Ministry of Foreign Affairs
Denmark

Government of Tanzania

United Republic of Tanzania

Health Sector Programme Support

HSPS IV (2009 – 2014)

Annex 1:

Support to the health sector in Mainland

Ref. No. 104.Tanzania.810-400-1

August, 2009

The SPS Document for HSPS IV consists of 4 volumes:

Main Programme Document
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)

This volume contains Annex 1 - the component description for Component 1: Support to the health sector in Mainland.

Table of Content

i. Acronyms and abbreviations

ADDO	Accredited Drug Distribution Outlet
AIDS	Acquired Immuno – Deficiency Syndrome
ANC	Antenatal care
APHFTA	Association of Private Health Facilities in Tanzania
ARI	Acute respiratory infections
ART	Anti retroviral therapy
ARV	Anti retroviral drugs
BAKWATA	Baraza Kuu La Waislam Tanzania (The National Muslim Council Of Tanzania)
BFC	Basket Fund Committee
BOT	Bank of Tanzania
CAG	Controller and Accountant General
CBF	LDGD Common Basket Fund
CBO	Community Based Organisation
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CCHP	Comprehensive Council Health Plans
CCT	Christian Council of Tanzania
TEC	Tanzania Episcopal Conference
CFS	Consolidated Funds Services
CHF	Community Health Fund
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CMO	Chief Medical Officer
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
D by D	Decentralisation by Devolution
Danida	Danish International Development Agency
DDH	Designated District Hospital
DED	District Executive Director
DfID	UK Department for International Development
DHS	Department of Hospital Services
TDHS	Tanzania Demographic and Health Surveys
DKK	Danish kroner
DMO	District Medical Officer
DP	Development Partner
DPG	Development Partners Group
DPP	Department of Policy and Planning
EED	Evangelischer Entwicklungs Dienst
EHP	Essential Health Package
EPI	Expanded Programme on Immunization
EU	European Union
FAMS	Financial and Administrative Management System
FBO	Faith Based Organisation
FY	Fiscal Year
GBS	General Budget Support
GDP	Gross Domestic Product
GOT	Government of Tanzania
HBF	Health Basket Fund
HBS	Household Budget Survey
HFGC	Health Facility Governing Committee
HFSB	Health Facility Services Board

HIR	Health Information and Research
HIU	Health Information Unit
HIV	Human immunodeficiency virus
HPPMA	Hospital Policy, Planning & Management Adviser
HMIS	Health Management Information System
HMT	Hospital Management team
HRA	Hospital Reforms Adviser
HRD	Human Resources Development
HRH	Human Resource for Health
HRIS	Human resources Information System
HRS	Hospital Reform Secretariat
HRTF	Hospital Reform Task Force
HSDG	Health Sector Development Grant
HSPS	Health Sector Programme Support
HSR	Health Sector Reforms
HSPPR	Health Sector Performance Progress Report
HSRS	Health Sector Reform Secretariat
HSSP	Health Sector Strategic Plan
ICT	Information and Communication Technology
IEC	Information, Education and Communication
ILS	Integrated Logistics System
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rates
IMR	Infant mortality rate
ITN	Insecticide treated net
JAHSR	Joint Annual Health Sector Review
JAST	Joint Assistance Strategy Tanzania
JEHSR	Joint External Health Sector Review
JRF	Joint Rehabilitation Fund
LGA	Local Government Authority
LGCDG	Local Government Capital Development Grant
LGDG	Local Government Development Grant (previous LGCDG)
LGRP	Local Government Reform Programme
LSRP	Legal Sector Reform Programme
MCH	Maternal and Child Health
MDA	Ministries, Departments, Agencies
MDG	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (in English: Primary Health Services Development Programme)
MMM	MKUKUTA Monitoring Master Plan
MMR	Maternal mortality rate
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
NACP	National AIDS control programme
NACSAP	National Anti-Corruption Strategy and Action Plan
NAO	National Audit Office
NCD	Non Communicable diseases
NDP	National Drug Policy
NGO	Non Government Organization

NHA	National Health Accounts
NHIF	National Health Insurance Fund
NPPPSC	National Public Private Partnership Steering Committee
OC	Other Charges (non-salary recurrent expenditures)
PER	Public Expenditure Review
PFMA	Public Financial Management Adviser
PFM	Public Financial Management
PFMRP	Public Financial Management Reform Programme
PFP	Private for profit
PHC	Primary Health Care
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
POW	Programme of Work
PPM	Planned Preventive Maintenance
PPP	Public Private Partnership
PPPA	Public Private Partnership Adviser
PSA	Pharmaceutical Services Adviser
PSRP	Public Service Reforms Programme
PSU	Pharmaceutical Services Unit
QA	Quality Assurance
RAS	Regional Administration Secretariat
RDE	Royal Danish Embassy
RDU	Rational Drug Use
RHMT	Regional Health Management Teams
RMO	Regional Medical Officer
RRHT	Regional Referral Hospital Team
SBS	Sector Budget Support
SC	Steering Committee
SFA	Senior Financial Advisor
SHSA	Senior Health Systems Advisor
STI	Sexually transmitted infections
SWAp	Sector Wide Approach
TA	Technical Assistance
TACAIDS	Tanzania Aids Commission
TB	Tuberculosis
TC-SWAp	Technical Committee of the SWAp
TC-LGDG	Technical Committee of the Local Government Development Grant
TDHS	Tanzania Demographic and Health Survey
TEC	Tanzania Episcopal Conference
TFDA	Tanzania Food and Drugs Authority
TGNP	Tanzania Gender Network Programme
TGPSH	Tanzania Germany Programme to Support Health
TIFF	Tanzania Inter-Faith Forum
TOR	Terms of reference
TQIF	Tanzania Quality Improvement Framework
U5MR	Under five mortality rate
URT	Union Republic of Tanzania
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organisation

ii. Executive summary for HSPS IV

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.

