Ministry of Foreign Affairs
Denmark

Government of Tanzania

United Republic of Tanzania

Health Sector Programme Support

HSPS IV (2009 – 2014)

Overall Programme Document

Ref. No. 104.Tanzania.810-400

June , 2009

Table of Content

i. Acronyms and abbreviations

AIDS	Acquired Immuno – Deficiency Syndrome
ANC	Antenatal care
APHFTA	Association of Private Health Facilities in Tanzania
APR	Annual Program Review
ART	Anti retroviral therapy
BAKWATA	Baraza Kuu La Waislam Tanzania (The National Muslim Council Of Tanzania)
BFC	Basket Financing Committee
BOT	Bank of Tanzania
CAG	Controller and Accountant General
CCHP	Comprehensive Council Health Plans
CIDA	Canadian International Development Agency
CMAC	Council Multi-sectoral AIDS Committee
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
D by D	Decentralisation by Devolution
Danida	Danish International Development Agency
DHS	Department of Hospital Services
DKK	Danish kroner
DP	Development Partner
DPG	Development Partners Group
DPP	Department of Policy and Planning
EED	Evangelischer Entwicklungs Dienst
FBO	Faith Based Organisation
FP	Focal Point
FY	Fiscal Year
GDP	Gross Domestic Product
GNI	Gross National Income
GOT	Government of Tanzania
HBF	Health Basket Fund
HMA	Hospital Management Adviser
HMIS	Health Management Information System
HRH	Human Resource for Health
HSF	Health Services Fund
HSPS	Health Sector Programme Support
HSSP	Health Sector Strategic Plan
ICT	Information and Communication Technology
ITN	Insecticide treated net
JAHSR	Joint Annual Health Sector Review
JAST	Joint Assistance Strategy Tanzania
JEHSR	Joint External Health Sector Review
JPO	Junior Professional Officer
LGA	Local Government Authority
LGCDG	Local Government Capital Development Grant
LGDG	Local Government Development Grant (previous LGCDG)
MDA	Ministries, Departments, Agencies
MDG	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (in English: Tanzania Strategy for Growth and the Reduction of Poverty)
MKUZA	Mkakati wa Kukuza Uchumi na Zanzibar

	(in English: Zanzibar Strategy for Growth and the Reduction of Poverty)
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (in English: Primary Health Services Development Programme)
MOFA	Ministry of Foreign Affairs, Copenhagen, Denmark
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
MVC	Most Vulnerable Children
NAO	National Audit Office
NCD	Non Communicable diseases
NGO	Non Government Organization
NHP	National Health Policy
NMSF	National Multi-sectoral Strategic Framework (for HIV/AIDS)
OC	Other Charges (non-salary recurrent expenditures)
PE	Personnel Emoluments
PER	Public Expenditure Review
PFM	Public Financial Management
PFMRP	Public Financial Management Reform Programme
PFP	Private for profit
PLHIV	People Living with HIV and AIDS
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PPP	Public Private Partnership
PPPA	Public Private Partnership Adviser
PSA	Pharmaceutical Services Adviser
PSU	Pharmaceutical Services Unit
QA	Quality Assurance
RDE	Royal Danish Embassy
RFA	Regional Facilitating Agents
RGOZ	Revolutionary Government of Zanzibar
RHMT	Regional Health Management Teams
SC	Steering Committee
SFA	Senior Financial Advisor
SHSA	Senior Health Systems Advisor
STI	Sexually transmitted infections
SWAp	Sector Wide Approach
TA	Technical Assistance
TAC	Technical AIDS Committee
TACAIDS	Tanzania Aids Commission
TC-SWAp	Technical Committee of the SWAp
VMAC	Village Multi-sectoral AIDS Committee
WMAC	Ward Multi-sectoral AIDS Committee
ZAC	Zanzibar Aids Commission
ZNHP	Zanzibar National Health Policy
ZHSRSP	Zanzibar Health Sector Reform Strategic Plan
ZANA	Zanzibar Nurses Association
ZHOA	Zanzibar Health Officers Association

ii. Executive summary

Introduction
Denmark has supported the health sector in Tanzania for decades. The fourth phase of Danish support to the Tanzanian health sector 2009-2014 comprises a budget of DKK 910 million in support to the health sector in Mainland, the health sector in Zanzibar and the multi-sectoral response to HIV/AIDS.

HSPS IV (2009-14) is in line with the Third Health Sector Strategic Plan (Mainland) 2009-2014, the Second Zanzibar Health Sector Reform Strategic Plan 2006-2010 and the National Multi-sectoral Strategic Framework for HIV/AIDS 2008-2012, the Joint Assistance Strategy for Tanzania..

Objectives
The overall aim for the Danish development assistance to Tanzania is to contribute to poverty reduction and to the achievements of the MDGs. The objectives of the Danish assistance through HSPS IV correspond to three inter-related and complementing objectives for the three sectors:

a) To provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable and with focus on those most at risk an responsive to the needs of citizens in order to increased the life span;
b) To ensure equitable access to quality health services in Zanzibar, in particular at the district level and below and to encourage the health system to be more responsive to people's needs and demands; and
c) To support the multi-sectoral response to HIV and AIDS in Tanzania through support to the implementation of the NMSF.

Strategic approach
The capacity of the health systems in Mainland and Zanzibar and the multi-sectoral response to HIV/AIDS will be strengthened using a mix of modalities. The majority of the funding will be provided through joint financing arrangements to the implementation of national or organisational strategic plans, supplemented by more targeted capacity strengthening through earmarked financing in specific intervention areas as well as by technical assistance.

A minor share of the total budget is earmarked for specific areas of support, but provided as flexible funding to be detailed in the annual work plans and budgets as appropriate in response to needs at the time. Thus, funds are primarily committed to broad areas of work rather than to specific activities. The areas selected for earmarked funding are based on expressed GOT & RGOZ needs and priorities and are areas where Danida has a comparative advantage, e.g. prior experience or considered preferred donor by government, or where such support is deemed more appropriate in terms of allowing innovation and experimentation.

The focus is on ensuring quality service delivery at district level and below and the strengthening of necessary central support and referral systems to support the lower levels. The program recognises the need to consider the health sector in its entirety and the need for strengthening the involvement of the non-government sector in public health and HIV/AIDS activities. Each component therefore contains three sub-components focusing around three types of intervention: a) Un-earmarked support through (and development of) joint funding arrangements; b) Earmarked support for capacity strengthening of central level support to systems development, management and strategic initiatives; and c) Support to PPP and private sector involvement, cf. Diagram of the HSPS IV (p. vi) for an overview.

Component 1: Support to the health sector in Tanzania Mainland
The health sector in Tanzania Mainland will be supported by a total grant amounting to DKK 528 million (including contingencies). Firstly, general support to the implementation of the HSSP III will be provided through the HBF and the LGCDG Health Window (for infrastructure) and may introduce an element of pay for performance. The majority of this support will be channelled through the HBF mechanism, which as of 2008 corresponds to sector budget support. Secondly, earmarked support will be provided for health systems and capacity strengthening including strategic initiatives with focus on supporting the implementation of hospital reforms and strengthening of the drug chain from policy level to end user. Finally, earmarked support will be provided for strengthening the non-governmental health sector and public private partnership with a view to provision of public health services.

Component 2: Support to the health sector in Zanzibar
The health sector in Zanzibar will be supported with a grant amounting to DKK 120 million (including contingencies). Firstly, unearmarked support to the implementation of district health services against district health plans will be provided through the HSF. The allocation to HSF may grow if RGOZ starts making its own contribution and if other DPs join the HSF. The HSF will include a performance based element in the district allocation formula. Secondly, earmarked support will be provided for selected central level for systems development, management and strategic interventions. The majority of the support will be provided in the area of Procurement and supply management of pharmaceutical products, maintenance and ICT. The other selected intervention areas are Human resource management and development, Quality assurance, Health promotion, HMIS, Health financing and sector performance monitoring, Strategic Initiatives. Finally, earmarked support will be provided to support NGOs, in particular professional associations, and public private partnerships.

Component 3: Support to the multi-sectoral response to HIV/AIDS
The multi-sectoral response to HIV and AIDS will be supported with a grant amounting to DKK 220 million (including contingencies). Firstly, unearmarked support to the implementation of the NMSF will be provided through the NMSF Grant for a harmonised support to the HIV/AIDS response provided that certain pre-conditions are met. Secondly, earmarked support will be provided for institutional capacity building of TACAIDS, including support to the development of a capacity building unit in TACAIDS, support to capacity building of TACAIDS regional offices and support for infrastructure development in the form of a new or rehabilitated office for TACAIDS. Finally, support will be provided to support non-government sector capacity for NMSF implementation in the form of continued support to some of the NGOs previously supported by Danida and in the form of support to strategic initiatives.

Capacity development support
The implementation of the HSSPs will require long term technical assistance for institutional capacity building as well as short term targeted technical support through short term TA or consultancies. The unearmarked and earmarked support for activities will therefore be supplemented by technical assistance to capacity building in key areas for implementation of the sector strategic plans.

HSPS IV includes funding for a total of 8 long-term advisers and a Junior Professional Officer (JPO):

- Five advisers (Hospital Reforms, Pharmaceutical Services, PPP, Health Policy, Planning & Management, Public Financial Management) will be provided to assist the MOHSW, Mainland. The latter may after agreement be lent out for limited technical support to TACAIDS.
- Two advisers (Health, Human Resources) and a JPO will be provided to assist MOHSW, Zanzibar
- One adviser (Organisational Development) will be provided to assist TACAIDS

Funding for a total of 120 person months will be available for short term TA.

All advisers will work within MOHSWs and TACAIDS with designated counterparts. They will report to their head of department. The Health Adviser in Zanzibar will head the HSPS Office.

Implementation arrangements

The programme will, wherever possible, be implemented using joint procedures as agreed in MOUs with government and development partners or between non-government institutions and development partners. For oversight and decision-making of the earmarked support a Steering Committee will be set up in Component 1 and 2, while it is envisaged to use the Joint Thematic Working Group for Component 3. The activities of the Steering Committees will be kept to a minimum.

There will be no HSPS management structure per se in Component 1 and 3. The HSPS Office in Zanzibar will be maintained with the Senior Health Adviser as team leader. The management capacity in the MOHSW is presently limited. The Zanzibar Component will technically operate as a decentralised accounting project as regards earmarked funding. Integration into government systems will be pursued. The responsibility regarding the HSF is expected to be handed over to RGOZ as it develops into a basket fund arrangement.

Budget Overview over indicative budget distribution

	Amounts	**Percentage distribution**	
	Millions of DKK	**within components**	**between components**
Component 1: Support to the health sector Mainland			
1.1 Support to the health basket funds	416.5	80%	
1.2 Support to Capacity strengthening	50.0	9%	
1.3 Support to PPP	25.0	5%	
Technical assistance (short and long term)	28.5	5%	
Administration	4.0	1%	
Contingencies	4.0	-	
Total - Component 1	528.0	100%	58%
Component 2: Support to the health sector Zanzibar			
2.1 Support to the Health Services Fund	32.2	28%	
2.2 Support to central level support systems	55.2	48%	
2.3 Support to NGOs and PPP	2.6	2%	
Technical assistance (short and long term)	18.5	16%	
Administration	5.5	5%	
Contingencies	6.0	-	
Total - Component 2	120.0	100%	13%
Component 3: Support to the HIV/AIDS multi-sectoral response			
3.1 Support to the NMSF Grant	100.0	48%	
3.2 Support to Capacity strengthening of TACAIDS	50.0	24%	
3.3 Support to non-government sector	50.0	24%	
Technical assistance (short and long term)	8.5	4%	
Administration	1.5	1%	
Contingencies	10.0	-	
Total - Component 3	220.0	100%	23%
Reviews, studies, etc.	10.0		1%
Unallocated funds	32.0		4%
GRAND TOTAL	910.0		100%

Broad overview over Health Sector Programme Support, Phase IV (2009-2014)

	Component 1 Health sector Mainland	Component 2 Health sector Zanzibar	Component 3 Multi-sectoral HIV/AIDS
Harmonised support	Health Basket Fund *DPP/MOHSW* LGCDG *PMORALG* *416.5 mill DKK*	Health Services Fund *HSPS/ MOHSW-Z* *32.2 mill DKK*	NMSF Grant *TACAIDS* *100 mill DKK*
Earmarked Capacity strengthening	Hospital reforms *MOHSW* Drug chain Strategic initiatives *50.0 mill DKK*	Pharma supplies, *MOHSW-Z* maintenance and ICT Capacity strengthening *55.2 mill DKK*	Central and regional capacity devt *TACAIDS* New office building *50 mill DKK*
Earmarked Non-government sector	Policies & regulation *MOHSW, CSSC,* Institutional development *APHFTA* Improved PPP at all levels *25.0 mill DKK*	Professional associations *ZANA/ZHOA* Support to PPP *MOHSW-Z* *2.6 mill DKK*	RFE *RFE* Femina HIP *Femina HIP* *50 mill DKK*
Technical assistance	Short & long term TA *28.5 mill DKK*	Short & long term TA *16.5 mill DKK*	Short & long term TA *8.5 mill DKK*
Administration	Administrative costs *4.0 mill DKK*	HSPS Office *5.5 mill DKK*	Administrative costs *1.5 mill DKK*
Contingencies	Contingency *4.0 mill DKK*	Contingency *6.6 mill DKK*	Contingency *10.0 mill DKK*
Joint budget line	Reviews, studies etc. *10.0 mill DKK*		
	Unallocated funds *32.0 mill DKK*		
Long term TA	Long term TA included above 5 TA	Long term TA included above 2 TA + JPO	Long term TA included above 1 TA

1. Introduction

Denmark has supported the health sector in Tanzania for decades. The Danish Health Sector Programme Support (HSPS) started with the HSPS I (1996-1999) comprising a total budget of DKK 290 million. This was followed by HSPS II (1999-2004) with a total budget of DKK 550 million. This included support through a health basket fund. The focus of support was on Tanzania Mainland.

