

During the 1990s health data pointed towards stagnation or deterioration of health indicators except of some successes in immunization coverage of children, TB treatment and in the accessibility to contraceptives. Most recently, the data show a positive trend resuming around 2000 and most of Tanzania's health indicators today either compare with or are above Sub-Saharan average (Annex 1). The latest Tanzania Demographic Health Survey (TDHS) 2004-05 shows a rapid decline in infant mortality and the under-five mortality has fallen more than targeted. Tanzania has achieved high rates of immunization and Vitamin A supplementation. Life expectancy at birth is a little better than the regional average.

Despite of the improvements, some health indicators remain of concern. The poor nutritional status of children under the age of five still counts as one of the main health problems: approximately one in five children is underweight; almost 40% of children under five are short for their age and approximately 13% of them are severely stunted. Malaria continues to be a major public health concern, especially among pregnant women and children under five. Hospital based data indicate a mortality rate of 12% of under-fives

due to Malaria. Maternal mortality (MM) is still unbearable high. Linked with maternal mortality is a plateau in the total fertility rate at 5.7, which evidently did not decline over the last eight years. The fact that the use of modern methods has tripled in the last 15 years shows some encouraging momentum and also suggests women may be using contraception rather than controlling fertility with abortion. 94% of mothers received antenatal care for their most recent birth from a trained provider. Professional personnel attend 46% of the deliveries and 47% of the women deliver at a health facility.

New data from the national HIV survey show better results than expected. Nationally, prevalence among the population aged 15-49 stands at 7% with figures in urban areas double as high as in rural areas. There are serious regional disparities in regard of HIV/AIDS. Though the beginning of a decline in HIV prevalence is encouraging – the epidemic will continue to undermine development and the attainment of the MDGs and national targets.

2.2 Equity Aspects

With a per capita income of 330 USD (2004) Tanzania remains one of the poorest countries in the world. The proportion of the population below the national food poverty line was 18.7% and that below the national basic needs poverty line was 35.7% in 2000/01. The proportion of poor households differs greatly between regions and districts. Tanzania's poor undoubtedly suffer a greater burden of ill health than their more privileged counterparts. This is apparent for various health indicators, including infant and under-five mortality, malnutrition and anaemia. Substantial differences between rich and poor and between urban and rural exist. In the TDHS, over half of the poorest quintile cited distance to facility and transport as the biggest problems. In contrast, less than 20% of urban women and those from the highest quintile encountered these problems. Furthermore, the single biggest problem encountered by women in seeking health care was 'getting money for treatment'.

2.3 The National Planning Frameworks

The current national frameworks are the Tanzania Development Vision 2025, the Medium Term Plan from 2000, the National Strategy for Growth and Reduction of Poverty from 2005 (NSGRP; in Swahili: MKUKUTA), and Sector Policies and Strategies. MKUKUTA is the national framework, which accords high priority to poverty reduction in Tanzania's development agenda. It identifies three clusters outcomes aimed at achieving Vision 2025 and the Millennium Development Goals (MDGs): (i) growth and reduction of income poverty; (ii) improvement of quality of life and social well being and (iii) good governance.

The NSGRP/MKUKUTA prioritises outcomes, which benefit the poor. Where health sector is concerned, these include: improvement of child nutrition, reduction of malaria and HIV/AIDS morbidity and mortality, and water programmes. The operational targets for 2010 for improved survival, health and well being of children and women and especially of vulnerable groups include: (i) reduced infant mortality from 95 in 2002 to 50 per 1,000 live births, (ii) reduced child (under-five) mortality from 154 to 79 per 1000 live births (iii) reduced hospital based malaria related mortality among under-fives from 12% in 2002 to 8%, (iv) reduced prevalence of stunting in under-fives from 43.8% to

20%, (v) reduced prevalence of wasting in under-fives from 5.4% to 2%, (vi) reduced maternal mortality from 529 to 265 per 100,000, (vii) increased coverage of births attended by trained personnel from 50% to 80%, and various indicators related to the HIV/AIDS pandemic including reduced HIV prevalence among women of 15-24 years from 11% in 2004 to 5%.

In 2002, the Government adopted the Tanzania Assistance Strategy, which sets out a coherent framework for the management of external resources and for government cooperation with the DPs. The strategy promotes good governance, accountability, capacity building, and improved effectiveness in aid delivery, in a spirit of transparency and trust between the government and the DPs. In response to the strategy and to adapt to the PRSP, most of the DPs elaborated a country assistance strategy, which spells out priorities and objectives for their actions as well as principles guiding their collaboration with the government. As a further step towards alignment with the Government's strategy (in particularly the MKUKUTA) and in line with the international move towards alignment and harmonisation, major DP organisations together with the Government are currently finalizing the Joint Assistance Strategy of Tanzania that is meant to replace the individual country strategies over time.