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 HIV Fund 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 health basket funds	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%

iii. Cover page

Country	:	United Republic of Tanzania
Sector	:	Health
Title	:	Health Sector Programme Support, Phase IV
National Agency	:	Ministry of Health and Social Welfare; Prime Minister's Office for Regional Administration and Local Government
Duration	:	5 years
Starting Date	:	July 2009 – June 2014
Overall Budget	:	910 million DKK.
Overall Component Budget	:	528 million DKK. (excluding unallocated funds, but including contingencies)

Signatures:

Ministry of Health and Social Welfare - Mainland
Government of Tanzania

Prime Ministers Office for Regional Authorities and Local Government
Government of Tanzania

Royal Danish Embassy
Government of Denmark

1. Introduction

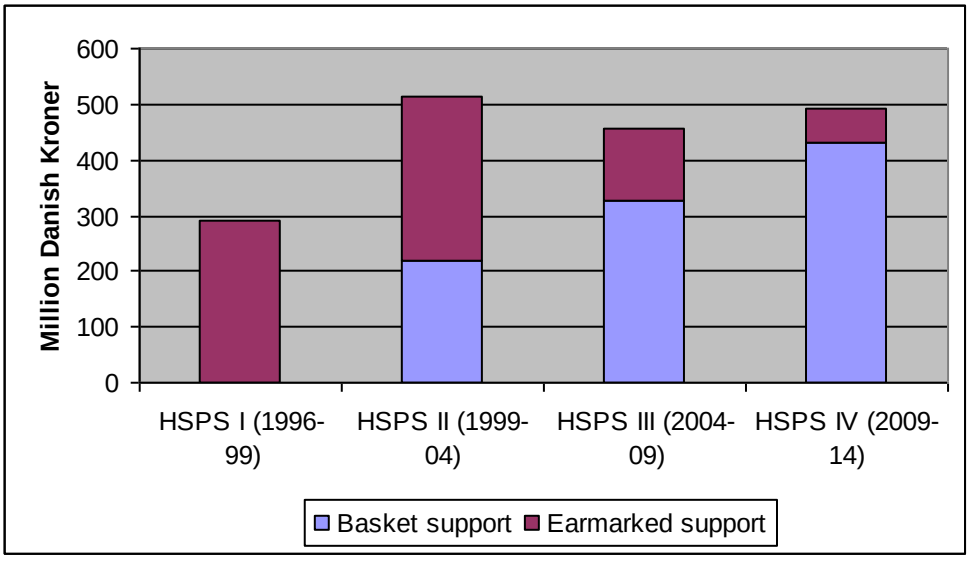
Denmark has supported the health sector in Tanzania for decades, traditionally being one of the largest donors in the sector. The Danish Health Sector Programme Support (HSPS) started with the HSPS I, in 1996-1999 comprising a total budget of DKK 290 million. This was followed by HSPS II (1999-2004) with a total budget of DKK 550 million. During HSPS II an increasing amount was allocated through a basket fund established together with DFID, WB, Switzerland, Netherlands, Germany and Ireland. 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, including a health service fund, drugs supply, rehabilitation and support for a number of central systems and capacity building. In Mainland, HSPS III support the implementation of the Second Health Sector Strategic Plan 2004-2009 (HSSP II) with the majority of funds (60%) channelled as basket support through three different baskets. The rest of the funds were earmarked for support to 1) Quality District Health Services in Tanzania Mainland including a) Demand driven district capacity building, b) Drug supply and use, c) Hospital Management Development, d) Support systems and e) Strategic initiatives.

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

The fourth phase of Danish support to the Tanzanian health sector 2009-2014 comprises a budget of DKK 910 million, which is an increase of more than 50% compared to the previous phase. 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 arrangements (around 80%).

Figure 1. Development in Danish support to health in Mainland Tanzania. Budget figures*.



* Excl. TA and administration which was not included in programme costs in all years.

With HSPS IV the trend in progressively increasing the un-earmarked support to Tanzania Mainland, cf. Figure 1, is continued. The second component continues to support the health sector in Zanzibar, and the third component provides support toward the national response to HIV/AIDS.

This programme document is the key reference document describing the agreement between all the parties involved in the HSPS IV. The document describes the programme's objectives, strategies, implementation modalities (including budget, activities, and programme management), monitoring and evaluation. Through the Government Agreement, the programme document is made a legal document and can be changed only according to agreed procedures.

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. The present Annex 1 describes Component 1: Support to the health sector in Mainland.

The present document is to a large extent based on joint documents, including the Joint External Health Sector Review 2007 (JEHSR) and the Generic Health Basket Fund Document 2008. See Appendix 7 for a list of key references.

2. Brief situation analysis: Sector context

2.1. National context[1]

The United Republic of Tanzania (URT) is a Union between Tanganyika and Zanzibar, which took place in 1964. URT has a projected population of close to 39 million in 2007, of which 1.1 million in Zanzibar. About 65% of the population is estimated to be below 25 years of age. Population growth has equalled 2.9% per year on Mainland and 3.1% in Zanzibar over the period 1988 to 2002.