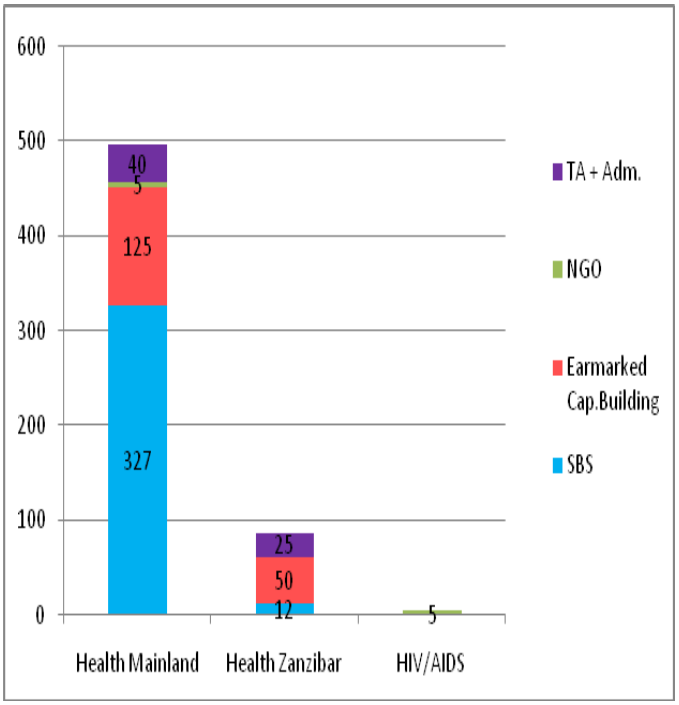
The third phase of Danish health sector support to the Tanzania, HSPS III (2004-2009) comprises a total budget of DKK 560 million. This includes DKK 60 millions in comprehensive support for the health system in Zanzibar. In Mainland, Danida supports the implementation of the Second Health Sector Strategic Plan 2004-2009 (HSSP II) with the majority of funds (60%) channelled through the Health Basket Fund mechanism.

Over the past years, Danida has supported several strategic civil society initiatives for HIV/AIDS through minor Embassy grants.

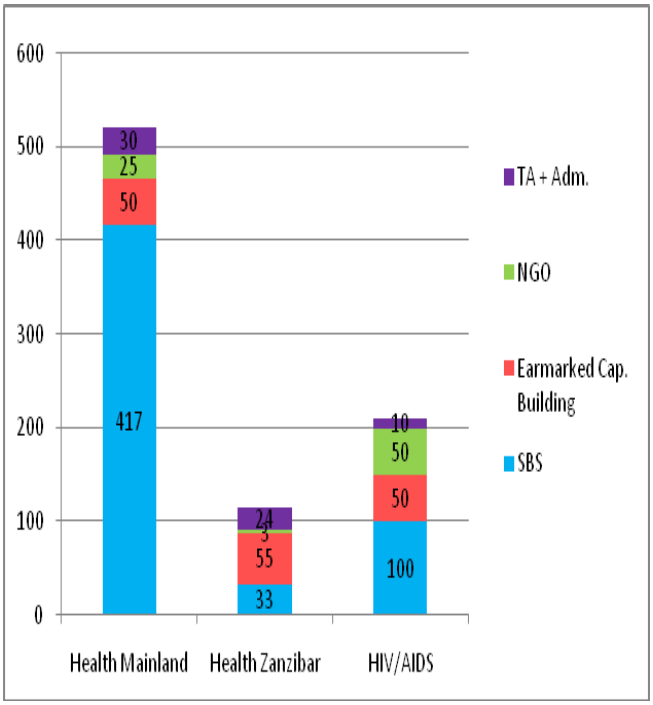
The fourth phase of Danish support to the Tanzanian health sector 2009-2014 comprises a budget of DKK 910 million in support to the health sector in Mainland, the health sector in Zanzibar and the multi-sectoral response to HIV/AIDS. HSPS IV is in line with the National Health Policy (2007), the Third Health Sector Strategic Plan 2009-2014 (HSSP III), the Second Zanzibar Health Sector Reform Strategic Plan (HSRSP) 2006-2010 and the National Multi-sectoral Strategic Framework for HIV/AIDS 2008-2012 (NMSF). The majority of funding will be provided through joint funding and un-earmarked arrangements (around 70%), cf. Figure 1.

Figure 1. Change in mix of funding modalities from HSPS III to HSPS IV

HSPS III budget allocation



HSPS IV budget allocation



The HSPS IV consists of three components that are to be implemented in three sectors independently of each other. The main responsibility for implementation of each component rests with three different institutions. Therefore, three separately Annexed Component Descriptions that can be used for reference by implementers in each of the three sectors have been developed. This Main programme document therefore mainly aims to provide the overview over the programme.

The present document is to a large extent based on existing joint documents, cf. key references listed in Annex 1-3.

2. Brief situation analysis: National and sector context

2.1. National context

The United Republic of Tanzania is a Union between Tanganyika and Zanzibar, which took place in 1964. The two countries have their own president, cabinet and parliament. The projected population was 39 million in 2007, of which 1.1 million in Zanzibar. About 65% of the population is below 25 years of age. The population growth 1988-2002 was 2.9% per year on Mainland and 3.1% in Zanzibar.

Macroeconomic situation

GNI per capita was around USD 365 in 2007. In recent years, both Mainland and Zanzibar have recorded annual growth rates of 6-8 % and the inflation rate has remained around 7% p.a. Inflationary pressure in first half of 2008 reflected the change in international fuel and food prices. Over the last five years, fiscal revenues have performed well reaching an estimated 14% of GDP in FY06, mainly due to improvements in tax administration, reduction in tax exemptions and broadening of the tax base. Government spending has also increased reaching an estimated 24% of GDP in FY06/07 – fuelled by increases in domestic revenues as well as in official development assistance and debt relief. The key challenge for fiscal management is to further enhance the quality and efficiency of public expenditure and ensure that efforts to strengthen the absorptive capacity keep pace with increases in government spending. The high aid dependency further makes Tanzania vulnerable to fluctuations in aid flows.

Poverty reduction

The poorest and most vulnerable groups do not benefit proportionally from the gains in economic performance. From 1992 to 2007, the proportion of people living below the national poverty line decreased from 39% to 33%. The largest reduction was in Dar es Salaam, from 28 to 16 % while income poverty in rural areas decreased from 41% to 37%. Income inequality in Tanzania has remained low compared to other SSA countries, but with significant regional differences. The rural poverty rates in districts vary from below 20% to above 50%. Almost 90% of the poor live in rural areas.

The National Strategy for Growth and Reduction of Poverty (2005) for Mainland Tanzania, known as the MKUKUTA (Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania) is committed to the achievement of the Millennium Development Goals (MDGs). It focuses on equitable growth and governance, and is an instrument for mobilising efforts and resources towards target poverty reduction outcomes. The MKUKUTA aims to foster greater collaboration among all sectors and stakeholders. It has mainstreamed cross-cutting issues (gender, environment, HIV/AIDS, good governance, disability, children&youth, elderly, employment&settlements). The strategy seeks to deepen ownership and inclusion in policy making, paying attention to address laws and customs that retard development and negatively affect vulnerable groups. The strategy identifies three clusters of broad outcomes: (i) growth and reduction of income poverty; (ii) improvement of quality of life and social well -being, and (iii) good governance.

Zanzibar's medium-term development and poverty reduction goals are articulated in the second Strategy for Growth and Reduction of Poverty, the MKUZA (2006-10). MKUZA explicitly addresses health, water and sanitation in the context of social services as critical elements for the development of the nation. It also recognizes specific sector reform programmes and emphasizes local stakeholder partnerships, harmonized assistance and interventions that will reduce inequalities and improve well-being among the poor. Cluster 2 of MKUZA covers health, nutrition, water & sanitation and HIV/AIDS, as part of social services and well-being, and it addresses broad issues of human capability.

Public sector reforms

There are a number of on-going public sector reforms and programmes that affect the health sector to varying extent. The reforms include for Mainland the Local Government Reform Programme, the Public Service Reform Programme, the Public Financial Management Reform Programme , the Legal Sector Reform Programme, the National Anti-Corruption Strategy and Action Plan, and for the RGoZ Economic and Financial Reforms, Institutional and Human Resource Reforms, and the Good Governance Reform.

Local Government Reforms - Since 1994 Tanzania Mainland has embarked on a Local Government Reforms Programme to decentralise and deconcentrate government to achieve greater responsiveness and enhanced accountability. The reforms aim to establish decentralisation by devolution (D-by-D), so that the elected local Councils and the Local Government Authorities (LGAs) take full responsibility for planning, budgeting and management of government services, including health, education, and water supply. However, resource allocation to local government and related planning and accountability systems continue to a large extent to be driven by the central government. Additionally, large resources for social development are channelled to the local level through parallel structures of line ministries.

Financial decentralization has been rapid. Total central government transfers to LGAs more than doubled from FY00/01 to FY05/06. However, LGAs are experiencing significant challenges managing and accounting for the increased flow of resources. Weaknesses include poor cash management, multiple data sets and large amounts of idle cash in numerous bank accounts. Some LGAs suffer from persistent and significant staffing problems and political interference in their operations.

The RGOZ is yet to start decentralising some authority to district councils. Local governments in Zanzibar are neither resourced properly nor managed as autonomous institutions. Local administrations are only marginally involved in service delivery. The reasons for this are partly political (lack of clarity on what form of decentralisation is pursued), but also constitutional and legal (e.g. lack of provision for local government institutions at grassroots level, duplication of roles and functions between agencies of governance) and institutional (particularly lack of coordination among sectors). Decentralisation within the health sector is thus constrained by the lack of a clear RGOZ policy, a legal and institutional framework, and is further compounded by general resource constraints.

Public Service Reform - Present challenges in improving public service performance hinge on three areas: pay reform, streamlined planning and budgeting, and increased accountability. The pay reform has been slow and many public sector workers have to supplement their incomes from other sources. Poor pay has, i.a., resulted in a distorted wage structure with progressively increasing discretionary allowances. Weak planning systems have contributed to poor performance and an inability to attribute results to public sector reforms. In 2006, a strategic planning manual was developed as a key first step to linking MKUKUTA to the budget at the level of Ministries, Departments and Agencies (MDAs). Linking it to an accountability framework will deepen performance management in the public sector. Accountability along the hierarchy of the public service, to Parliament and to the public is weak.

Zanzibar has a Good Governance Strategic Plan in place, which in principle provides a suitable framework for public sector reform and a successful local government reform. Civil Service reforms need particular emphasis. The Civil Service Commission is responsible for the recruitment of

government staff on behalf of all ministries. It is claimed however, that many staffs do not meet the required qualifications and that political interest rather than professional competence are at play. Few of those currently employed have formal job descriptions and there is no staff performance appraisal system in place in any of the ministries. The motivation of government employees is further compounded by low salaries, uncertain retirement benefits, unclear promotion criteria and a lack of balance in remuneration packages (including allowances).