2.4 Health Sector Policies and Plans

The revised National Health Policy (NHP) of 2003 takes account of the Health Sector Reform (HSR) and wider government strategies impacting on health. Its vision is "to improve the health and well being of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people". Areas for which the NHP provides detailed guidance include the devolution of responsibility for health services provision to councils, human resources development, health sector financing, public private partnership, and relationship with cooperating partners.

The Programme of Work 1999-2002 and subsequently the Second Health Sector Strategic Plan (HSSP 2) 2003-08 build the guiding framework for the implementation of Government policy and sector reforms as well as DPs' assistance. Current activities within the health sector are directed by the MTEF, which operationalizes the strategies articulated in the HSSP and MKUKUTA and aims at reflecting government and externally funded activities. The MTEF is linked to the Integrated Financial Management System to enable comparison of spending in relation to stated policy priorities.

Previous annual reviews have documented considerable achievements in health policy development and reform processes in the health sector. These include effective decentralisation of planning, budgeting and health service provision to the district level. Accelerated by the Local Government Reform (LGR) since 2000, local government authorities and council health management teams play a crucial role in these contexts. Comprehensive council health plans create the basis for decentralized management and the council basket funding mechanism.

In efforts to address the financing difficulties and shortfalls in the health sector budget allocation, the MOHSW embarked on far-reaching health financing reforms with new responsibilities assigned to local councils; the introduction of new financing schemes for health care, including the stepwise introduction of health insurance for the formal and informal sector and the introduction of pre-payment schemes and fee-for-services.

Continuing efforts are made to raise quality of care through standardisation and closer monitoring, including the formulation and introduction of a comprehensive package of essential health interventions.

Considerable challenges remain. Key obstacles in provision of and access to health services include long distances to health facilities, inadequate and unaffordable transport systems, and continuous limited quality of care. The single most worrying aspect of the health system is the deterioration in health personnel. The public sector as well as the non-for-profit private sector suffers a massive drainage of skilled personnel, which disproportionately impacts on rural health services. Availability of essential drugs improved, however, recurrent shortages continue to occur reducing access to adequate care in case of sickness. The health management information system, though focus of extensive DPs' support since many year, is still far from satisfactory functioning. The regional structures – as the “prolonged arm of the MOHSW” – are still struggling with their role and function as competent coordinators and supervisors.

In light of the large investment needs and the increasing costs of the health interventions, the system is faced with a widening resource gap in recurrent funding. To achieve the MDGs for health a rise to USD 43 per capita over the next 10 years is projected driven inter alia by the cost of HIV/AIDS related interventions and the cost to combat endemic diseases such as Malaria. This compares to USD 11 spent on health today, out of which approximately USD 6 are borne by the patients themselves. With the exemption of the financial year 2003/04, the support of the DPs increased steadily over the years. In 2004/05, the share of “off-budget” donor funding (e.g. the share which is disbursed through donor-specific mechanisms) was about 50-55% of the total external financing of the sector.

2.5 Collaborative Programmatic Support to the Health Sector

In 1998, DPs' support in the health sector was coordinated in from of a SWAP followed by subsequent basket funding arrangements in 2000. A number of DPs shifted their approaches from the former direct project support to the collaborative programmatic approach and joint funding mechanisms. It was expected for example that the SWAP would promote comprehensive planning which facilitates the effective use of scarce resources; that it would reduce transaction costs and increase capacities of planners and managers and transparency of financial management.

The SWAP in Tanzania today is known as one of the more advanced examples of cooperative programme support and partnership between Government and DPs in the region. Within the framework of SWAP, most of the DPs support the implementation of the HSSP; however, a significant share of donor support is still disbursed through direct project/programme funding. Most recently, the sector financing mechanisms have been questioned in the ongoing debate over the respective merits of general budget support versus sector baskets particularly in view of the shift of relevant financing partners from sector basket to general budget support.

Also other changing conditions and dynamics in the health sector, such as the HIV/AIDS epidemic, malaria and tuberculosis create a significant challenge for the health care system. Concerns were expressed that the answer of the international community by introducing large global funding initiatives such as Global Fund to fight AIDS,

Tuberculosis & Malaria, Clinton Foundation, President's Emergency Plan for AIDS Relief, Global Alliance for Vaccines & Immunization and others. These, if not integrated in the collaborative processes, might undermine the aim of the Paris Declaration and jeopardize the efforts and achievements of the programmatic sector approach.

2.6 District Self-Assessment

The MOHSW through the Health Sector Reform Secretariat (HSRS) will support randomly selected districts to carry out a self-assessment of health sector performance and cooperation modalities at district level in the eight health zones. This approach will foster the involvement and thus the ownership of local authorities for the evaluation results and will provide an indispensable input to the inception phase. The self-assessment will be completed by the end of 2006 prior to the start of the planned Joint External Evaluation activities in the beginning of 2007. The MOHSW will be responsible for the ToR, the planning, preparation and the implementation as well as the results of the self-assessment and might apply standard tools (such as tested assessment instruments elaborated by WHO). The MOHSW will make sure that the data and information from different districts are disaggregated to ensure comparability of the district performances. The MOHSW will organize a stakeholder meeting including the external evaluation core team where the district representatives will present the results of the self-assessment as a starting point for the Joint External Evaluation. The results of the self-assessment of the districts will be critically analysed during the inception phase and validated in the field studies of the evaluation.