The speed of health sector reforms and the health service delivery in the coming years will to a large extent depend on the overall political and socio-economic situation as well as on the implementation of overall strategies and reforms.

Macroeconomic situation

GDP per capita was USD 365 in 2007. The Tanzanian economy continues to perform well. Real GDP is estimated to have grown by 7.1% in 2007 compared to 6.7% the previous year and the medium-term prospects are strong (IMF 2008). The slow down since 2004 which was due to acute drought, energy shortages and hike in oil prices, seems to have reversed. The inflation rate has remained moderate and fairly stable around 7% p.a. in recent years. Inflationary pressure in first quarter of 2008 reflected change in international fuel and food prices. The full implication for Tanzania of the international financial crisis is not yet known.

Over the last five years, fiscal revenues have performed well, showing a steady growth since 2003, reaching an estimated 14% of GDP in FY06/07 (16% projected in FY07/08), mainly due to improvements in tax administration, reduction in tax exemptions and broadening of the tax base. Government spending has, however, also increased substantially reaching an estimated 24% of GDP in FY06/07 (projected 28% in FY07/08) – fuelled by increases in domestic revenues as well as in official development assistance and debt relief.

[1] This section to a large extent builds on the Joint Programme Document 2006 developed by GOT and DPs as part of the Joint Assistance Strategy as well as on the IMF Country Report No. 08/178 of June 2008.

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 makes Tanzania vulnerable to fluctuations in aid flows. A primary challenge for the monetary policy is management of large aid inflows and their potential impact on the exchange rate, interest rates and inflation rate – all of which could potentially impact on the health sector as the real value of domestic and foreign financing will be affected.

Poverty reduction

The macroeconomic growth has not yet translated into microeconomic development. This means that the poorest and most vulnerable groups do not benefit proportionally from the gains in economic performance. Incomes in Tanzania are low relative to the rest of Africa Between 1992 and 2007, the proportion of people living below the national poverty line fell from 39% in 1992, to 36% in 2001 and 33% in 2007. Poverty in Dar es Salaam showed the largest reduction from 28 to 16 %, however mainly in the period up to 2001 (18%), while in rural areas income poverty remained more or less unchanged with a decrease from 41% in 1992, to 39% in 2001 and 37% in 2007. Despite the decrease in the proportion of poor, the number of poor people is increasing as the reduction in the poverty ratio has not been sufficient to compensate for the population growth of 2.6% p.a..

Income inequality in Tanzania has remained low compared to other SSA countries and fairly stable (Gini coefficient 0.34 and 0.35 in 1991 and 2001), but with significant regional differences. Analysis combining HBS and census data[2] has produced poverty estimates at the district level for the first time. The rural poverty rates in districts vary from below 20% to above 50%. Poverty remains largely a rural phenomenon as 87 percent of the poor live in rural areas. Detailed data from the Household Budget Survey (HBS) 2007 is yet to be released. The long intervals between data is a problem for policy making.

The National Strategy for Growth and Reduction of Poverty, known as the MKUKUTA (Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania) was approved by Cabinet in February 2005 for implementation over five years and is the successor to the Poverty Reduction Strategy Paper. The MKUKUTA is informed by Tanzania's Vision 2025 and 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, disability, children, youth, elderly, employment and 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.

Based on the current trend the MDGs and MKUKUTA income-poverty target of reducing poverty to 19% by 2015 will be missed.

Public sector reforms

There are a number of on-going public sector reforms and programmes that will also affect the health sector. The reforms include the Local Government Reform Programme (LGRP), the Public Service Reform Programme (PSRP), the Public Financial Management Reform Programme (PFMRP), the Legal Sector Reform Programme (LSRP), the National Anti-Corruption Strategy and Action Plan (NACSAP), and for the RGoZ Economic and Financial Reforms, Institutional and Human Resource Reforms, and the Good Governance Reform.

[2] See "Poverty and Human Development Report 2005": http://www.tanzania.go.tz/pdf/PHDR%202005%20FINAL.pdf

Local Government Reform - Since 1994 Tanzania has embarked on a Local Government Reforms Programme (LGRP) with a view to decentralisation and deconcentration of government to achieve greater responsiveness and enhanced accountability. The aim of the reforms is to establish decentralisation by devolution (D-by-D). This implies that 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 Local Government Authorities (LGAs) doubled between 2000/01 and 2004/05 from Tsh 180bn to Tsh 360 bn. GOT through PMO-RALG, implements the Local Government Capital Development Grant (LGCDG) system[3], which provides discretionary funding to LGAs for rehabilitation and expansion of infrastructure. Over time the LGCDG is intended to become the mechanism through wich all development funds will be transferred to LGAs. GOT has committed itself to start a Window for Health in FY08/09. In 2005/6, new capital and capacity development funds at LGA level totalled Tsh 66 bn, of which Tsh 55 bn is discretionary.

The LGRP (July 2008 – June 2013) aims to eliminate the institutional, legal, organisational and operational bottlenecks to realisation of the D-by-D policy at all levels of government, and to improve collaboration with other ministries. Capacity building in LGAs will be stepped up and further fiscal decentralisation, decentralisation of human resource management and delegation of operational tasks from line ministries is planned..