Public Financial Management (PFM) Reform - Reforming public financial systems is a work in progress. Tanzania has made great strides in expenditure control (the first objective of good PFM) and is on the way to the second objective: the allocative efficiency of resources through improved distribution to the different sectors in conformity with government policies. Achievement of the third objective—the efficient and effective use of public resources for public services, through improved operational management—is still a way off, as is the case in most other developing countries. Notwithstanding these weaknesses, the system is working better than expected. The Government continued to improve its management of public expenditure, including in 2005, an election year.

An Integrated Financial Management System has been rolled out throughout MDAs and parts of LGAs. Budget preparation has improved, but predictability and timeliness of releases are still impaired by the late approval of the budget. Implementation of the Procurement Act 2004 has begun, but human resources for managing the new procurement regime is in shortage. In 2006, the National Audit Office (NAO) produced an audit report on time, for the first time. Important challenges remain in the independence of the NAO and the quality of the audit reports.

Joint Assistance Strategy for Tanzania

To support the implementation of the growth and poverty reduction strategies of both Tanzania mainland (MKUKUTA) and Zanzibar (MKUZA), a joint assistance strategy has been developed between the government and development partners. The Joint Assistance Strategy for Tanzania (JAST) includes, among other issues, commitments on alignment and division of labour in order to reduce the number of actors in the sectors.

2.2. Summary of situation analysis – Health sector in Mainland

Significance of the sector

Infant and child mortality has decreased, but neo-natal and maternal mortality are largely unchanged and remains high. Immunisation and ANC coverage is fairly good. Institutional deliveries are still limited to less than half of all deliveries. Morbidity is high, but good progress has been made in some areas, e.g. malaria and TB and HIV/AIDS. Nevertheless, these remain leading health problems. Life-style related NCDs increase. Mental disorders and substance abuse continues to contribute significantly to the disease burden. Considerable geographical and socio-economic inequalities in mortality and morbidity and in access to and utilisation of health services exist. Constraints include distance, financial access barriers and poor quality or non-availability of services due to by lack of human resources, inadequate human resource management and limited drug availability at peripheral level.

Institutional set-up/structure of the sector

A pyramidal referral system from dispensaries up to referral hospitals is in place. Faith-based organisations (FBOs) and private for-profit providers (PFP) provide an estimated 40% of health services in Mainland Tanzania.

The responsibility for health service delivery has been decentralised to LGAs. The Council Health Management Team is responsible for planning, budgeting, implementation and monitoring of district health services. Since 1996 Regional Health Management Teams (RHMTs) became part of the regional administration answerable to the regional secretariat, however, professionally accountable to the MOH.

This has created some unclarity and disputes about the role, responsibilities and composition of the RHMT. At national level the MOHSW and PMO-RALG are jointly responsible for service delivery.

Private sector partners are coordinated by two major umbrella organisations. The Christian Social Service Commission (CSSC) represents the large number of FBOs and also houses the secretariat for the Inter-Faith Forum. The Association of Private Health Facilities in Tanzania (APHFTA) presently represents about 10% of private hospitals and clinics, mainly in urban areas.

Key sector policies, legislation and programmes

A new National Health Policy (NHP) was formulated in 2007. The mission is to provide basic health services in accordance with geographical conditions, and which are of acceptable standards, affordable and sustainable. The NHP is operationalised in 5 year Health Sector Strategic Plans (HSSP) and long term development plans for capital investments. The MMAM (2007-17) aims to accelerate the provision of primary health care for all. The main strategy is to strengthen the health system through rehabilitation of infrastructure, human resource development, improving the referral system, increased health sector financing and improved provision of medicines, equipment and supplies.

The HSSP III (2009-14) maintains the emphasis on improved accessibility to district health services of good quality with a view to the need for adequate referral services in secondary and tertiary hospitals and the need for well-functioning central level support systems. Accessibility will be improved by enabling the delivery of standard packages of health interventions designed for each level of care by ensuring sufficient and better managed financial and human resources, functioning central level support systems, including the drug distribution system and implementation of the Tanzania Quality Improvement Framework. Maternal, new-born and child health will receive specific attention across the sector. The focus on HIV/AIDS, TB and malaria will continue, but there will also be increased focus on leprosy and disability prevention, neglected diseases, prevention and treatment of NCDs and improvement in measures taken with regard to environmental health.

Sector financing

In recent years, the overall budget for health in real terms as well as the domestic funding share has been increasing. Funding from DPs, especially targeted at HIV/AIDS, TB and malaria programmes, have increased. Most of this is not incorporated in the official government budget. Over the years an increasing percentage of the government budget has been allocated to health, but there are some indications that it is stagnating at around 10%, below the Abuja target. In 2007, the public health per capita expenditure on health was estimated to be 9 USD (HSSP III).

Unearmarked funding is provided through the Health Basket Fund mechanism (HBF) and included in the MTEF-ceilings provided to MOHSW, PMO-RALG and LGAs for planning. First, an agreed per capita allocation is allocated to LGAs, following an agreed resource allocation formula as unearmarked support for the implementation of the CCHPs, complementing the GOT District Health Block Grant. From the FY08/09 the LGA allocation will be 1.0 USD per capita. Secondly, a small part of the funds goes to supportive supervision by PMO-RALG and RHMTs to ensure quality of planning and reporting at LGA level. Finally, the remaining funds are used to finance activities at central level in the MOHSW MTEF. Until 2008, a share of the HBF was used for infrastructure rehabilitation at district level. As of FY08/09 a Health Window (for infrastructure) under the LGCDG has been established.

The increase in financial resources is insufficient for meeting the costs of delivering on health sector goals. A financial projection for HSSP III reveals a financing gap of about 24% of the expected costs. The imbalance can be addressed by increasing the resource envelope, scaling down the interventions or adopting a slower pace of implementation. The strategic focus by MOHSW is on seeking additional resources, including attracting off-budget to on-budget development assistance.

Effective and efficient financing of the health sector, and thus implementation of activities, is hampered by challenges in the planning and prioritisation of sector resources; obstacles caused by the financial management and financial administration processes within the MOHSW; as well as the need to align the sector's finances in accordance with the sector strategy of decentralised service delivery.

Cross-cutting issues

Gender – There are significant gender and other equality issues in health. The specific gender issues include substantial numbers of women confronting reproductive health challenges, such as maternal mortality, STIs/HIV, breast cancer, cervical cancer. Despite efforts to mainstream gender into the policies and strategies, the implementation has suffered from the absence of analysis of gender inequality and approaches to address them. A gender analysis is included in the MTEF for FY08/09.

Environment – The majority of diseases found in Tanzania, especially among children under the age of five, are caused by poor environmental health conditions. Water and sanitation is addressed within the MKUKUTA. The MOHSW is finalising the National Environmental Health, Hygiene and Sanitation Strategy. A Health Care Waste Management Plan and an Insecticide Management Plan is in place.

Human rights and good governance – Despite efforts to focus on patients' rights and rights of vulnerable groups in the policy framework, targeted interventions, awareness creation and advocacy is limited. Democratisation within the health sector is being extended through increasing use of boards and committees at LGA and facility levels. Many are, however, not functioning.

Partner coordination

The coordination structures for DP collaboration with GOT is laid out in the TORs for the Development Partners Group (DPG). Sectoral DPGs have been created. The DPG Health includes 20+ bi-lateral and multi-lateral agencies lead by a troika.

The Health SWAp provides the framework of collaboration among the stakeholders: MOHSW, PMO-RALG, MOF, civil society, private sector and DPs. The Technical Committee of the SWAp (TC-SWAp) comprising representatives of the stakeholders in the SWAp, serves as a joint monitoring and advisory body of the health sector. There are several sub-committees of the TC-SWAp.

The Basket Financing Committee (BFC), comprising representatives of the MOHSW, PMO-RALG, MOFEA and basket-donors, is responsible for overseeing operation of the HBF. The BFC have two meetings per year to discuss commitments and release of funds for the next fiscal year, the level of per capita allocation to LGAs, inputs to the budget/CCHP guidelines and to review progress. The Audit Sub-Committee of the TC-SWAp is responsible for analysing the CAG Audit report, discussing follow up measures, monitoring their implementation and proposing special targeted audits.

2.3. Summary of situation analysis – Zanzibar

Significance of the sector

Over the past 4-5 years, significant progress has been observed in some key health indicators. The prevalence of malaria has been reduced significantly. This has been achieved through a combination of measures, including prevention campaigns (promotion of ITN), early diagnosis (including the introduction of rapid tests) and prompt treatment, control of malaria in pregnancy, and a strong emphasis on surveillance and operational research. Successes are also reported in relation to HIV/AIDS (of which the prevalence has so far been contained to 0.7%), sexually transmitted diseases, tuberculosis and child immunisation coverage. The availability of essential drugs and the financing of primary health care services have significantly improved.

Institutional set-up/structure of the sector

The health sector in Zanzibar is governed by the Ministry of Health and Social Welfare (MOH&SW). The MOH&SW is responsible for overall policy formulation, technical monitoring and supervision.

Zanzibar's health service infrastructure in the public sector relies on a fairly dense network of Primary Health Care Units, providing basic PHC services; four Primary Health Care Centres, providing inpatient care and medical investigations; three district hospitals: providing second-line referral services, including surgery; and one general referral hospital (Mnazi Mmoja hospital, MMH), a large maternity hospital and one mental health hospital.

The private sector in Zanzibar comprises four registered hospitals, 80 private dispensaries and a number of private pharmacies and drug outlets. In urban areas, the service demand from private providers is larger than from public sector. There is no umbrella organisation for health NGOs.

The Zanzibar AIDS Commission (ZAC) is responsible for the coordination and monitoring of the multi-sectoral response to HIV/AIDS.

Key sector policies, legislation and programmes

Health sector development in Zanzibar is guided by the National Health Policy (ZNHP) and the 2nd Zanzibar Health Sector Reform Strategic Plan 2006/07-2010/11 (ZHSRSP). The overall goal of the ZNHP is to "improve and sustain health status of all Zanzibar people" (The policy comprises 11 areas of reform, of which the driving force is to increase the efficiency of the health system and to maximise the utilisation of budget resources.

Based on the ZNHP the ZHSRSP II emphasises five core strategies/themes: Strengthening human resources for health (HRH); Strengthening decentralised health service delivery; Ensuring coverage for vulnerable groups; Improving efficiency through integration; and Improved transparency, accountability and partnership. The ZHSRSP II further distinguishes between five categories of "priority health interventions" around which the health system is built and which the ongoing health sector reforms try to strengthen. These five priority health interventions constitute the core business of the health sector as a whole. DPs are expected to support this intervention framework and indicate how their contributions are aligned with it. The MoH&SW has developed an essential health care package, which stipulates a uniform package of services for each level of care.

The Zanzibar National HIV Strategic Plan July 2005 – June 2009 (ZNSP) guides the multi-sectoral response to HIV/AIDS.

Sector financing

The overall resource envelope for the public health sector in FY05/06 corresponded to around US$ 13 per capita, of which 63% was contributed by external sources, 1% from cost sharing and the remainder by RGOZ. For FY07/08 the RGOZ health budget has increased significantly in nominal terms. The share of overall government recurrent spending in the FY06/07 budget for the health sector at 8% fell short of the Abuja target of 15%.

In FY05/06 Danida was the largest bilateral donor in the health sector. Some national programmes have considerable external funding from vertical funding initiatives. The fragmentation of financing prevents a full and systematic analysis of the overall allocation of funds within the sector. External financing estimates for FY07/08 remain incomplete, but are expected to exceed 4.5 USD per capita.

The non-salary costs of the health sector continue to absorb only a small proportion of the total government budget (13%), of this amount health facilities receive only around 15%. Much of this goes to purchasing hospital food, leaving very little for primary level facilities.

The Health Service Fund (HSF), which has been instituted through HSPS, provides essential support to districts, hospitals and zonal offices. The absolute level of funding has more than doubled from TSh 306m in FY04/05 to TSh 700m in FY2007/08.

The 2007 Health Sector PER recommended several key actions including using the PER data to keep pressure on MoFEA for an increased share of the budget; allocating the OC budget according to the

same formula as HSF funding, and channelling it directly to the accounts at zonal level in order both to ensure that they are received and used by the districts and hospitals, and to demonstrate government commitment to the concept of a district basket for health services. This will strengthen the case for investment in such a basket by other partners.