3. Rationale for a joint evaluation

The international community has agreed about the importance of monitoring various indicators to measure progress and achievements towards the MDGs and the Paris Declaration on Aid Effectiveness. The new modes of assistance – such as SWAP, basket funding, general budget support as well as other collaborative initiatives and programmes – are creating a growing need for joint work in monitoring and evaluating their implementation.

The new modes of aid that emphasise joint donor-partner country efforts and basket and other forms of co-financing require the use of joint evaluations. It is next to impossible to perceive meaningful evaluations in this area of cooperation that would allow for a single-donor approach. Furthermore, joint evaluations are a powerful tool for working towards more ownership and participation of partner countries in aid evaluation. Finally, joint evaluations are one way of contributing to coordination and harmonisation in the field of evaluation, both among donors and between the donors and partner country.

Since the beginning of the health sector reform in the early 90es, tremendous effort and funds have been put into and spent on the implementation of the health sector reform programme by the Government as well as the DPs in Tanzania. Seven annual joint health sector reviews and numerous studies and assessments have been done to measure progress and achievements throughout the process. Yet, the impact and effectiveness of the spending have not been measured over a period of time. The existing monitoring tools are effective, however, they do as such not comprehensively capture an overview over the results of all relevant health sector interventions and are lacking bringing all evidence together and translating it into information.

Plans to conduct an external evaluation of the Health Sector have been on the table for some time. As there is a very close partnership and joint support of and pooled funding to the health sector within the SWAP, the evaluation has been proposed as a joint evaluation.

4. Objectives

4.1 Overall Objective

The overall objective of the Joint External Evaluation is to provide solid evidence about the relevance and effectiveness of the joint development work in the health sector. The purpose is to demonstrate results, and to show "what works" and "what made/makes the difference" in order to learn from experience and to link evidence to policy and strategic development.

The evaluation should be "action oriented". The aim is that the evaluation becomes a learning tool for Government, DPs, civil society and other stakeholders, makes recommendations to possible adjustments of the policies and strategies, helps to promote good governance and enables the partners to become fully accountable and cost-effective. The results will feed into the development of the HSSP 3 (2008-15) which will be elaborated shortly after completion of the evaluation.

4.2 Specific Objectives

1. Evaluate the performance of the health sector in the period 1999-2006 against the MDGs, and the objectives of the PRSP/MKUKUTA in general and the HSSP 1 (1999-2002) and HSSP 2 (2003-08) in particular in light of the needs of the Tanzanian population; specifically:
 - assess results, particularly the possible impact on health of the target groups and the outcomes in terms of effective access to and quality of health services with emphasis on the users' perspective, district disparities and different segments of the target population
 - assess the responsiveness of health sector interventions/reforms to the needs of the target population (relevance)
 - assess efficiency – "value for money" – with emphasis on the allocation and flow of funds to the decentralized level and the use of financial resources at local level
 - assess whether the environment (including policy, system development and institutional framework) has been enabling for the implementation of health policy and strategies and whether it created an impact
 - formulate lessons learned and recommend on how to improve strategies and future interventions to feed into the formulation of HSSP 3 (2008-15).

2. Evaluate partnership in terms of cooperation modalities, harmonization and alignment between the Government, the DPs, and other stakeholders over the same period; specifically:
 - assess the current partnership arrangement and modalities of cooperation for dialogue and support between Government, DPs, civil society and other stakeholders in light of the situation at the beginning of the programmatic support, developments during the period being evaluated, the Paris Declaration, and Tanzania-specific processes such as the SWAP
 - learn from experiences to apply lessons learned and recommend necessary changes of further improvements of the cooperation process and the partner dialogue.

4.3 Intended Users/Audience of the Evaluation

The intended users/audience of the evaluation are: The Ministry of Health and Social Welfare; The Prime Minister's Office, Regional Administration and Local Government; the Ministry of Finance; the Ministry of Planning, Economics and Empowerment; other interested and concerned government institutions; the DPs; the interested and concerned general public respectively civil society organisations and the private sector; and the DAC members.

5. Approach and methodology

5.1 General Principles and Methods

The evaluation will be carried out in accordance with the OECD/DAC evaluation principles and guidelines and with OECD/DAC Evaluation Quality Standards (2006). Relevant methodologies will be chosen and applied in accordance with international standards. Achievements will be assessed against the MDGs, the objectives of the PRSP/MKUKUTA and the contemporary goals and objectives of the health sector strategic plans. The key issues of the scope of work will be evaluated in light of the evaluation criteria (*relevance, efficiency, effectiveness, impact, sustainability*) as defined in the OECD/DAC "Glossary on Evaluation and Results-Based Management" (2002) which shall be adhered to throughout the evaluation. Assessment of impact and effectiveness will generally be restricted to the overall level of achievements of the combined support from DPs and the country's own efforts. "Gender" and "equity" will be crucial aspects to consider in the assessment of the issues under question.