Public Service Reform - Tanzania's Public Service Reform Programme is considered one of the best in Africa. However, present challenges in improving public service performance hinge on three areas: pay reform, streamlined planning and budgeting, and increased accountability. The Government wants to enhance the incentive structure to recruit and retain qualified personnel by continuing to undertake civil service pay reform and by further strengthening and extending the Performance Management System, which has been introduced under the PSRP. However, the pay reform has been slow and many public sector workers have to supplement their incomes from other sources. Poor pay has, among other things, resulted in a distorted wage structure with progressively increasing discretionary allowances. Weak planning systems have also contributed to poor performance and an inability to attribute results to public sector reforms. Accountability along the hierarchy of the public service, to Parliament and to the public is weak. In 2006, the Ministry of Finance, President's Office, Public Service Management and Ministry of Planning, Economy and Empowerment developed a strategic planning manual. The manual is a key first step to linking MKUKUTA to the budget at the level of Ministries, Departments and Agencies (MDAs). Developing guidelines to this manual and linking it to an accountability framework will deepen performance management in the public sector.

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.

[3] The name was recently changed to the Local Government Development Grant.

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.

Tanzania has elaborated the Integrated Financial Management System (IFMS), and has rolled it out throughout central government and parts of local government. Budget preparation has also progressed. Predictability of resources to the MDAs and the appropriate timing or resource transfers 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 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.

2.2. Significance of the sector[4]

Mortality trends –The infant mortality rate declined from 147 to 112 per 1000 live births between 1999 and 2005, while under five mortality rate decreased from 99 to 68 per 1000 live births (TDHS 2004-05). The neonatal mortality has not changed over the past decade though there was a small decline from the 1999 rates from 40 to 32 per 1000 live births. Factors influencing this positive trend include sustained high coverage of vaccination and increased coverage of effective interventions, e.g. vitamin A distribution. More effective prevention and treatment of malaria are likely to be important contributors to improved health, especially in reducing infant and under-five mortality. Analysis of infant mortality in the 1990s suggests a widening gap between the poorest and less poor. Maternal mortality is unchanged, and continues to be very high (578 per 100,000 live births) (TDHS 2004-05). Only 3% of babies are delivered by C-section, which suggests that many mothers with complicated pregnancies are not getting an essential maternal health service. Life expectancy at birth was estimated at 49 years during the population census in 2002. It is estimated that around half of all newborn babies are delivered by a health professional (HSPPR 07/08).

Morbidity pattern - Good progress has been made in preventing and treating malaria over the last three years with a large increase in the proportion of children under-five that sleep under an insecticide treated net (JEHSR 2007). Malaria, however, remains a serious significant public health problem. Two thirds of the adult population claim to have suffered from malaria in the previous year (Views of the People Survey 2007). Malaria is the leading factor for OPD attendances, followed by ARI, Pneumonia, Diarrhoea. Furthermore malaria is the number one cause of mortality in the general population and a major childhood killer, contributing more than 40% of death among U5s (HSPPR 06/07).

HIV/AIDS is a leading health, social and economic problem, affecting health, growth, quality of life and social well-being. About 6.5 % of the adult population (15 - 49 years) is HIV infected, corresponding to about 1.3 million adults. Women are more likely to be infected than men. There are large regional differences with urban residents having prevalence rates twice those in rural areas. Latest data show signs of a possible stabilisation of the epidemic. However, with successful introduction of Anti-retroviral Therapy (ART), overall prevalence will tend to rise as less people are dying. (cf. Comp 3)

Tuberculosis is a major cause of morbidity and mortality in Tanzania especially among adults, after HIV/AIDS and malaria. The treatment success has remained high – above 80% despite the dramatic increase in the workload to the health care providers and the overstretched health systems. The number of TB cases is beginning to show a declining trend.

Immunisation coverage is good. The IMCI strategy was adopted in 1996 as a key strategy for reduction of under-five mortality and was implemented by 94% of districts in 2005. Measles and DPT3 coverage increased from 76 and 79% in 1999 to 92 and 94% in 2006.

[4] Although improving, the HMIS data quality in terms of reliability and accuracy is a problem for point estimates as well as trends.

Although 95% of the pregnant mothers attend ANC services at least once, less half deliver in a health facility. Insufficient numbers of health facilities are equipped and staffed to standards for providing emergency obstetric care and many districts do not have a functional referral system.

With increasing life expectancy non-communicable diseases (NCD) are becoming more prominent, e.g. cancer, cardio-vascular diseases, nutritional disorders, diabetes, chronic respiratory diseases, dental problems and blindness. Mental disorders and substance abuse contribute significantly to the morbidity burden.

Nutrition - The fraction of chronically undernourished or stunted children declined from 44 % in 1999 to 38 % in 2004, which is still very high (UNICEF 2007). It is estimated that childhood malnutrition remains an underlying factor of almost 50 percent of under-five mortality. There are substantial urban-rural, regional and socio-economic differences. Rural poor children are more likely than their urban counterparts to die, and when they survive, they are more likely to be malnourished.

Environmental health issues - The proportion of the rural population with access to safe water remains low (47% in 2001). Data from MOHSW indicate a decline on cholera cases from 12, 919 in 2003 to 1,244 in 2005. For 2007 no cholera cases in Dar Es Salaam was reported. Government efforts over the last three years have been directed into strengthening of diseases surveillance, emergency preparedness, community awareness on hygiene promotion and addressing squatter settlement.

Distribution of health - Analysis of 2002 Census data shows considerable geographical variation in mortality rates. U5MR ranged from 58 in Arusha to 217 in Lindi. There are some geographic concentrations of districts which have a more general pattern of relatively poor indicators. Districts in the Southeast have the worst adult literacy rates, under five mortality rates and access to improved water. There is an increasing rural-urban divide, with pockets of poverty and ill-health in remote rural areas, where services are poor, people's capacities to improve their own health are minimal, and thus disease statistics are worse.