Partner coordination

Most of the key development partners in Tanzania Mainland are not active in Zanzibar. Zanzibar has started to develop a coordination mechanism in the health sector. Biannual partner coordination meetings were introduced in 2005. The first Annual Health Sector Performance Report was presented at the AJHSR meeting in 2007. DPs also participate in four Technical Working Groups which operate under the stewardship of the Health Sector Reforms Secretariat.

The first review of the joint response to HIV/AIDS in Zanzibar was conducted in 2007 (covering 2004-2007).

Cross-cutting issues

Gender – With some of the health indicators stagnating, awareness of gender issues in relation to health is emerging among health service providers, programme managers and policy makers. Gender dimensions are considered in activity implementation. A plan of action has been developed to build capacity and promote gender mainstreaming in the various departments of the ministry and in the various national priority programmes. Efforts are underway to disaggregate health information according to gender, so as to detect and act upon gender imbalances.

Environment – Department of Public Health, MOH&SW, is responsible for health aspects of water, sanitation and environmental issues. Environmental health officers posted at health facilities have the task to oversee the health dimensions of the environment. Hospitals have a special responsibility to ensure that their clients find themselves in a clean and safe environment. The recommendations of a study to assess the environmental impact of the planned disposal of expired and unwanted pharmaceutical products in Zanzibar feed into the policy of the Pharmacy Department and in particular the Central Medical Stores to dispose of such products in a safe manner.

2.4. Summary of situation analysis – HIV/AIDS

Significance of the sector

HIV and AIDS in Tanzania poses a major threat to development. The adult prevalence rate is 6.5%, with large variations between regions as well as within regions. Prevalence rates are now decreasing. However, the prevalence rate is expected to increase in the future with scaled-up ARV treatment. Female adults (15-49) are 40% more at risk of being infected than males. As a result it is now widely recognised and accepted in Tanzania that gender issues need to be prioritised in any effective campaign.

In total around 1.4 million persons are infected, mostly adults aged 15-49 with 56% being women. Most HIV infected persons live in rural areas. Deaths due to HIV/AIDS are around 140,000 per year. The number of orphans is steadily increasing and is currently estimated around 950,000.

Prevention interventions have been credited with the success in reducing prevalence rates. STI services, Voluntary Counselling and Testing services, male condom availability and prevention of Mother to Child Transmission services have all increased. Government leadership for prevention is high Care and treatment is being scaled up rapidly, with approx. 130,000 adults on treatment by December 2007. Care and support services to the community and household level are being expanded, including provision of Home-based Care and interventions for Most Vulnerable Children (MVC).

An important challenge in Tanzania hampering the rapid scale-up of priority interventions is the lack of human resources, in terms of quality and quantity, for service delivery, particularly in the health sector.

Institutional set-up/structure of the sector

The Tanzania AIDS Commission (TACAIDS), reporting to the Prime Minister's Office, is mandated to provide strategic leadership and coordinate and strengthen the multisectoral response to HIV/AIDS. Capacity of TACAIDS staff at headquarters remains insufficient both in absolute numbers and in quality. TACAIDS has recently undertaken an internal review and is currently awaiting approval by the Ministry of Public Service of a restructuring exercise, which would create a number of additional units.

The MOHSW is in charge of the health sector response to HIV. Its Social Welfare Department coordinates interventions for people affected by HIV and AIDS (PLHIV) and MVCs.

TACAIDS coordinates mainstreaming into the public sector, private sector and civil society. HIV and AIDS Focal Points (FPs) have been appointed in all MDAs and Technical AIDS Committees (TACs) have been established. Many focal points lack support, materials and financial resources.

There is no TACAIDS structure at regional level. Instead, within each Regional Administrative Secretariat a Focal Point for the multisectoral HIV and AIDS response has been appointed, mostly the Regional Community Development Officer. The FP is mandated to coordinate, supervise and facilitate support to districts. Evidence suggests that the Regions are insufficiently staffed and equipped to meet their obligations. In 2005 TACAIDS contracted 11 agencies to act as Regional Facilitating Agencies (RFAs), to support the LGAs in planning and managing the response and to provide grants to civil society organisations. Experience with the RFAs has varied a lot.TACAIDS is now proposing to create its own regional structure: Regional TACAIDS Offices to be based within the RAS, initially consisting of 1 officer per region.

At district level, responsibility for implementing the multisectoral response lies with the LGA, assisted by the Council Multisectoral AIDS Committee (CMAC) supported by a Technical Aids Committee (TAC). CMACs include representatives from the LGA, religious groups, youth, PLHIV and NGOs. District level performance varies considerably. The CMAC is cascaded down to the ward and village level: Ward Multisectoral AIDS Committee (WMAC) and Village Multisectoral AIDS Committee (VMAC). WMACs have been established in all wards but VMACs not yet. Again, proactiveness of MACs varies widely.

TACAIDS and partners have developed a minimum interventions package to guide the LGAs in selecting the priority interventions to be implemented in their district. The current package, based on the NMSF priorities, is rather ambitious and restrictive.

Key sector policies, legislation and programmes

The principles of the Tanzanian response are laid out in the National HIV and AIDS Strategy of 2001. The policy for Tanzania mainland is defined in the National Multi-Sectoral Strategic Framework on HIV and AIDS for 2008 – 2012 (NMSF). The health sector response is defined in the Health Sector HIV and AIDS Strategic Plan 2008-2012. MOHSW and partners developed the National Costed Plan of Action for Most Vulnerable Children 2007-2010. The HIV and AIDS (prevention and control) Act was passed in 2008.

Sector financing

Currently, much of the funding for HIV and AIDS is earmarked for specific projects, difficult to coordinate, slow to disburse and unpredictable in volume. A recent external PER found that external financing for the sector is growing rapidly, but is fragmented, projectised, and administratively complex. Unpredictable timing and levels of disbursements weaken the ability of the GOT to budget accurately and appropriately respond to longer-term programming needs. TACAIDS and CIDA recognised this situation and created a system for thematic budget support for HIV and AIDS, the HIV Fund (now named the NSMF Grant), in 2006.

The MOHSW and TACAIDS accounted for over 97% of actual spending on HIV in 2005/06. TACAIDS accounts for 41% of GOT spending, mostly transfers to other MDAs, LGAs and other implementing parties. Only 16% of the annual GOT allocation goes to regions and districts. 64% of HIV spending is for care and support.

For district implementation, public funding is channelled to LGAs through PMO-RALG. Evidence suggests that LGAs have not fully utilised resources provided by the HIV Fund / NMSF Grant. Health-related HIV and AIDS expenditure at LGA level is mostly off budget. TACAIDS guidance on priorities for HIV and AIDS implementation has now been integrated into the LGA annual budget guidelines.

Total spending on HIV and AIDS (GOT and donor) increased by 76% from 2005/06 to 2006/07. Most remarkable feature is the continued rapid growth in donor spending, mainly from off-budget sources of finance, and largely due to rising PEPFAR allocations, which doubled from 2006 to 2008.

Partner coordination

The HIV and AIDS response is a thematic area under JAST. The DPG-AIDS, supports the coordination of the HIV response. The Joint Technical Working Group on HIV and AIDS, which include representatives of TACAIDS, MDAs, DPs, civil society and other key stakeholders. DPs have signed a Memorandum of Understanding (MoU) with TACAIDS, in which they agree to support the NMSF. TACAIDS and DPs meet bimonthly as well as in the Biannual Joint Review to review performance of the HIV response in Tanzania mainland. The last Review took place in November 2008. Coordination of civil society active in HIV and AIDS in Tanzania is weak and civil society is fragmented.

Cross-cutting issues

Gender awareness of the particular factors making women more vulnerable to HIV has increased in the recent years, but there are still major issues/constraints for addressing gender equality in practice. Gender focal points have been established in all MDAs, regions and districts, but have limited capacity and budget.

In Zanzibar, HIV prevalence is much lower than on Tanzania mainland: prevalence among women attending ANC clinics has risen since 2002, but with 0.87% in 2005 it is well below the rate found in other countries in Sub-Saharan Africa. HIV prevalence rates among different sub-populations vary enormously confirming that Zanzibar has a concentrated epidemic. Zanzibar has its own HIV and AIDS Strategy, the Zanzibar National HIV Strategic Plan (ZNSP) 2005 - 2009. The Zanzibar AIDS Commission (ZAC) is in charge of coordinating the response.

3. Agreed assistance

3.1. Objectives

The overall aim for the Danish development assistance to Tanzania is to contribute to poverty reduction and to the achievements of the MDGs. The development objective for HSPS IV 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

This objective is in line with the Health Policies for Zanzibar (2002) and Tanzania Mainland (2007) and will support the overall broad outcome of Cluster Two of both the MKUKUTA and MKUZA.

The objectives of the Danish financial and technical assistance through HSPS IV corresponds to three inter-related and complementing objectives for the three sectors:

- To provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable and with focus on those most at risk an responsive to the needs of citizens in order to increased the life span
- To ensure equitable access to quality health services in Zanzibar, in particular at the district level and below and to encourage the health system to be more responsive to people's needs and demands
- To support the multi-sectoral response to HIV and AIDS in Tanzania through support to the implementation of the NMSF.

3.2. Strategic approach

The programme is designed in the context of the health sector SWAp and the results and experiences gained through more than a decade of Danish support to the development of the health sector in Tanzania. Further it is designed in line with the principles of Danish development aid and internationally agreed principles to which Denmark is signatory, most notably the Paris Declaration on Aid Effectiveness, the Accra Agenda of Action and the JAST. In accordance with overall Danish priorities an increased amount is allocated to the fight against HIV/AIDS.

The programme aims to enhance GOT's capacity to achieve the MDGs and the MKUKUTA/MKUZA objectives through the provision of comprehensive support to the health sector in Mainland and Zanzibar and the multi-sectoral response to HIV/AIDS. Furthermore, the programme (indirectly) supports key aspects of the implementation of the D-by-D policy and other public sector reform programmes in the health sector, e.g. the public financial management reforms.

The focus is on ensuring quality service delivery at district level and below and the strengthening of necessary central support and referral systems to support the lower levels. The strategic approach is to provide general support to implementation of the sector strategic plans at district, regional and central level supplemented by targeted support for systems strengthening and capacity building. Furthermore, since the private sector in the form of NGOs, FBOs or private for profit providers plays an important role in service delivery, efficient and equitable use of the constrained resources requires that the health sector is considered in its entirety, that the MOHSWs/TACAIDS are able to take on their stewardship roles in guiding the decision-makers at decentralised levels as well as in the collaboration with the private sector as regards provision of public health services and Public Private Partnership (PPP).

The capacity of the health systems in Mainland and Zanzibar and the multi-sectoral response to HIV/AIDS will be strengthened using a mix of modalities. The majority of the funding will be provided through joint financing arrangements to the implementation of national or organisational strategic plans. The financial support to general implementation of the sector strategic plans is supplemented by more targeted capacity strengthening through earmarked financing in specific intervention areas as well as by technical assistance.

Joint financing arrangements

The share of funding through joint financing arrangements will gradually increase over the programme period. The preferred modality of support is joint financing arrangements with government and other DPs, preferably in the form of sector budget support. In practice, the different sectors and sub-sectors are at very different stages of development of joint financing arrangements and any blueprints cannot be applied.

On the one hand is the HBF in Tanzania Mainland, which during its 8 years of existence has become increasingly aligned to GOT policies and procedures. With the new MOU of June 2008, the HBF mechanism basically corresponds to sector budget support. The HBF is planned, budgeted, implemented (including procurement), reported and (as of 2008) audited using GOT modalities and

procedures. The HBF is included in the MTEF and subject to Parliamentary control and priority setting.

At the other end, is the HSF in Zanzibar, which is a mechanism for providing un-earmarked support to the implementation of district health services. It is currently only supported by Danida, and the administration and overall accounting responsibilities rests with the Zanzibar HSPS Office, although accounts are prepared at zonal level. It thus has the nature of a pre-basket arrangement which is planned to evolve into a full-fledged basket during the HSPS IV programme period.

The NMSF Grant has already been established, but is experiencing some teething problems. GOT has decided initially to focus on making the NMSF Grant functional exclusively for transfers to district level.

Where joint financing arrangements are not yet established the programme aims at developing such mechanism. The programme aims to support capacity building and systems strengthening that will make the system more robust, improve performance and increase attractiveness of joint funding to other DPs.

In addition, joint funding arrangements will also be favoured whenever possible, when supporting private sector organisations. Examples are the planned joint funding by Danida, Cordaid and EED of the implementation of the CSSC strategic plan and the existing joint funding arrangements with other DPs for NGO support in the area of HIV/AIDS.