The evaluation will rely as extensively as possible on available data at central, regional, district and local levels. The evaluation team will consider particularly the analysis of the data included in the existing set of indicators (input, output, outcome, impact) elaborated under the SWAP. The comprehensive literature study will include the analysis of the health management information data and other statistics, the JAHSR results over the past seven years, other programme reviews and evaluation results, and documentation and studies and research results on different aspects of the health care system as well as the cooperation modalities/ sector dialogue. A plausibility approach will be sufficient where data reliability and/or availability are lacking.

The results of the self-assessment of sample districts planned by the MOHSW prior to the evaluation (See Section 2.6) will be critically analysed and used (among other) as basis for the situation analysis and the prioritisation of the scope of work during the Inception Phase. Results of the district self-assessment will be verified in the field study phase if necessary.

The evaluation will thus include a strong element of field studies and district participation (see below under Phase 2 of the evaluation). The results of the literature study and the self-assessment of the districts will provide the basis for and a significant input to the main evaluation in the field. Both, the literature analysis and the district self-assessment will guide the main evaluation activities and will determine the detailed methodology, the extent and kind of validation requirements respectively the extent and content of qualitative and quantitative assessments in the field.

The involvement of all relevant stakeholders will be essential to ensure valuable results reflecting the entire health sector situation and to guarantee broad acceptance of and input into the evaluation. The methodology of *how* to include the stakeholders will be crucial for the success of the evaluation and the achievement of its objectives.

Phasing

The evaluation will comprise three phases:

The **Inception Phase** will include the comprehensive desk study on the analysis of available documents, information, data/statistics, triangulation of different studies etc. In the beginning of the Inception Phase, the consultant will prepare an analytical framework plan for carrying out the evaluation.

The **objectives** of the Inception Phase are to analyse available information, data and study results, to draw preliminary conclusions and assumptions related to the scope of work, to identify major weaknesses, strengths, opportunities and threats. Conclusions will be drawn in regard to the validity of data and information and subsequent validation requirements as well as identify data and information gaps. The Inception Phase will also include extensive stakeholder consultations feeding into the determination of criteria for priority setting for the scope of work.

Based on the analysis, the evaluation team will determine the extent and kind of qualitative and (semi-) quantitative survey activities to be carried out during the field studies. At the end of the Inception Phase, the consultant will elaborate a draft Inception Report including criteria for priority setting for the scope of work, and proposals for the precise focus of the evaluation, a proposal for a detailed work plan for phase two of the evaluation with survey activities and a detailed time frame. In addition, the consultant will elaborate details of the methodology for Phase 2, the field studies, to achieve the “scope of work” adequately and effectively.

The priorities to be set for the scope of work as well as the detailed methodology for the scopes to be evaluated will be defined primarily on the basis of:

- The desk study (mapping and analysis) on available literature and documents
- Critical analysis of the results of the self-assessment of the districts

- Extensive and regular stakeholder consultations including at least three meetings with relevant stakeholders throughout the Inception Phase to direct and guide the prioritisation process
- The Inception Workshop in the end of the Inception Phase (see below).

Phase 2 of the evaluation – the actual field studies – will be carried out according to the detailed work plan elaborated in the Inception Phase. The fieldwork will apply relevant scientific methods according to international standards as worked out by the consultant during the Inception Phase. The **objectives** of the field studies are to verify the results of the desk study and to fill eventual information gaps to be able to draw final conclusions and provide sound recommendations. At least 10% to 15% of the 123 districts should be represented in the evaluation (including the eight districts involved in the district self-assessment). The methods will comprise qualitative surveys and the verification of the results of existing quantitative surveys, semi-structured interviews, focus group discussions, verbal autopsy, interviews (males/females), and other appropriate methods as elaborated in the Inception Phase. Quantitative surveys will be carried out only to a limited extent and only to the extent necessary for crosscheck and verification of the desk study results and the results of the district-self assessments and to eventually fill data and information gaps.

Phase 3 of the evaluation – the final analyses – will combine the results of the Inception Phase and the field studies. The **objectives** are to elaborate and present the conclusions, recommendations, lessons learned and “best practices” to provide an input to the HSSP 3 in terms of both the improvement of the health sector performance and the partner dialogue.