The HBSs 2000/01 and 2006/07 collected information on whether individuals had been ill or injured in the preceding four weeks. The proportions reporting illness did not change between the two HBSs. Individuals in rural areas are most likely to report having been ill or injured (28% of the rural population), compared to Dar es Salaam (19%) and other urban areas (24%). The highest rates of reported illness occurred in under-fives and older adults. Women reported higher levels of morbidity than men at all ages, with the exception of under-fives where boys have higher morbidity levels.

Access to and utilisation of health services – There are geographical and socio-economic inequalities in access to and utilisation of health services. Access to health care is constrained mainly by long distances to health facilities, poor road infrastructure, lack of transport and poor quality of services and sometimes non-availability of services. Most public dispensaries lack access to funds to provide appropriate services of reasonable quality. Financial access barriers in the form of formal and informal user fees and cost of transportation (if available) also exist.

In 2000/01, 75% of the population lived within 6 kms of a dispensary/health centre, and 32% lived within 6 kms of a hospital. However, 74% of the rural population had more than 10 kms to the nearest hospital. The mean distance to hospitals was 21 km. (Smithson 2005). Recently it was estimated that 90% of the population lives within 5 kms of a health facility. Only 10% are 10 kms from a health facility (MOHSW 2006; HSA). However, due to geographical barriers and difficulties for the sick and pregnant women to cover such a distance when services are needed, more facilities are still required. (MMAM 2007)

The HBS 2000/01 reports that over two-thirds of individuals who reported being ill or injured in the past four weeks said that they had consulted a health care provider of which approximately half a government provider. In 2006/07 the proportion who consulted a health care provider was inchanged.

Threre was a general increase in the proportion that consulted government facilities (from 55% to 65% in 2007). There are indications of a small increase in user satisfaction with government providers and fewer people reporting lack of drugs[5]. Individuals in Dar es Salaam are most likely to have consulted a health care provider, but two-thirds reported a consultation even in rural areas. The poor population has to travel longer distances to reach a hospital than non-poor and have less resources to pay for fees, transport and drugs. When ill or injured, the poor are less likely to consult a health provider and less likely to use a government provider than the non-poor population. HMIS data shows an increasing trend in OPD utilisation with and OPD utilisation rate of around 1 visit per capita in 2006 (HSPPR 06/07).

Significance of the sector - Tanzania is a poor country with high morbidity and mortality. Good health is a measure of people's well-being as well as an important asset. Tanzania's future development will depend not only on economic improvements, but also on a healthy and educated population to supply its labour force. Human capital development is a central strategy in the MKUKUTA. Health services are needed to develop and maintain improvements in health. Consequently, a key focus area is to develop an effective and equitable health sector.

Health services are, however, but one of many factors affecting health. The health sector therefore also has an important role in cross-sectoral initiatives to improve health, e.g. HIV/AIDS interventions, nutrition, water and sanitation, occupational health and safety, consumer health and safety etc.

2.3. Institutional set-up/structure of the sector

Service delivery system – A pyramidal referral system from dispensaries, health centres, district hospitals, regional hospitals up to referral hospitals are in place. In 2006, there were 5379 health facilities of which 4679 were dispensaries (SAM 2005-06). Faith-based organisations and for-profit private sector are part of the service delivery system. It is estimated that voluntary agencies run about 40% of all health facilities and provide 40% of hospital beds. The private sector also provide care in health centres and dispensaries, although to a lesser extent. The non-subsidised private sector has grown considerably, predominantly in urban areas.

It is estimated that the health sector employs about 65,000 health care workers. However, only 1,339 are physicians (including 445 in the private sector) (HSPPR06/07). About half of these are in Dar es Salaam Region, leaving 14 regions with 1 doctor or less per 100,000 population. The national average per 100,000 population is 4 doctors, 7 doctors/AMOs, and 38 nurses/midwives with a bias to Dar es Salaam and the more urbanised regions with referral services. In December 2006 MOHSW received permission to recruit additional 3890 health staff, of which 95% had been recruited by July 2007. Progress from LGAs on actual posting is awaited, but there are information that not all staff have reported at post or have left after short time. (HSPPR 06/07).

The human resources for health crisis is one of the most critical factors reducing the access to and delivery of health services. It is estimated that only around one third of all government posts are filled. GOT, FBO and private facilities compete for the same work force. In addition, the huge investment ART is also draining the little workforce available. The human resource for health crisis has received a lot of attention recently and both basket and project funds are increasingly geared towards this problem, at least as regards pre-service and in-service training.