Earmarked support

While joint funding arrangements are generally well justified, it is also recognised that there may be areas where earmarking of funds has its justifications. Earmarking will secure funding for areas of crucial importance to the success of the implementation of the strategic plans, but where funding is scarce. This includes strengthening of capacity and systems that will contribute to increased effectiveness of the joint funding arrangements and thus enable continued and increased use of basket fund modalities by more DPs. Furthermore, access to flexible earmarked funds will enable MOHSWs, TACAIDS and partners to respond quickly and flexibly to arising needs and opportunities and particularly to support innovative activities.

A minor share of the total budget is therefore earmarked for specific areas of support, but provided as flexible funding to be detailed in the annual work plans and budgets as appropriate in response to needs at the time. There has been a consistent effort to maintain flexibility in both selection of activities and modalities. The needs are subject to change. Accordingly, the components themselves must seek a balance between being sufficiently tight to ensure focus, whilst sufficiently flexible to ensure responsiveness to the needs. Thus, funds are primarily committed to broad areas of work rather than to specific activities. This allows for true process management, as funds can be accessed for the activities required to advancing the process, whenever opportunities for innovation and progress present themselves.

The areas selected for earmarked funding are based on GOT needs and priorities and are areas where Danida has a comparative advantage, e.g. prior experience or considered preferred donor by government, or where such support is deemed more appropriate in terms of allowing innovation and experimentation. Within the health sector Mainland, DPs and MOHSW attempt to pursue a division of labour as regards focus of earmarked funding and policy dialogue. Danida has for example had a special role on Mainland with regard to drugs, hospital management, infrastructure, regional supportive level and district capacity building. The MOHSW has requested that Danida continue its support in the area of drugs, hospital management and strategic initiatives and further play a larger role in Public Private Partnership (PPP). On Zanzibar Danida has a special role in sector reforms, horizontal primary health

care, essential drugs and infrastructure. The Zanzibari MOH&SW has requested that Danida maintain and expand this role.

Technical assistance
Technical assistance is at present a non-pooled resource. Harmonisation and alignment could in future be further improved through pooling of technical assistance either by using part of the central basket for technical assistance or by establishing an independent TA pool that can also be used by non-basket DPs. The preparation of a National Technical Assistance Policy is however yet to take off. As the TA pool mechanisms is not yet in place a limited number of bilateral advisors is proposed, see below. In case a TA pool with financial contribution from individual DPs and engagement of TA by the MOHSWs or TACAIDS is established, some of the HSPS IV funding for TA may be transferred to such a pool. In addition, unallocated funds may be used to finance such a TA pool.

3.3. Brief narrative summary of programme

The programme objectives will be supported by at total grant amounting to DKK 910 million. The objectives will be addressed by providing support to:

1) Support to the health sector - Mainland
2) Support to the health sector – Zanzibar
3) Support to the multi-sectoral response to HIV/AIDS

Component 1 and 2 represent the continuation of HSPS III activities, whereas Component 3 is a new initiative. Each component contains three sub-components focusing around three types of intervention:

a) Un-earmarked support through (and development of) joint funding arrangements
b) Earmarked support for capacity strengthening of central level support to systems development, management and strategic initiatives
c) Support to PPP and private sector involvement

Component 1: Support to the health sector in Tanzania Mainland
The health sector in Tanzania Mainland will be supported by a total grant amounting to DKK 528 million (including contingencies). Firstly, general support to the implementation of the HSSP III will be provided through the HBF and the LGCDG Health Window (for infrastructure) and will introduce an element of pay for performance. The majority of this support will be channelled through the HBF mechanism, which as of 2008 corresponds to sector budget support. Secondly, earmarked support will be provided for health systems and capacity strengthening including strategic initiatives with focus on supporting the implementation of hospital reforms and strengthening of the drug chain from policy level to end user. Finally, earmarked support will be provided for strengthening the non-governmental health sector and public private partnership with a view to provision of public health services.

Component 2: Support to the health sector in Zanzibar
The health sector in Zanzibar will be supported with a grant amounting to DKK 120 million (including contingencies). Firstly, unearmarked support to the implementation of district health services against district health plans will be provided through the HSF. The allocation to HSF may grow if RGOZ starts making its own contribution and if other DPs join the HSF. The HSF will include a performance based element in the district allocation formula. Secondly, earmarked support will be provided for selected central level activities for systems development, management and strategic interventions. The majority of the support will be provided in the area of Procurement and supply management of pharmaceutical products, maintenance and ICT. The other selected intervention areas are Human resource management and development, Quality assurance, Health promotion, HMIS, Health financing

and sector performance monitoring, Strategic Initiatives. Finally, earmarked support will be provided to support NGOs, in particular professional associations, and public private partnerships.

Component 3: Support to the multi-sectoral response to HIV/AIDS

The multi-sectoral response to HIV and AIDS will be supported with a grant amounting to DKK 220 million (excluding contingencies and unallocated funds). Firstly, unearmarked support to the implementation of the NMSF will be provided through the NMSF Grant for a harmonised support to the HIV/AIDS response provided that certain pre-conditions are met. Secondly, earmarked support will be provided for institutional capacity building of TACAIDS, including support to the development of a capacity building unit in TACAIDS, support to capacity building of TACAIDS regional offices and support for infrastructure development in the form of a new or rehabilitated office for TACAIDS. Finally, support will be provided to support non-government sector capacity for NMSF implementation in the form of continued support to some of the NGOs previously supported by Danida and in the form of support to strategic initiatives.

The three components in combination is relevant for achieving the health related MDGs for the Union of Tanzania. Support to strengthening of the health sector is needed in both Mainland and Zanzibar. There are many determinants of health outside the health sector, which it goes beyond this programme to address. However, progress on halting the AIDS epidemic, in particular, requires interventions of multi-sectoral nature to complement the health sector activities. Although the sectors covered by the three components are very different, e.g. in size (Zanzibar small), complexity (multi-sectoral), systems capacity and financing arrangements, experiences can be shared and lessons learnt from the implementation across components, e.g. on joint funding arrangements, concrete pilot interventions etc.

3.4. Capacity development support

The implementation of the HSSPs will require long term technical assistance for institutional capacity building as well as short term targeted technical support through short term TA or consultancies. The unearmarked and earmarked support for activities will therefore be supplemented by technical assistance to capacity building in key areas for implementation of the sector strategic plans.

HSPS IV includes funding for a total of 8 long-term advisers and a Junior Professional Officer (JPO):

- Five advisers (Hospital Reforms, Pharmaceutical Services, PPP, Health Policy, Planning & Management, Public Financial Management) will be provided to assist the MOHSW, Mainland. The latter may after agreement be lent out for limited technical support to TACAIDS.
- Two advisers (Health, Human Resources) and a JPO will be provided to assist MOHSW, Zanzibar
- One adviser (Organisational Development) will be provided to assist TACAIDS

All advisers will work within MOHSWs and TACAIDS with designated counterparts. They will report to their head of department. The Senior Health Adviser in Zanzibar will head the HSPS Office. Counterpart institutions will bear the responsibility and be accountable for implementation of TA assisted interventions. The advisers will refer to the RDE as regards personnel administrative issues.

Funding for a total of 120 person months will be available for short term TA.

Counterpart departments/institutions will be involved in the drafting of TORs, identification and selection of short and long term advisers. Furthermore, counterparts will be responsible for development of and regular review of TOR and performance assessment of both long and short term TA.

In addition to the TA budget line under each component, a budget line at overall programme level includes funding for reviews and studies, training (e.g. fellowships), and financial management support.

3.5. Measures to address cross-cutting issues and priority themes

Gender – There are significant gender and other equality issues in health and HIV/AIDS. HSPS IV will support the implementation of the HSSP, the ZHSSP and the HIV/AIDS NMSF in which gender issues are integrated and which include interventions geared towards institutionalisation of gender approaches. In the present phase HSPS has supported the development of an action plan to build capacity and promote gender mainstreaming in the MOHSW in Zanzibar. For Mainland, the planned gender analysis for FY 2008/09 may present opportunities for addressing gender issues that may be eligible for earmarked funding in HSPS IV. Efforts are on-going in both Mainland and Zanzibar health sectors and in HIV/AIDs to disaggregate data according to gender, so as to allow detection of gender imbalances and targeted action address these. Gender issues are being addressed jointly by likeminded DPs through the policy dialogue in relation to the development of sector strategic plans, policies and their implementation. According to the agreed division of labour between DPs the RNE is presently the lead on gender issues in health on Mainland.

HIV/AIDS – The support for the multi-sectoral HIV/AIDS response is integrated into HSPS IV as a separate component. HSPS IV will, however, also be supporting HIV/AIDS activities indirectly, since activities financed by the MOHSW in Mainland under the HSSP are aligned with the NMSF and will therefore indirectly be supported through the basket funding.

Children and youth – There is a strong focus on MDGs in the MKUKUTA/MKUZA and inthe sector strategic plans (HSSP III, ZHSSP II and HIV/AIDS NMSF) especially on MDGs 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria). The general support to the implementation of the strategic plans contributes to the achievement of the MDG targets and priority objectives related to children and youth. The support to the NMSF Operational Plan will benefit prevention and mitigation interventions geared towards Most Vulnerable Children and Youth. Also, HIV edutainment campaigns are highly youth friendly.

Environment – No major environmental impact of HSPS IV is expected. HSPS IV will support the implementation of the HSSP, ZHSSP and NMSF, including environmental activities. Administration of hazardous waste is being guided by relevant policies and activities. In Mainland funding from the HBF will enable the MoHSW to assist the districts in improving pharmaceutical and waste management at district and health facility level. Furthermore the Danish earmarked financial support to drug management in the health sector will further support this. Safe disposal of expired drugs will be addressed in the health sector SWAP Forum in which the RDE participates actively. In Zanzibar, the implementation of the policy on disposal of expired and unwanted pharmaceutical in a safe manner is guided by recommendations by an environmental impact study of disposal of expired drugs funded by HSPS in 2007.

The rehabilitation of primary health care facilities to be supported through the LGCDG Health Window in Mainland may improve environmental conditions, e.g. access to water and sanitation. Sanitation aspects are to some extent included in primary health care, but health education is an area in which further environmental opportunities may arise. Such opportunities, if they arise, can be promoted through policy dialogue and funding through the joint financing mechanisms.

Democratisation, good governance and human rights – The programme supports a rights-based approach to health services and HIV/AIDS prevention, care and mitigation in that it supports the GOT efforts to ensure equity and equal access. The protection of the rights of patients and vulnerable groups is included as a target in the MOHSW strategic plan, but may well be one of the areas at risk of being side-lined. In Mainland, earmarked funding under HSPS III has supported studies and initiatives

in areas such as user fee exemptions and mental health. It is expected that such activities would still be eligible for earmarked funding under HSPS IV. Support to the HIV/AIDS NMSF will enable focus on the rights and special needs of women and children and poor communities. In all three components, the programme will both through the basket funds and through earmarked funding and TA support the development and strengthening of systems that will facilitate increased accountability and transparency in the sectors.

Private sector – The non-government health sector as well as NGOs working in HIV/AIDS will be supported through earmarked funding under all components. PPP will be addressed in all components.

RDE will raise cross-cutting issues in the policy dialogue with the MOHSWs in Mainland and Zanzibar and TACAIDS.

3.6. Coherence with national policies and other sector activities

HSPS IV is fully aligned with national policies, i.e. the MKUKUTA, MKUZA, the national health policies of Tanzania Mainland and Zanzibar, NMSF for HIV/AIDS, in terms of content, objectives, sector monitoring and indicators. Moreover Danida is supporting harmonisation efforts with respect to planning and budgeting, procurement, reviews, monitoring and evaluation of the health and HIV/AIDS sector development in the context of the SWAp. The support is in line with the JAST. The agreed division of labour between DPs within the sectors, together with expressed priorities of senior management in each sector, has guided the choice of intervention areas.