Workshops will be held in the end of each phase to ensure the involvement, participation and ownership of the stakeholders in the results of the study. Stakeholder inputs will be required in the following:

- **An Inception Workshop** towards the end of the Inception Phase with all relevant stakeholders involved to discuss the results of the Inception Phase as presented in the draft Inception Report, the detailing of the scope of work and the instruments/methodologies as well as the framework and the action plan proposed by the consultant.
- The preliminary findings, results, conclusions and “lessons learned” from the field studies will be presented and discussed during a **second workshop** in the end of the field studies. The key elements of the final evaluation report to be proposed by the consultant will also be discussed.
- **A third** workshop on the final draft evaluation report will be carried out in conjunction with the Joint Annual Review 2007 replacing the technical review. The final report will be completed subsequently reflecting the discussions and proposals made in the JAHSR.

Intermediate products (Analytical Framework Plan, Inception Report, Report from Field Studies and Draft Final Evaluation Report) will be presented to the Management Group (see Chapter 9) and to the stakeholder audience. The MOHSW will be free to use intermediate products and results for the preparation and pre-formulation of the subsequent HSSP 3. The consultant, however, will not be requested to guarantee the validity of the preliminary findings and results at any point in time earlier than by completion of the final draft evaluation report presented at the third workshop.

Expected Outputs – Deliverables

The consultant will produce the following primary outputs (See also Chapter 11: Timing)

- Analytical Framework Plan for carrying out the evaluation (in the beginning of the Inception Phase)
- Draft Inception Report (in the end of the Inception Phase prior to the Inception Workshop) and a final Inception Report after completion of the Inception Workshop
- Inputs to the workshops, intermittent status reports and power point presentations if required to keep stakeholders informed throughout the process
- Draft final evaluation report (prior to the final workshop)
- A final evaluation report of no more than 80 pages (details to be presented in annexes on a CD-ROM) at the end of Phase 3 including a separate 'synthesis' product including all relevant recommendations delineating appropriate management actions (as far as possible related to the structure of the HSSP).

6. Scope of work

The main coverage of the evaluation will be:

- The relevance of the objectives of the health sector strategic and implementation plans in light of the MDGs and the MKUKUTA/PRSP and the needs of the target groups in a changing environment
- The results and appropriateness of the joint health sector interventions with focus on the decentralized level with a strong user/client perspective
- The effectiveness of different aid modalities
- The coherence and alignment of the relevant development partners' support for the implementation of the health sector reform and strategies.

The time period to be evaluated shall include the financial years 1999-2006.

The following includes a tentative list of topics relevant to the stakeholders and development partners, which will be prioritised and narrowed down through the analysis of available literature and data with broad stakeholder participation throughout the Inception Phase.

6.1 Achievement of Health Sector Objectives

Assess with specific emphasis on gender and vulnerable groups the achievements in terms of:

- People's health improvements and conditions for different health indicators (e.g. high maternal mortality, poor nutritional status of children; but decreasing infant and child mortality rates)
- Improvement of effective access (geographical, financial, and cultural) to preventive and clinical health care services (consider different ownership) including equity in terms of barriers to access

- Improvements of quality of care and cost effectiveness of preventive and clinical health care services including equity of supplies and demands in terms of quality of care received. (Health care services include a) services at district (primary and secondary level) and referral levels; and b) services of different ownership: public, faith-based and other non-government, private, traditional.)

Assess whether health services are more likely today to impact upon the burden of disease due to inputs and reforms which took place between 1999 and 2006.

Special focus should be put on:

- Reproductive health and maternal care
- Integrated health services HIV/AIDS/STD, malaria, tuberculosis
- Performance of the referral services system.

Assess the efficiency of inputs – value for money with emphasis on the allocation and flow of funds to the decentralized level (related to aid modalities) and the use of financial resources at local level.

Assess the effects of other relevant reforms and general framework conditions, such as the local government and the civil service reform on the achievements of the health sector objectives and whether reforms presumed to include greater harmonization, improved efficiency, larger and better targeted public spending.

Assess impact and effectiveness of multi-sectoral approaches and communication in light of the PRSP and the MDGs at central and at district level.

6.2 Performance of the Health System

At central and regional levels

Assess whether targets/objectives/strategies were rightly defined (HSSP 1 & 2, MKUKUTA, MDGs); in light of the disproportionate burden of disease borne by the poorest women and children.

Assess the consistency and intervention logic of health sector policy, strategies and interventions with the pro-poor focus, the MDGs and PRSP objectives and the needs of the Tanzanian population, and assess the responsiveness of policy, strategies and interventions to:

- Major health problems and new diseases/epidemics
- Changing conditions and needs of the population/target groups (e.g. in terms of global challenges, escalating costs, growing uncontrolled private sector and others)
- Conditions preventing the target groups from using the health care system
- Inequities between rich and poor, rural and urban areas, men/boys and women/girls, between districts and between regions.

Assess whether the shift from input- and process oriented approaches (under the POW) towards service and consumer-oriented approaches (as aimed at in the HSSP) has successfully been achieved.