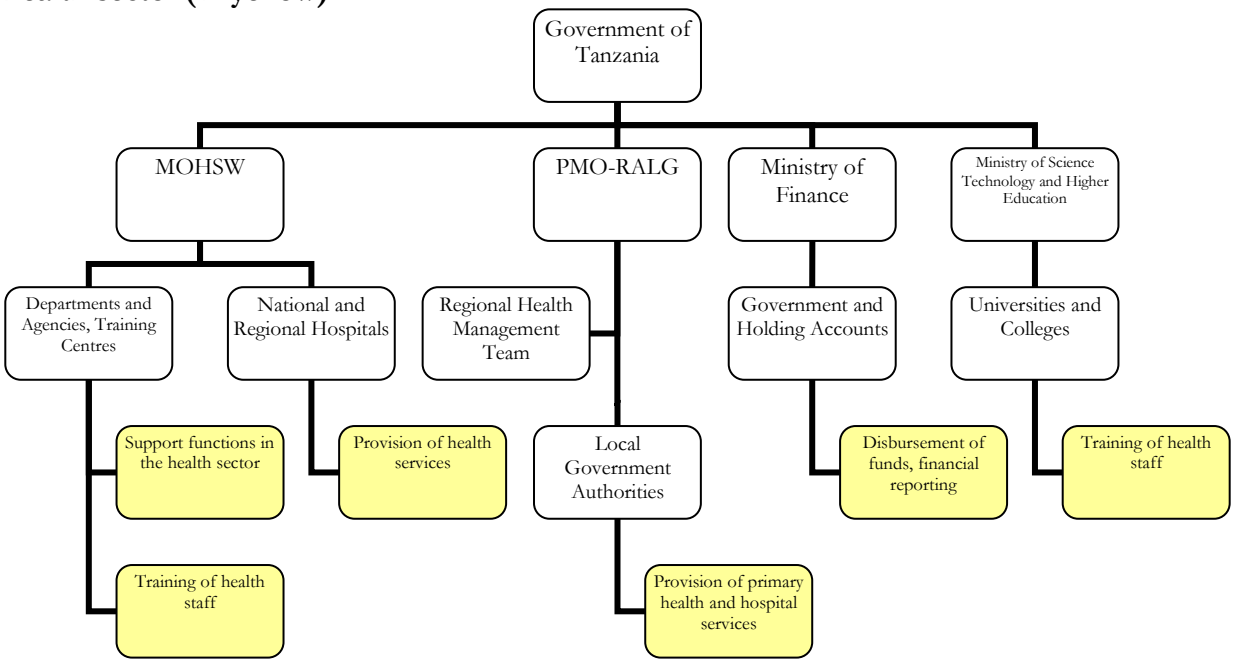
Government responsibilities – The health system is based on decentralised responsibility for service delivery to LGAs in line with the "D by D" policy of the government, cf. Figure 2.

[5] Should be seen in the context of a 200% increase in real spending for health over the same period!

The Council Health Management Teams (CHMTs) are responsible for council health services, including dispensaries, health centres and district hospitals. Councils now plan, budget and implement health care services for the communities that they serve. In the country there are 132 Councils, in districts, municipalities and towns and 21 Regions. The District Medical Officer (DMO) heads the CHMT and is accountable to the District Executive Director on administrative and managerial matters and to the Regional Medical Officer (RMO) on technical matters. In 1996 the Government decided to restructure the regional administration, giving more room for development of the Councils. Regions became facilitators, rather than implementers. In the devolution process the Regional Health Management Teams (RHMTs) became part of the Regional Administration, instead of the MOHSW.

At the national level, the MOHSW and PMO-RALG are jointly responsible for the delivery of public health services. The councils are overseen by PMO-RALG. At the national level laws, systems and guidelines are developed, helping LGAs to perform their tasks. The central MOHSW is responsible for policy formulation and the development of guidelines to facilitate policy implementation. The Office of the RAS under PMO-RALG interprets these policies and monitors their implementation in the districts they supervise using RHMTs.

Figure 2. Ministries Departments and Agencies and their responsibilities in relation to the health sector (in yellow)



Source: Generic HBF document 2008.

Private sector organisations – Private sector partners are coordinated by two major umbrella organisations. The Christian Social Services Commission (CSSC) represents a large number of Faith Based Organisations, from Catholic and Protestant background. These organisations have health institutions and health programmes all over the country. The Association of Private Health Facilities in Tanzania (APHFTA) represents a smaller number of private hospitals and clinics, mainly based in urban areas. A smaller umbrella organisation for Muslim agencies, BAKWATA, exists. Collaboration takes place within the Interfaith Forum, the secretariat of which is located with CSSC. The MOHSW chairs a PPP Steering Committee, in which representatives from the private sector. There is so far not

one overriding umbrella organisation for NGOs. A number of advocacy NGOs are involved in health issues, many from a human rights or a gender perspective.

2.4. Key sector policies, legislation and programmes

In Tanzania a coherent system of Government policies, strategies and programmes is emerging, giving direction to development. Consistency between general and sectoral policies is increasing. The health sector reform strategy aims at improving accessibility and quality of health services and improving health outcomes through decentralisation and deconcentration of government to achieve greater responsiveness and enhanced accountability.

National Health Policy

The MOHSW has formulated a new National Health Policy in 2007. The vision of the Government is to have a healthy society, with improved social well-being that will contribute effectively to personal development and the nation at large. The mission is to provide basic health services in accordance with geographical conditions, which are of acceptable standards, affordable and sustainable. The health services will focus on those most at risk and will satisfy the needs of the citizens in order to increase the lifespan of all Tanzanians.

Specifically the Government wants:

(i) To reduce morbidity and mortality in order to increase the lifespan of all Tanzanians by providing quality health care;
(ii) To ensure that basic health services are available and accessible;
(iii) To prevent and control communicable and non- communicable diseases;
(iv) To sensitize the citizens about the preventable diseases;
(v) To create awareness to individual citizen on his/her responsibility on his/her health and health of the family;
(vi) To improve partnership between public sector, private sector, religious institutions, civil society and community in provision of health services
(vii) To plan, train, and increase the number of competent health staff;
(viii) To identify and maintain the infrastructures and medical equipment; and
(ix) To review and evaluate health policy, guidelines, laws and standards for provision of health services.