The objectives of the sector strategic plans (HSSP III, ZHSSP II, NMSF) reflect the objectives of the MKUKUTA/MKUZA and are guided by the pursuit of the MDGs to which Tanzania is committed. HSPS IV will support MDGs 1, 4, 5 and 6:

MDG	Target
MDG 1: Eradicate extreme poverty and hunger	Target 2: Reduce, by one half, the proportion of people who suffer from hunger from 1990 to 2015. Indicator 2 – % of under-weight children under 5 Indicator 3 - % of under-height children under 5
MDG 4: Reduce child mortality	Target 5: Reduce by two-thirds the under five mortality between 1990 and 2015. Indicator 1 - Infant mortality rate (per 1000 live births) Indicator 2 - Under five years mortality rate (per 1000 live births) Indicator 3 – Proportion of children vaccinated against measles
MDG 5: Improve maternal health	Target 6 Reduce maternal mortality by three quarters between 1990 and 2015: Indicator 1 – Maternal mortality rate (per 100,000 live births) Indicator 2 – Births attended by skilled health personnel
MDG 6: Combat HIV/AIDS, malaria and other diseases	Target 7: By 2015 halt and begin to reverse the spread of HIV/AIDS Indicator 1 – HIV and AIDS prevalence among adults Indicator 2 – Contraceptive use prevalence rate Target 8: By 2015, halt and begin to reverse the incidence of malaria and other major diseases Indicator 1 – Malaria prevalence rate (percentage of diagnosis) Indicator 2 - TB prevalence rate (per 100,000)

Sub-component 1.1 will address all four MDGs directly as the HSSP is guided by the MDG targets; Sub-component 1.3 will address the MDGs indirectly as the strengthening of the capacity of the private sector umbrella organisations and the PPP is expected to result in a more efficient operation of the private sector and increased collaboration in provision of public health services. Component 2 will address all four MDGs directly through Sub-component 2.1. Sub-component 2.2 and 2.3 will indirectly address all four MDGs through the focus on, i.a. systems strengthening and quality of care. Component 3 will contribute to MDG 6, target 7 directly and may indirectly affect target 8 by reducing opportunistic infections and incidence of TB and to MDG 4 by reducing mother to child transmission.

4. Overview of components

This chapter provides a brief overview over the 3 components. Detailed component descriptions can be found in Annex 1-3.

4.1. Component 1: Support to the health sector Mainland

Development objective	To provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable and with focus on those most at risk an responsive to the needs of citizens in order to increased the life span (NHP 2007)
Immediate objectives	1. To enable the health sector achieve its objectives for the HSSP III through contribution to the HBF. 2. To strengthen capacity and health systems with a focus on making policies work through -support to the implementation of the HSSP Referral Hospital Services Strategy by supporting the implementation of hospital reforms - support to the implementation of the strategic objectives regarding pharmaceuticals in HSSP III with a focus on strengthening capacity in the drug chain to ensure timely availability of affordable quality drugs with focus at the district level - to improve health services through support to strategic initiatives as and when relevant 3. To support the implementation of the HSSP Public Private Partnership Strategy with a focus on strengthening the relationship, collaboration and partnerships between public and private stakeholders in the health sector for increased coverage, equity and quality of health services.
Outputs	1.0 Progress on achievement of health sector objectives. 2.1 Improved hospital management capacity, governance arrangements and quality of care at the level of regional and district hospitals. 2.2 Drug chain strengthened and better able to deliver affordable quality drugs at the district level when needed. 2.3 Strategic initiatives have been taken and outputs have been achieved according to expectations specified in the planning of these initiatives. 3.1 Improved policies, regulation and actions fro private health sector involvement in the health sector, including institutional development and capacity building of MOHSW. 3.2 Improved relevance and functionality of PPP co-ordination fora, including institutional and capacity building of MOHSW, CSSC and APHFTA. 3.3 Improved PPP arrangements at zonal, regional and district level
Strategy/sub-components	Sub-component 1.1 General support to the implementation of the HSSP through the Health Basket Fund and the Local Government Capital Development Grant - Health Window About 80% of the funding will be provided as unearmarked support to the implementation of the HSSP through the HBF and the LGCDG Health Window (for infrastructure). Sub-component 1.2 Support to health systems development and capacity strengthening HSPS IV will support hospital reforms including its supportive structures with focus on systems development and capacity building at national, district, and in particular the regional levels. A phased approach will be adopted. The initial focus will be on strengthening of the national level to lead the reforms, and on strengthening the accountability and governance at the regional level through the establishment and development of functioning hospital boards, the implementation of financial management systems and strengthening hospital management capacity. Furthermore, taking point of departure in lessons learnt from recent successful initiatives in the Lake Zone few concrete initiatives to improve quality of services can be supported. A special review after 2 years will determine how to proceed HSPS IV will support the monitoring and managerial systems necessary for securing

<table>
<tr><td></td><td>essential drugs and supplies at all levels as well as the rational use of such provisions. Activities will aim at strengthening the entire drug chain in terms of the overall budget and flow of funds, the policy framework, guidelines and policy management, supply, the use of drugs and the supervision, monitoring and evaluation.
HSPS IV will provide continued financial and technical support to strategic initiatives that require speedy response to emerging problems and opportunities as they arise.

Sub-component 1.3 Support to strengthening the non-government health sector and public private partnership (PPP)
HSPS IV will assist in the evolution of PPP in the entire health sector (including private-for-profit) with respect to the provision of public health goods. Assistance will be given to capacity development (skills and systems) in MOHSW, CSSC, APHFTA and other relevant organisations with focus on institutional strengthening to improve the quality of the policy dialogue and on facilitating participation of the private sector in provision of public health goods of good quality. The latter will involve capacity building with regard to contractual arrangements (service agreements) as well as with regard to quality improvements, supervision and M&E. This may include support to selected NGOs for exploring mechanism for PPP.</td></tr>
<tr><td>Budget</td><td>
<table>
<tr><th></th><th>Mill DKK</th><th>Pct</th></tr>
<tr><td>1.1 Support to the health basket funds</td><td>416.5</td><td>80%</td></tr>
<tr><td>1.2 Support to capacity strengthening</td><td>50.0</td><td>9%</td></tr>
<tr><td>1.3 Support to PPP</td><td>25.0</td><td>5%</td></tr>
<tr><td>Technical assistance (short and long term)</td><td>28.5</td><td>5%</td></tr>
<tr><td>Administration</td><td>4.0</td><td>1%</td></tr>
<tr><td>Contingencies</td><td>4.0</td><td>-</td></tr>
<tr><td>Grand total</td><td>528.0</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>Technical assistance</td><td>Long term TA will be provided to the Directorate of Hospital Services, MOHSW in the following areas corresponding to the Intervention Areas for earmarked funding:
• Hospital Reform Adviser (placed in the Hospital Reform Unit)
• Pharmaceutical Services Adviser (placed in the Pharmaceutical Services Unit)
• Public Private Partnership Adviser (placed in the PPP Unit)

In addition, the following long term TA will be provided to the Department of Policy and Planning, MOHSW:
• Health Policy, Planning & Management Adviser (placed in DPP)
• Public Financial Management Adviser (initial placement in the Budget Section)
Cf. Annex 1, Appendix 1-5 for draft job descriptions.

In addition, funding for 40 person month of short term technical assistance is available.</td></tr>
<tr><td>Management and organisation</td><td>The implementation of the unearmarked support is guided by an MOU between HBF partners. The objectives, outputs and activities for this component coincide with those defined by the HSSP III and operationalised in the annual MTEFs and CCHPs. Progress will be monitored using the sector-wide indicators and milestones developed for the HSSP III by MOHSW and PMO-RALG and agreed by SWAp and HBF partners. The sector policy dialogue will remain an important activity. The same principles cover the LGCDG Health Window.

For the Earmarked support a Steering Committee will be appointed for oversight and approval of annual budgets. The Head of the recipient institutions/organisation will be responsible for the implementation of relevant activities. The day-to-day management may be delegated to senior staff. There will be no separate HSPS management per se. Funding for the earmarked activities in MOHSW will be disbursed to a designated bank account in Bank of Tanzania (BOT). Use of funds will follow GOT procedures. MOHSW will be responsible</td></tr>
</table>

	for accounting.

4.2. Component 2: Support to health sector Zanzibar

Development objective	To improve the health status and well-being of the people of Zanzibar with a focus on those most at risk by ensuring equitable access to quality health services, in particular at the district level and below, and by encouraging the health system to be more responsive to people's needs and demands.
Immediate objectives	1. To create a sustainable financing mechanism that enables DHMTs and district level health facilities to perform their duties and provide quality health services. 2. To ensure that central sector support systems in the MOHSW are functional and supportive to the delivery of quality health services in both the public and private sector. 3. To encourage non-governmental parties to link supply and demand for quality health services, in particular at the level of local communities.
Outputs	*Summarised outputs (for detailed outputs, cf. the Component Description in Annex 2)* 1.1 Financing for district level health services ensured 1.2 Transformation of the HSF into the routine RGOZ budget and accounting system 2.1 Improved capacity for procurement and supply management of pharmaceutical products, maintenance and ICT 2.2 Human resource management and development strengthened 2.3 National framework for quality assurance developed and implemented 2.4 Improved capacity for health promotion at community level 2.5. Increased use of evidence-based decision-making 2.6 Improved health financing and sector performance monitoring 3.1 Stronger involvement of NGOs, in particular professional associations, promoting and protecting professionalism 3.2 Policy guidelines for PPP in the health sector, with an implementation framework and concrete instruments (e.g. standard service agreements)
Strategy	<u>Sub-component 1: Support to the HSF, as a precursor to harmonised sector budget support</u> While supporting the HSF, care will be taken to ensure that all funds are properly accounted for and that all accounts are audited on a regular basis. In the expectation that other partners will start channelling funds to the HSF, the current central level management and accounting system, which is ensured by the HSPS programme implementation unit, will at a certain stage be transferred and integrated into the Government financial and accounting system. HSPS will build the necessary capacity towards this end through training and technical support and a stepwise approach towards integration will be taken. Presently, accounts are prepared manually by zonal accountants and handed over to the HSPS accountant. It is planned to introduce computerised accounting for the HSF at the zonal level. The computerised system will be compatible with the government system, which will facilitate integration as and when the RGOZ system is decentalised to the Zonal level. Next step might be that MOHSW takes over the accounting responsibility for HSF funds from the HSPS accountant until sub-votes have been created for districts and zones and full integration can be completed. The level of integration and way forward will be an item for discussion during annual reviews. This will then turn the HSF into a modality for harmonised budget support for district health services. <u>Sub-component 2: Earmarked central sector support to systems development and strategic interventions</u> Two types of interventions fall under this sub-component:: <u>I. Procurement and supply management of pharmaceuticals and other products</u> A combination of strategies will be used to improve procurement and supply management of pharmaceuticals, equipment and other products. Focus will be on procurement of

pharmaceuticals, including procurement of right types and qualities in a timely manner, storage and distribution of pharmaceuticals and other supplies, rational prescription, system for maintenance of equipment and facilities, supported by a functioning ICT unit and adequate transport., a transport policy and a transport management information system

II. Capacity strengthening

Capacity strengthening covers a broad range of activities:

With regard to human resources for health, HSPS will employ a combination of strategies and modalities to support pre-service training, recruitment, rational staff deployment, in-service training, retention and modern human resource management for improved staff productivity and performance.

With regard to health promotion, HSPS proposes a three-pronged approach: (a) Support to implementation of the community health strategy, (b) Support to the design and implementation of a school health strategy with inputs from various national health programmes, and (c) Establish a health promotion common fund ('basket') with inputs from various national health programmes and development partners.

The approach of HSPS in support of informed decision-making in the health sector will consist of technical and financial assistance to the HMIS unit. This will be done firstly by further strengthening the capacity of designated HMIS officers, programme managers and service providers at all levels, mainly through training and by offering external technical expertise to strengthen the HMIS system itself. Secondly, the HSPS approach will be to encourage national health priority programme staff to participate in the periodic review of core indicators, instruments, guidelines and health information reports/bulletins; and to avoid any undue parallel data collection and reporting.

With regard to quality assurance, HSPS proposes a two-pronged approach to improve the quality of care: (a) support to focused initiatives to improve health outcomes in referral institutions; and (b) support to professional associations to promote and enforce quality of care, in both the public and the private sector. For the first approach, resources will be made available and technical support will be mobilised to address medical conditions and problem situations in a comprehensive manner.

The new HSPS will further have a provision to undertake and support strategic initiatives for strengthening health sector performance.

Sub-component 3: Support to NGOs and public-private partnerships.
For the second approach to quality assurance to be successful, firstly the roles and responsibilities of various actors need to be clarified. On the side of the Government, the mandates and resource base of the various Boards and Councils need to be clarified and reinforced (Private Hospitals Board, Food and Drugs Board; Medical Council, Nursing Council). On the side of NGOs, there is scope to reinforce the Zanzibar Nurses Association (ZANA), the Zanzibar Health Officers Association (ZHOA) and others, to fulfil their roles as protectors of professionalism. In view of the recent interest of external private parties in engaging in health service delivery, there is also a need for close monitoring and periodic critical-supportive reviews of the various innovations and unfolding public-private partnerships, with a view to informing national policy and exploring a possible scale-up of such initiatives.