Assess whether policy and strategies have been adequate, whether they have created an enabling environment for the decentralized health care system and whether systems and structures have effectively been put in place. Particularly:

- Allocation and use of financial and human resources
- Institutional set-up and developments, roles, mandates and capacities, and bottlenecks in light of the changing roles and function at different levels of the system
- Decentralization with devolution: to what extent and how does this have an effect on the health care system including changes of roles and responsibilities
- To what extent did capacity building of the health system succeed in improving the operational capacities (e.g. financing of running costs, training of health personnel, incentive system to ensure availability of personnel in remote rural areas)?
- Devolution of financial management and transparency and accountability of the financial management systems
- Performance of the health management information system
- Effectiveness and responsiveness of the Essential Health Package (EHP) approach addressing the needs of the poor
- Performance of the Medical Stores Department at different levels
- Partnership between the Government and the non-for-profit and/or private sector.

Assess whether sufficient funds have been allocated to achieve the health sector objectives and whether budgets have been targeted to the basic health care services and the EHP to finance priority initiatives to tackle major causes of burden of disease. Particularly:

- Reflection of health sector objectives in the MTEF
- Allocation and use of financial and human resources
- Institutional set-up and developments, roles, mandates and capacities, and bottlenecks in light of the changing roles and function at different levels of the system
- Decentralization with devolution: to what extent and how does this have an effect on the health care system including changes of roles and responsibilities
- To what extent did capacity building of the health system succeed in improving the operational capacities (e.g. financing of running costs, training of health personnel, incentive system to ensure availability of personnel in remote rural areas)?
- Assess the development of the shares of financing between the Government and DPs and the degree of self financing of the health sector
- Priorities and decision making processes for health sector budget allocation
- Implications of the cluster approach of the PRS on health sector budget allocation.
- Social protection mechanisms/strategies and strategies to minimize the disparities between rural and urban areas and between rich and poor.

Assess the relationship and cooperation between the relevant ministries at central and regional levels and the implications on the performance of the health care system and the achievements of the objectives.

Assess the adequacy of roles, responsibilities and functioning of regional health structures).

Assess the adequacy and effective responsiveness of the reforms and strategies of the health sector and their implementation in view of the chronic human resource problem

and the conditions for continuous major deficiencies and constraints in this context. Particularly:

- Distribution and utilization of existing human resources
- Adequacy of standards and norms of human resources at different levels of the health care system – workload assessments
- Effectiveness of human resource development plans
- Human resources management/training/capacity building/recruitment and retainment aspects and implications of other reforms
- Interrelation in terms of availability of human resources in and human resource management between the public, NGO/faith-based organisations and the private sector.

Assess the adequacy of policy and strategies of the hospital reform, and the conditions and effectiveness of implementation of the reform. Particularly:

- Achievements in terms of facility development (managerial, administration, financial management information system, quality assurance)
- Link between hospital reform, district management and the referral system
- Link between hospital reform and other major interventions such as the infrastructure and equipment rehabilitation and maintenance activities; drug programmes, etc.
- Integration of NGO/faith-based service and private providers.

Assess the conditions for and implications of continuous major deficiencies of the support systems and whether policy and strategies have adequately addressed these deficiencies and have considered cooperation with other major stakeholders. Particularly:

- Health management information system
- Infrastructure development and equipment maintenance
- Drug supply and distribution systems
- Transport and communication systems.

Assess the consistency and effectiveness of policy and strategies in view of public private partnership and the conditions and implications of continuous deficiencies. In particular:

- Involvement of the civil societies and the private sector
- Capacities and willingness to cooperate
- Service agreements and consistency with existing structures and approaches.

Assess the effectiveness and efficiency of research and studies in the health sector and whether the results and recommendations were complementary (avoiding overlapping) and effectively used.

Assess the effectiveness of monitoring and feedback mechanisms at central and regional levels from the implementation of policy and strategies. Particularly:

- The use of lessons learned and recommendations in strategic development and policy formulation processes
- Institutionalisation of publication of information and lessons learned to informing the public/civil society.

At decentralized/local level

Assess whether political, administrative and structural institutional changes at district council level have brought the expected health service improvements and are responsive to local realities and needs. Particularly in terms of:

- Management, planning and budgeting capacities and performance
- Integration of major vertical programmes (such as infrastructure development through the “earmarked basket”, HIV/AIDS, Malaria and TB Programmes) into council health planning
- Human resources – availability and qualification
- Availability of drugs and supplies to affordable costs
- Maintenance of infrastructure and equipment
- Intersectoral cooperation
- Integration of non-government and private health service providers
- Fiscal autonomy of the district councils, financial management and transparency/accountability
- Quality assurance (public, NGO and private sectors)
- Reporting requirements
- Facility development and link with hospital reforms and referral system
- Utilization of the HMIS for planning, monitoring and steering purposes.

Assess whether the health sector investments by the Central Government/DPs channelled through district councils address the priorities of the local government and the lower administrative levels as well as the needs of the communities/civil societies. In particular:

- Adequacy of formula based funding mechanisms of the district basket in view of the actual needs and priorities of the districts
- Participatory (rural) planning approaches and community involvement, integration of the non-government sectors
- Relationship between participatory based planning and budgeting of resources (financial, human, etc) at community and district levels
- Poverty assessment at lower levels.