Health Sector Reform

Health Sector Reforms (HSR) started in 1994 and aims at improvement of access, quality and efficiency of primary health (district level) services, as well as strengthening and reorientation of secondary and tertiary service delivery in support of primary health care. The programme also aims at strengthening of support services at the central level, in the MOHSW, it agencies and training institutions. The Sector Wide Approach (SWAp) is based on the Health Sector Strategic Plan (HSSP) which lay HSR activities down as a mechanism for sustainable relations with other service providers in health and the DPs.

The HSR Programme covers a wide range of dimensions: managerial reforms in decentralised health services; financial reforms relating to for example user-charges, health insurance and community health funds; public/private mix reforms, e.g. encouragement of private sector to complement public health services; organisational reforms e.g. integration of vertical health programmes into the general health services; health research reforms such as establishment of a health research users fund and promotion of demand oriented health research. In a later stage hospital reforms were added as element of the reforms, because the quality of hospital services was not improving in line with the sector reforms.

Health Sector Strategic Plan III (2009-2015)

The Health Sector Strategic Plan (HSSP) III maintains the emphasis on improved accessibility to district health services of good quality, but also with a view to the need for adequate referral services in secondary and tertiary hospitals. The strategic approach is to ensure this through ensuring a sufficient number and distribution of infrastructure in adequate condition and adequately equipped.

Furthermore, accessibility will be improved by enabling the delivery of standard packagaes 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 (TQIF), and monitoring and evaluation systems to support evidence-based decision-making. Increased coverage, quality and production of human resources for health will also be achieved through increased collaboration with the private health sector. Further strengthening of community involvement and decentralisation of management functions will contribute to increased accountability. Maternal, new-born and child health will receive specific attention across the sector. The disease control programmes will benefit from the general measures. 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.

HSSP III contains eleven strategies concentrate on specific topics in the health service delivery related to diseases and management: District health services; Referral hospital services; Central level support; Human resources for health; Health care financing; Public private partnership; Maternal, newborn and child health; Prevention and control of communicable and non-communicable diseases; Emergency preparedness and response; Social welfare and social protection; and Monitoring, evaluation and research. The cross-cutting issues elaborate on the approach towards quality, equity, gender and governance.

MMAM

In 2007 the MOHSW developed the Primary Health Care Service Development Programme (Mpango wa Maendeleo ya Afya ya Msingi, MMAM) 2007 -2017 to address the new Health Policy and the health related MDGs. The objective of the MMAM programme is to accelerate the provision of primary health care services for all by 2012, while during the remaining five years of the programme consolidation will be achieved. The main areas of focus will be on strengthening the health systems through rehabilitation of infrastructure, human resource development, improving the referral system, increased health sector financing and improved provision of medicines, equipment and supplies. This programme will be implemented by the MOHSW in collaboration with other sectors including PMO-RALG, RSs, LGAs and Village Committees.

The workforce will be increased by doubling the throughput in the existing training institutions upgrading 4 schools for enrolled nurses, production of more health tutors and upgrading the skills of existing staff. Infrastructure development through rehabilitation of existing health facilities, construction of new ones as well as improving the outreach services aims at having 8,107 primary health facilities, 62 district hospitals, 128 training institutions by year 2012. The Referral System will be strengthened by improving information communication system and transport.

The programme costs are estimated to be around 11.8 trillion TSH, which is beyond the presently available budget range.

Legislation

The existing health sector legislation mainly comprises of:

- Public Health legislation which is for the control of epidemics, infectious diseases and environmental health protection, The Public Health Bill is going to be presented before the National Assembly in the October-November 2008 Parliamentary Session.
- Health professional legislation which governs the practice and conduct of health professionals such as doctors, dental practitioners, pharmacists, nurses etc,
- Legislation which establishes autonomous health institutions for a particular need, such as institutions for medical research, national and special hospitals etc.
- Health financing legislation which is aiming at providing alternative health financing mechanism with the aim of complementing government efforts to finance health services in the country.

As in many other developing countries lack of regular reviews and effective implementation and enforcement is a problem.

2.5. Sector financing

Trends in health sector expenditures (resource availability)

The sector is financed by government resources (mainly tax-based), external resources and complementary domestic financing (fees for services; pre-payment schemes and national health insurance).

The overall budget for health is increasing in both nominal and real terms due to increases in funding from both GOT and DPs. From 1999 to 2006, estimated total public expenditures for health in Tanzania tripled, from USD 143.6 million to USD 427.5 million in real terms (JEHSR 2007). In the same time period, the domestic share of expenditures rose from 46 to 56%. Considerable amounts of funding are off-budget, e.g. an estimated 20% in FY06 (PER Update 2006). In recent years increased funding from DPs has become available, especially for targeted programmes in HIV/AIDS, TB and malaria. Most of the project funding is not incorporated in the official government budget.

The percentage of GOT expenditure on health is around 10% of total expenditures including the Consolidated Fund Services (CFS) and around 11% excluding the CFS. This falls below the Abuja target of 15%. Estimates for the fiscal years 07/08 and 08/09 remain at the same level. The per capita expenditure on health was around USD 5.8 in 2004, and increased to USD 9.0 in 2007 (HSSP III). Total funding of the private health sector is not known; and total out-of-pocket spending is not known.

External funding mechanisms

Donor support is provided as earmarked/project funding or un-earmarked through the Health Basket Fund mechanism (HBF). In addition, DP's support the implementation of the MKUKUTA through the General Budget Support facility anchored in the MOFEA, i.e. indirectly supporting the health sector by helping the GOT increase its funding to the sector.