Budget

	Mill DKK	Pct
2.1 Support to HSF	32.2	29
2.2 Support to central level support systems	55.2	48
2.3 Support to NGOs and PPP	2.6	2
Technical assistance (short and long term)	18.5	16
Administration	5.5	5

	Contingencies	6.0	-
	Grand total	120.0	100
Technical assistance	Long term TA will be provide to the MOHSW, Zanzibar: • Senior Health Adviser (placed in the Health Sector Reform Secretariat) • Human Resource Management and Quality Assurance Adviser (placed in the Human Resource Division) • Junior Professional Officer (placed in the Health Promotion Unit) Cf. Annex 2, Appendix 2-4 for detailed job descriptions. In addition, funding for 40 person month of short term technical assistance is available. Funding under the Administration budget line will allow for ad hoc financial systems advice in relation to future integration with GOT.		
Management and organisation	A Steering Committee for oversight and decision-making regarding the implementation of Component 2 will be appointed. The Zanzibar HSPS Office will be maintained with the Senior Health Adviser as team leader. Part of the support provided under HSPS IV will aim to strengthen the capacity in MOHSW in order allow phasing out of the HSPS Office. The Zanzibar component will continue to operate as a Decentralised Accounting Project as regards the earmarked funding. Initially, in a transition period, this will also be the case for the support to the HSF. A strategy for integration into government systems will be pursued in at least three areas: financial systems, procurement systems and sector performance monitoring and review. HSPS will continue to support and work in very close conjunction with the Health Sector Reform Secretariat, including its various technical working groups.		

4.3. Component 3: Support to the multi-sectoral response to HIV/AIDS

Development objective	Tanzania united in its efforst to reduce the spread of HIV and to provide the best available care for those infected and affected by the virus within a human rights and empowerment framework
Immediate objective	To support the multi-sectoral response to HIV and AIDS in Tanzania through the implementation of the NMSF
Outputs	1. NMSF operationalised through thematic budget support. 2. Institutional development and capacity of TACAIDS strengthened for effective coordination of NMSF implementation 3. Non-government sector capacity for NMSF implementation strengthened
Strategy/Sub-components	<u>Sub-component 3.1: Support to NMSF implementation.</u> Danida will channel half of its support under Component 3 through the NMSF Grant, a mechanism for thematic budget support, to benefit non-medical priority areas at district level within the NMSF Operational Plan. The Grant is a joint arrangement with other DPs, presently CIDA. Details of the mechanism, including an MoU, are to be developed in the first half of 2009. Danida will be able to start using the NMSF Grant once the mechanism for the modality has been mutually agreed upon. Allocation of funds from the NMSF Grant will be decided yearly during the annual planning exercise of the NMSF Annual Operational Plan / MTEF. Progress will be monitored using NMSF indicators and milestones and agreed by TACAIDS and DPs. <u>Sub-component 3.2: Support to institutional development and capacity of TACAIDS for effective coordination of the NMSF implementation</u> Danida will support institutional development and capacity of TACAIDS at central and regional levels in close coordination and collaboration with other Development Partners. At central level, Danida will support the establishment of the TACAIDS Capacity Building Unit (within the National Response Division) by providing earmarked funds for

<table>
<tr><td></td><td>organisational development activities identified in the NMSF Annual Operational Plan. Priority areas for support may include M&E, Gender focus and financial management. The mechanism to provide this earmarked support could in future include funding through a joint pool for Technical Assistance / Technical Support.

Danida will also provide a long-term Technical Adviser (Organisational Development Adviser) to assist with the establishment of the Capacity Building Unit, the coordination of capacity development support for central and regional offices and with the coordination of short-term technical assistance to all TACAIDS Divisions and Units.

Furthermore Danida will support the construction and refurbishment of a new TACAIDS Headquarter Offices in Dar es Salaam.

<u>Sub-component 3.3 Support to non-government sector capacity for NMSF implementation</u>
Danida will support non-government initiatives, where they are strategic and/or innovative and where they are delivered through joint mechanisms with other Development Partners. Support to civil society will include assistance to the Rapid Funding Envelope, a Grant Mechanism for CSOs and NGOs, as well as to Femina-HIP for production of innovative edutainment products used by a broad group of actors.</td></tr>
<tr><td>Budget</td><td><table>
<tr><th></th><th>Mill DKK</th><th>Pct</th></tr>
<tr><td>3.1 Support to NMSF Grant</td><td>100.0</td><td>48</td></tr>
<tr><td>3.2 Support to Capacity building TACAIDS</td><td>50.0</td><td>24</td></tr>
<tr><td>3.3 Support to non-government sector</td><td>50.0</td><td>24</td></tr>
<tr><td>Technical assistance (short and long term)</td><td>8.5</td><td>4</td></tr>
<tr><td>Administration</td><td>1.5</td><td>1</td></tr>
<tr><td>Contingencies</td><td>10.0</td><td>-</td></tr>
<tr><td>Grand total</td><td>220.0</td><td>100</td></tr>
</table></td></tr>
<tr><td>Technical assistance</td><td>Long term TA will be provide to the TACAIDS in the following area:
• Organisational Development Adviser
Cf. Annex 3, Appendix 2 for detailed job descriptions.

In addition, funding for 40 person month of short term technical assistance is available. The Financial Management Adviser placed in MOHSW Mainland will be available for limited support.</td></tr>
<tr><td>Implementation arrangements</td><td>The implementation of the unearmarked support will be guided by an MOU between NMSF Grant partners and TACAIDS. The objectives, outputs and activities for this component coincide with those defined by the NMSF and operationalised in annual operational plans. Progress will be monitored using agreed indicators and milestones developed for the NMSF. The policy dialogue will be an important activity. In the medium term Danida will consider the possibility of entering into silent partnership with another DP.

For the earmarked support it is envisaged to use the Joint Thematic Working Group on HIV and AIDS for oversight and approval of budgets for both support to the NMSF Grant and capacity strengthening of TACAIDS. The Head of the recipient organisations will be responsible for the implementation of activities. Day-to-day management may be delegated to senior staff.

Funding for the earmarked activities in TACAIDS will be disbursed to a designated bank account in Bank of Tanzania (BOT). The use of funds will follow GOT procedures. TACAIDS will be responsible for the accounting. If and when the NMSF Grant can be used for central level support, Danida will assess the possibility of using the NMSF Grant for channelling the support to TACAIDS capacity strengthening..</td></tr>
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5. Budget

Under HSPS IV Danida will support the Union Republic of Tanzania for the five year period July 2009 to June 2014 with a grant of up to 910 million DKK, cf. Table 1.

Table 1. Overview over indicative budget distribution

	Amounts	Percentage distribution	
	Millions of DKK	within components	between components
Component 1: Support to the health sector Mainland			
1.1 Support to the health basket funds	416.5	80%	
1.2 Support to Capacity strengthening	50.0	9%	
1.3 Support to PPP	25.0	5%	
Technical assistance (short and long term)	28.5	5%	
Administration	4.0	1%	
Contingencies	4.0	-	
Total - Component 1	528.0	100%	58%
Component 2: Support to the health sector Zanzibar			
2.1 Support to the Health Services Fund	32.2	28%	
2.2 Support to central level support systems	55.2	48%	
2.3 Support to NGOs and PPP	2.6	2%	
Technical assistance (short and long term)	18.5	16%	
Administration	5.5	5%	
Contingencies	6.0	-	
Total - Component 2	120.0	100%	13%
Component 3: Support to the HIV/AIDS multi-sectoral response			
3.1 Support to the NMSF Grant	100.0	48%	
3.2 Support to Capacity strengthening of TACAIDS	50.0	24%	
3.3 Support to non-government sector	50.0	24%	
Technical assistance (short and long term)	8.5	4%	
Administration	1.5	1%	
Contingencies	10.0	-	
Total - Component 3	220.0	100%	23%
Reviews, studies, etc.	10.0		1%
Unallocated funds	32.0		4%
GRAND TOTAL	910.0		100%

The majority of funding is channelled through joint funding arrangements (1.1, parts of 1.3 (support to CSSC), 2.1, 3.1, 3.3), corresponding to 82%, 28% and 71% in Components 1, 2 and 3 respectively, or around 70% of the total budget excluding unallocated funds.

Reallocation between budget lines within the components is possible subject to approval by RDE. The budget lines for TA can, if need be, be used for necessary start up cost for equipment for the TAs. The budget line for Programme reviews and audits, cross-cutting seminars and training activities (e.g. fellowships) is administrated by the RDE.

Unallocated funds to the tune of 32 million DKK is available under the overall programme budget. The unallocated funds may be used for activities across components or to unforeseen major initiatives of strategic importance within the components. Such initiatives and activities should be within the

development objective of the overall programme and such that cannot easily be accommodated within the existing component budgets.

The Steering Committee under each Component may propose activities for funding and forward these to the RDE. The decision to approve or reject the proposal will be made by letter of exchange between the signatories to the overall programme, i.e. the Danish Ambassador and the PS of MOFEA after the signatories to the Components, i.e. the PSs of MOHSW Mainland, PMO-RALG Mainland, MOH&SW Zanzibar and the Executive Director of TACAIDS, have had the opportunity to comment[1]. Depending on the magnitude of the proposed funding, the proposal will have to go to Danida Copenhagen (Bilateral Chief) for final approval.

6. Overview of Implementation Arrangements

6.1. Management and Organisation

The MOHSWs in Mainland and Zanzibar and TACAIDS will be responsible for programme implementationm except for support provided through non-governmental organisations.

Oversight and decision-making

The three components will be managed separately. There will be no overall body for oversight of the programme.

For support provided through joint funding arrangements the joint oversight and decision-making structures will be used. The implementation arrangements will be governed by the agreements made in signed Memoranda of Understanding between DPs and relevant institutions.

For Component 1 and 2, a Steering Committee (SC) will be established to oversee the implementation of the earmarked support. The activities of the SCs will be kept to a minimum. Where earmarked funding is used in joint funding arrangements, e.g. for private sector organisations, the SC will be involved in the decision on the allocation, but the decision on use of funds will rest with the structures agreed among the partners contributing to the joint funding arrangement and stipulated in an MOU. The SC will receive a copy of plans and progress reports.

For Component 3 it is envisaged to use the Joint Thematic Working Group for HIV and AIDS for oversight and decision-making of the earmarked support. Under Component 3, the possibility of entering into silent partnerships with another DP will be explored during the programme period, as the NMSF Grant matures. Silent partnerships will also be considered in relation to joint support to NGOs.

Day to day management

The day to day management may be delegated to senior staff of the responsible organisation with direct responsibilities for coordination and implementation of activities. The responsibility for daily management of the implementation should be delegated to the units that would normally be responsible for implementation of such activities.

There will be no HSPS management structure per se in Component 1 and 3.

The PS/MOHSW Mainland may prefer to appoint a HSPS focal point/coordinator in a transition period (e.g. 6 months) who will be tasked with facilitating that management responsibilities are acknowledged by the implementing Units and assist in instilling good management practices.

[1] I.e. the RDE will send the proposals for comments within a specified period. No comments before the deadline will be taken for no objection.

The HSPS Office in Zanzibar that was established in HSPS III will be maintained with the Senior Health Adviser as team leader. The management capacity within the MOHSW is limited. Part of the support provided under HSPS IV will aim to strengthen the capacity of MOHSW in order to allow phasing out of the HSPS Office. In the meantime, the Zanzibar Component will technically operate as a decentralised accounting project as regards earmarked funding. The responsibilities regarding the HSF is expected to be handed over to RGOZ as it develops into a basket fund arrangement.

Technical assistance
The need and scope for TA will be jointly assessed as part of sector reviews and will be coordinated with other donors.

Except for the Senior Health Adviser in Zanzibar who heads the HSPS Office, the advisors will in general have only limited Danida programme management tasks unless delegated so by their head of department. The Health Policy, Planning and Management Adviser and the Public Financial Management Adviser in Mainland will provide some limited assistance to the SC and regarding preparation of budgets, accounts and audits for the earmarked support.

The advisers will relate to RDE for personnel administrative issues. The advisers will not represent Danida or RDE unless specifically requested to do so. The advisers are expected to participate in regular mutual briefings with RDE. The advisers are expected to inform RDE on major developments that will hamper the implementation of the programme.

6.2. Financial management and procurement

As far as possible, financial management of the programme will be aligned with national structures and procedures. The text below attempts to outline the general principles, the details may be found in the Component Descriptions in Annex 1 to 3.