Assess whether financial resources have been effectively distributed and utilized at local level in terms of:

- The burden of diseases and the health sector objectives;
- Reflection of the needs of vulnerable groups and gender aspects in budget allocations, distribution and utilization
- Activity based versus result oriented budgeting.

Assess the efficiency of different cost-sharing systems in terms of increasing of availability and utilization of funds at local level to improve the health service system:

- Assess the potential to increase the mobilisation of funds from users (user fees)
- Analyse the fee structure for medical services (incl. Drugs) incl. subsidies for poor people
- Compare the availability / willingness to pay for such services and level of cost recovery and assessment of sustainability of service delivery
- Assess effectiveness of current systems to protect the poor and vulnerable population.

Assess the adequacy of policy and strategies in terms of community/civil society empowerment and whether they have been implemented effectively:

- Demand driven service delivery and their responsiveness to the public/consumers
- Ability of the target population to articulate their demands and needs
- Community based strategies and concepts in terms of improvement of access to and quality of care.

Assess the effectiveness of policy and strategies and their implementation and the conditions and achievements in terms of public private partnership at local levels:

- Involvement of the NGO/faith-based organizations and the private sector; true partnership and capacities and willingness for cooperation between the Government, NGOs/and faith-based organizations, and the private sector
- Sharing of responsibilities and resources at district level
- Sustainability of NGO/faith-based health services systems in terms of financial and human resources at local level.

6.3 Aid Modalities of Dialogue and Support

Assess the current partnership arrangement and modalities of cooperation for dialogue and support between Government, other relevant stakeholders and DPs especially in light of the Paris Declaration (modalities include all kind of cooperation support such as sector dialogue, direct project funding, basket funding, earmarked pooled funding, general budget support and "off-budget support)

Assess the adherence of the DP's support with the health sector objectives and strategies and the results and effectiveness of the different partnership arrangements in terms of effective contribution to the performance and the achievements of health sector and PRSP objectives and the MDGs.

Assess the implications of the PRSP cluster approach and to what extent is it considered in the current dialogue and objectives of the partnership.

Assess the coherence and consistency of stakeholders and DPs with the Memorandum of Understanding (MOU) and the Government's leading role and ownership in promoting and following the cooperation approach as laid down in the MOU.

Assess the implications of non-adherence to the MOU by DPs and whether the different approaches jeopardize the partnership and affect the achievement of objectives.

Assess what the SWAP has achieved in positive terms and whether it has brought the expected results of:

- Facilitating ownership by the Government and involvement of all relevant stakeholders
- Promoting comprehensive planning and effective use of all available scarce resources regardless of ownership (e.g. public private partnership)

- Providing flexibility according to needs and demands instead of the more rigid project individual support and increasing efficiency and effectiveness of the support to the implementation of the health sector strategic plan
- Reduction of transaction costs on both the Government's and the DPs' side
- Boosting functionality of the system and transparent financial management
- Increasing capacities of planners and managers in a decentralized system
- Increases the available resources at decentralized levels and ensuring appropriate use of these resources
- Effective and efficient use of technical assistance (TA) and appropriateness of TA modalities in view of the SWAP.

Assess sustainability of district health system financing and sustainability of health sector achievements at district level in light of changing collaboration (financing) policies and modalities of the DPs.

Assess performance and efficiency of established cooperation structures at different level (such as SWAP Committee, the Technical Sub-committee, the Basket Committee etc) and effectiveness of communication between the Government and the partners and other stakeholders such as NGOs, faith-based groups and the private sector.

Assess the conditions why – with the sector-wide approach – most burning and continuous weaknesses and limitations of the health care system could not be addressed effectively up to date. Particularly:

- Financing of the health sector
- Human resources
- HMIS
- Drug supply system
- Public private partnership
- Hospital development.

Assess the major challenges for the partnership and the partner dialogue and to what extent these challenges can jeopardize carefully established cooperation arrangements. Particularly:

- Complementarity of sector programmes and aid modalities
- General budget support
- Continuous severe shortages of human resources and lack of absorption capacities
- Government budget ceilings.

Assess the implications and actual and possible affects of global funding mechanisms and ambitious programmes of international NGOs (focusing on selected diseases and/or aspects of the health care system) on the general health sector performance and the collaborative approach/sector dialogue.

Assess effectiveness and efficiency of the joint monitoring and review mechanisms and whether they have an effect/implications on strategic development and performance of the system.

Assess the coordination and harmonisation of health information (see also possible results of the task force) and whether the efforts are effective.