A short Procedures Manual for the implementation of HSPS IV earmarked programme activities, including an Accounting Manual or a reference to the GOT Accounting Manual to be followed, will be developed for each component prior to the start of HSPS IV or within the 1st semester. The Procedures and Accounting Manuals will be approved in the first meeting of the relevant SCs.

Joint Funding Arrangements
For Joint Funding Arrangements, e.g. HBF, LGCDG, NMSF Grant, RFE, Hip-Femina, the mechanisms for flow of funds, financial management and procurement will follow the agreements of the latest MOU to which RDE is signatory. For any joint funding arrangements that emerge during the programme period and which Danida will join, e.g. HSF, CSSC, RDE will participate in the development of an MOU.

Earmarked support
Prior to entering into an agreement with a non-government institution/organisation, an assessment of its financial management systems and capacity to meet Danida requirements should be made available to RDE. An MOU will be developed, which include management agreements, i.a. on financial management and reporting.

Planning and budgeting – Before the start of each year, each department/organisation is responsible for developing an annual work plan and budget (based on their 5-Year Strategic Plans) and for GOT institutions these should be fully integrated in the MTEF. The RDE will notify the MOHSWs, TACAIDS and other implementing agencies well in advance of the total earmarked funding available for the next FY. For government institutions, the planning and budgeting for the earmarked funds should follow the normal government procedures and time lines for development of work plans and budgets and be an integral part of the planning exercise for GOT funding. Where non-government organisations are implementing agents, a similar process will be followed, i.e. the recipient agency will

develop yearly work plans and budgets in line with their own strategic plans and as an integral part of planning for their total resource envelope. The work plans and budgets will be reviewed and approved by the relevant SC.

Disbursement and flow of funds – RDE will disburse funds half-yearly against approved annual work plans on request from the recipient organisation unless otherwise agreed. For MOHSW Mainland, funds will be transferred from RDE through the MOFEA to MOHSW and deposited in a designated bank account in BOT. Disbursements will depend on financial reporting on previous periods. Government mechanisms for onwards disbursement will be used. A similar procedure will be used for funding to TACAIDS.

The Zanzibar component will be run as a decentralised accounting project and the RDE will disburse funds into a separate HSPS account. The HSPS Zanzibar programme management (SHA and counterpart) will be responsible for the onwards disbursement.

Where a private sector implementing agency has been agreed upon, e.g. CSSC and Femina-HIP, the RDE will disburse directly to the joint funding mechanism of the implementing agency against approved annual work plans and budgets and according to a contract to be entered between RDE and the implementing agency. Disbursements will depend on financial reporting on previous periods. The implementing agency will be responsible for ensuring timely onward disbursement.

Procurement – For government institutions on Mainland, procurement will follow GOT procedures, unless otherwise specified in the Procedures Manual. For non-government implementers procurement will follow the procedures agreed in MOUs with non-government implementers. Procurement procedures on Zanzibar are different. They will be specified in the Procedures Manual. In the beginning a combination of procedures will be used, RGOZ procedures, Danida procedures and using a procurement agent.

For international TA contracted through Danida Copenhagen, Danida's procedures and regulations will apply. Payment will be made directly by Danida in Copenhagen to the advisers and consultant according to a contract between these parties. Goods and services paid for directly by Danida are considered to be grant-in-kind assistance. Should a TA pool be established, then procurement of TA will follow the rules agreed between partners.

Accounting and auditing – HSPS Component 2 will be run as a project with decentralised accounting, similar to the set-up in the previous phase (HSPS Phase III, expiring in June 2009). This implies that the programme management will be directly accountable to Danida and that there will be a specific accounting system for HSPS Component 2. However, it is foreseen that there will be a successive integration in the GRZ financial system.

Otherwise, the recipient organisation will be responsible for the management of funds, for timely accounting and financial reporting in accordance with agreed procedures. The Chart of Accounts will be compatible with the Chart of Accounts of the recipient institution in order to facilitate integration into the overall financial reporting.

The RDE will inform the implementing agencies about any direct payments for technical assistance and other items, that may have been booked by MOFA, Copenhagen, on the individual budget lines. Recipient organisations will prepare quarterly financial statements and submit these in a timely manner to Danida.

At the end of the financial year there will be an external audit of the earmarked support either by the National Audit Office (NAO) (e.g. TACAIDS or MOHSW) or if otherwise agreed, by a certified audit company of international standard appointed by the recipient institution/organisation (e.g. CSSC) and

approved by RDE. The audited financial reports including a management letter will be made available to Danida no later than 6 months after the end of the financial year.

6.3. Monitoring, reporting, reviews and evaluations

Monitoring mechanisms
Danida depends on the national monitoring and information systems to provide a reliable set of core indicators. Monitoring of HSPS IV will make use of several monitoring systems. Monitoring will follow the agreed joint monitoring systems (performance assessment framework indicators and milestones) for the HSSP III, HSRSP II and the NMSF respectively.

A set of indicators and milestones will be agreed with the private health sector organisations supported. Recipient organisations, e.g. MOHSW, CSSC, APHFTA will be responsible for monitoring and reporting on progress. The development in indicators and milestones will be a subject for discussion in annual review meetings.

Progress reporting and financial reporting
Recipient organisations, e.g. TACAIDS, MOHSWs, CSSC, APHFTA and others, will prepare quarterly financial statements and half-yearly progress reports on physical progress.

Joint Sector Reviews
Joint Annual Health Sector Reviews take place in Mainland and Zanzibar. Joint Bi-Annual HIV and AIDS Reviews are undertaken by TACAIDS and DPs. These will be comprehensive reviews of health outcomes/impact and performance indicators, medium-term plans for the sector and critical short-term achievements, and the agreed upon milestones. Independent technical reviews may be conducted prior to the full annual review. MOHSW and PMO-RALG in Mainland, MOHSW in Zanzibar and TACAIDS on the HIV/AIDS response will provide a report covering all indicators for this technical review. The findings of the technical review will feed into the Joint Review Meetings. The Review Meetings will conclude on the performance of the sector and appropriateness of forward allocation of GOT and DP resources. New critical short-term achievement targets or milestones will also be agreed at the end of these joint reviews.

Danida will, as far as possible, incorporate issues of special interest into the technical reviews and contribute with expertise resources to support the exercise.

Earmarked Funding
For those activities that will be financed with earmarked funds (sub-components 2 & 3 in all Components), which should be included in the annual plans of the recipient department/organisation, routine monitoring will primarily be based on processes and systems already agreed upon in the MoU for the joint funding arrangements, and in the component descriptions.

At least every second year a small bilateral review (1-2 days) by Danida and relevant partners (mainly MOHSW and non-government partners) focussing on the earmarked funding will be conducted back-to-back with the Joint Annual Health Sector Review Meetings in Mainland and Zanzibar. However after two years the Annual Programme Review of the Component 1 sub-components 2 and 3 will be replaced or preceded by an external review of the progress of sub-component 2 and 3. Otherwise such reviews will be kept to a minimum.

Back-to-back with the Joint Bi-Annual HIV and AIDS Review of the multi-sectoral HIV and AIDS response expected 2010 1nd 2012, Danida and TACAIDS will conduct a small bilateral review, (1-2 days) focussing on the earmarked funding. In years with no Bi-Annual Review Danida may field own bilateral programme reviews. Otherwise bilateral reviews will be kept to a minimum.

Evaluations
Danida will, if the need arises, carry out separate evaluations. Such a decision will be taken in consultation with TACAIDS, MOHSWs, PMO-RALG, private sector partners and DPs as relevant, in order to minimise the administrative burden on and maximise the benefits for the involved institutions. It is expected that independent evaluations as far as possible will be carried out jointly with DPs and GOT/GRZ and will not occur frequently.

Technical Assistance
Although recruited and paid for by Danida, the technical advisers will be based within Tanzanian institutions to whom they are accountable. In the process of recruitment and final revision of the TOR some indicators may be incorporated in the performance contracts of the Technical Advisers in order to facilitate the performance assessment. Technical advisers will be assessed each year by the counterpart institutions and the RDE, based on their TORs and mutually agreed work plans, including capacity building targets.

7. Assessment of key assumptions and risks

Commitment of management in implementing institutions/organisations
It is assumed that the present DP commitment to development in terms of direct financing or technical assistance will be sustained, and that DPs will continue to be committed to the SWAp approach.

The commitment of senior management in the implementing institution/organisation, e.g. TACAIDS, MOHSWs, agencies, PMORALG and LGAs, to the implementation of their strategic plans is crucial to the success of HSPS IV. It is assumed that the present general commitment to implementation of the Strategic Plans will continue.

The earmarked support is to a large extent focused on strengthening capacity in areas that are complex and at risk of being side-lined. Long term technical assistance will be provided in some of such complex areas. The commitment and interest from senior management in the recipient institution will be crucial for the success of this support. It is assumed that senior management is committed and that this will be reflected in the attention and resources dedicated to these areas.

Availability and efficient use of funding
An important assumption is that GOT and RGOZ will continue to prioritise poverty reduction and ensure adequate allocation of resources to health and the multi-sectoral response to HIV/AIDS using transparent resource allocation mechanisms. There is no doubt that, even with considerable support from GOT, RGOZ and DPs, the health sectors in Zanzibar and, in particular, Mainland is underfunded compared to its aspirations. In Mainland this is reflected in the funding gap of the HSSP III and the estimated cost of implementation of the MMAM. For HIV/AIDS the funding is growing rapidly but mainly for care and treatment, leaving the multi-sectoral response underfunded compared to visions. Furthermore, funding is fragmented, projectised, administratively complex and unpredictable.

There is a risk that this under funding and fragmentation will render attempts to improve the performance of the health system and the multi-sectoral response to HIV/AIDS ineffective. It is assumed that the GOT will continue to allocate sufficient resources to the health sector; will demonstrate a willingness to prioritise essential health care and multi-sectoral HIV/AIDS activities with focus on those most risk; and will pursue the realisation of efficiency gains.

Availability and efficient use of human resources
One of the major constraints to the implementation of the HSSP, the HSRSP and the NMSF has been shortage and poor distribution of health workers. The human resource shortage will remain a challenge, which is further exacerbated by the staff requirements for the response to HIV/AIDS. Despite recent

improvements, there is a risk that the human resource situation will not improve as required to keep pace with needs, thus hampering expansion of service.

This poses a risk for the achievement of the goals for the three strategic plans affecting also the performance on the poverty reduction strategies. Human resources is the most important resources for the health sectors as well as the HIV/AIDS response. It is assumed that government leadership will guide and support efforts to improve quality and number of human resources, distribution of human resources and management of human resources, encouraging productivity and performance of the staff.

As mitigation measure HSPS IV resources on Zanzibar are allocated to address human resource issues. On Mainland, basket funding and other DPs pay special attention to HR issues.

8. Implementation plan

The HSPS IV implementation plan and budget will be fully integrated into the annual action plans and budgets of the recipient institutions/organisations. There will therefore be no separate detailed implementation plan for HSPS IV.

Overview over timing over key planning and monitoring activities

Timing	Component 1	Component 2	Component 3
2009	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Annual Program Review	March to June: Approval of annual POA September: JAHSR + Annual Program Review	March to June: Approval of annual MTEF Optional Annual Programme Review
2010	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Optional Annual Program Review	March to June: Approval of annual POA September: JAHSR + Optional Annual Program Review	March to June: Approval of annual MTEF Bi-annual Joint Review + Annual Program Review
2011	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Annual Program Review Special Review of earmarked support	March to June: Approval of annual POA September: JAHSR + Annual Program Review	March to June: Approval of annual MTEF Mid-term review of Danida HSPS IV Programme
2012	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Optional Annual Program Review	March to June: Approval of annual POA September: JAHSR + Optional Annual Program Review	March to June: Approval of annual MTEF Bi-annual Joint Review + Annual Program Review
2013	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Annual Program Review	March to June: Approval of annual POA September: JAHSR + Annual Program Review	March to June: Approval of annual MTEF Optional Annual Programme Review

Annexes

The HSPS IV consists of three components that are to be implemented in three sectors independently of each other. The main responsibility for implementation of each component rests with three different institutions and it has therefore been decided to develop separate component descriptions that can be used for reference by implementers in each of the three sectors. For easy reference the Component Descriptions are printed in three separate volumes.

Annex 1: Support to the health sector in Mainland (Component 1)

Annex 2: Support to the health sector in Zanzibar (Component 2)

Annex 3: Support to the multi-sectoral response to HIV/AIDS (Component 3)