6.4 Conclusions and recommendations

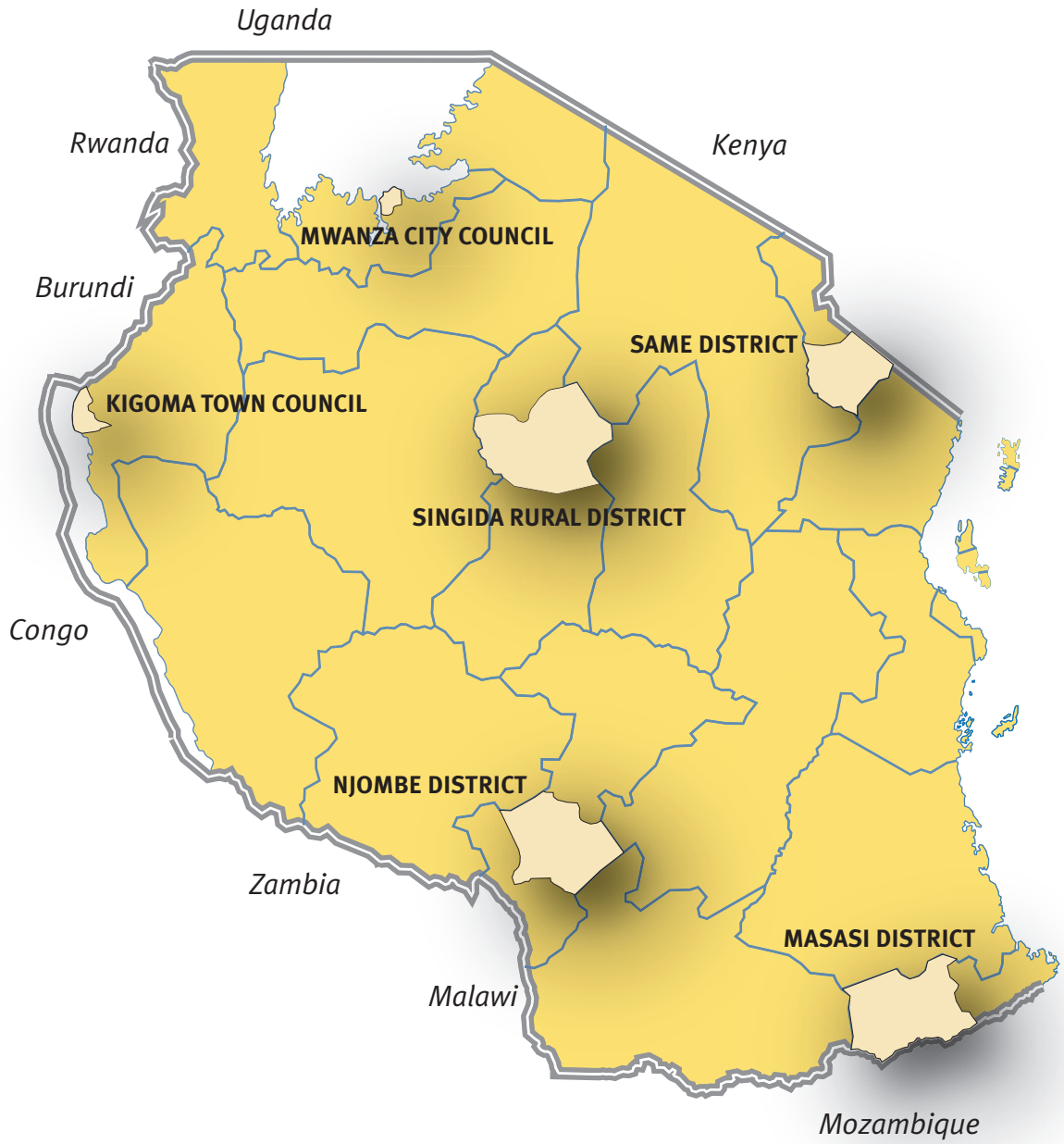
Draw conclusions (highlight strengths and weaknesses) and lessons learned and make recommendations in terms of the prioritised aspects of the health sector performance particularly in view of:

- Adequacy of objectives and strategies responding to the need of the population, incl. need of specific population groups, and changing environment and conditions
- Minimizing major weaknesses and deficiencies of the health care system to improve access to and quality and use of health services.

Draw conclusions (highlight strengths and weaknesses) from and lessons learned of the effect of different aid modalities and the partner dialogue in each of the priority areas of concern and recommend on necessary changes of further improvements of the cooperation process and the partner dialogue including technical assistance to ensure the consistency with the MOU and to contribute effectively to the achievements of the health sector and the PRSP objectives and the MDGs.

Note: For the full text of the Terms of Reference, please see the CD-ROM.

Map of Tanzania



Eight government agencies, more than 20 development partners, many non-government organisations, faith-based organisations, civil society organisations as well as the private sector were engaged in the joint evaluation exercise. In addition, more than 300 community members took part in focus group discussions during the evaluation.

Six development partners: Belgium, Canada, Denmark, Germany, the Netherlands and Switzerland have been the major funders of the direct cost of the study. The management of the evaluation was conducted by a management group comprising of Denmark, Germany and Tanzania.