The HBF is a joint funding mechanism developed in partnership between MOHSW, PMO-RALG, MOFEA and DPs within the context of the health sector SWAp. The basket DPs contribute funding to a joint US Holding Account from which, firstly, an agreed per capita allocation is allocated to LGAs following an agreed resource allocation formula. The funds are provided as unearmarked support for the implementation of the CCHPs and are meant to provide a stable and predictable resource base for LGAs, complementing the GOT District Health Block Grant. 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 included in the MOHSW MTEF. Until 2008, a share of the basket funds was also used for infrastructure rehabilitation at district level under the Joint Rehabilitation Fund (JRF).

Initially, councils received on average USD 0.50 per capita from the HBF. In 2007 the amount was increased to USD 0.75 per capita. From FY08/09 onwards, the LGA basket funding will be increased to USD 1.00 per capita, including a new element of pay for performance. In the future further increases may be considered.

Since 2005, councils can also request funds from the Local Government Capital Development Grant (LGCDG) system, which is jointly funded by the GOT and 11 DPs. Total funding is 17 billion Tshs in 2007/08. According to estimates from the first couple of years councils spend approximately 8-9% of their LGCDG resources on the construction and rehabilitation of health infrastructure and other health-related development expenditures. The JRF has in 2008 been replaced by the LGCDG Health Window.

In line with the JAST, DPs aim to shift a larger share of their external development assistance for health to pooled funds (i.e., the HBF and the LGCDG). New partners have recently entered the health basket (CIDA, UNFPA, UNICEF, One UN and Norway). Some efforts are made to encourage global initiatives to disburse earmarked financing through the HBF.

Resource allocation

Input categories – Government recurrent health expenditure remained more or less the same over the last three years, but expenditure on personal emoluments increased, while expenditure on "other charges" decreased as salaries have been raised and more personnel has been hired. The HBF is especially focusing on funding other recurrent costs, e.g. money for fuel, maintenance, training, etc.

Beneficiaries – Since 2004 the government health block grant and the health basket fund allocation to the LGAs has been allocated using a formula, in which 70% of the health block grant is allocated by population, 10% by district poverty count, 10% by relative size of vehicle route and 10% by district under-five mortality. A resource allocation formula for equitable drugs and medical supplies has been developed in 2007/08 and will be applied for the first time for the FY 2008/09.

The allocation of JRF funds for districts was based on a formula that ensured that all districts receive support over time, that poor districts receive more support than the better off, and that districts that have received little support in recent years get priority. The relative weight given to population was 50%, to number of PHC facilities 10%, to rural nature of district (measured by route-mileage) 10%, regional poverty ranking 15% and to cost of key building materials at district headquarters 15%.

In 2005, the government started allocating discretionary development grant funds through the LGCDG system to districts according to an allocation formula taking into account population (70%), Poverty count (20%) and council area (10%)[6]. A possible adjustment of the allocation formula for the Health Window is currently being discussed among partners.

In the coming years performance based incentives systems will be introduced in the form of Pay for performance (P4P) and Results Based Bonuses.

Levels of care – The allocation to the LGA level has increased significantly in recent years. The expenditure patterns indicate that the increase in PHC spending is a result of both GOT and HBF funding, with GOT block grants being the main source. Disentangling expenditures by levels of care is difficult due to off-budget funding and some funding for lower levels being included in central level budgets, e.g. for drugs and supplies. There has been a slight but steady reduction in the share of budgeted block grants allocated to first line facilities, from 63% in FY03 to 57% in FY06. However, in the absence of a more complete analysis this tells little about council level spending patterns.

[6] Guidelines for the preparation of medium term plan and budget framework for 2004/05 -2006/07. Issued by The President's Office and Ministry of Finance, January 2004.

Health care financing reforms

In efforts to address the financing difficulties and shortfalls in the health sector budget allocation, the MOHSW embarked on extensive health financing reforms in order to improve efficiency and effectiveness of the use of resources.

Health care financing reforms were initiated under the HSR Programme of Work (1999 – 2002), reinforced in HSSP II (2003-08) and the ongoing PFMRP and will be further strengthened in HSSP III. The reforms mainly focus on the following key areas: Strengthening of the budgetary framework; Financial resource mobilization (GOT budget, DPs through HBF and outside HBF); Cost sharing through user fees; Community Health Fund; National Health Insurance Fund; and Capitalisation of Hospital Pharmacies and Drug Revolving Fund.

The budgeting framework has been strengthened to increase its transparency and resources practicability. The pattern of health expenditures has since 1998 been analysed in annual PERs, which has become an established component of the government planning and budgeting process.[7]

Future financing needs and resource envelope

Despite a substantial increase in financial resources over the last few years, they are insufficient for meeting the costs of delivering on health sector goals. In 2006, the MOHSW projected the financial resources required over the period 2006/07 to 2014/15 to reach the MKUKUTA and MDG targets in mainland Tanzania[8]. According to the projection expenditure must double in the coming seven year, if MDGs and MKUKUTA targets are to be met. Depending on government policies, the costs may have to be shared among the public sector and private sources. Huge investments in infrastructure, equipment and human resource development is needed to implement the MMAM.

A financial projection has also been developed for HSSP III (DRAFT HSSP III DATED 29 AUG 2008). Resource availability is projected assuming that past growth rates for recurrent and development budget as well as on-budget development assistance can be maintained. Expenditures are projected based on a combination of extrapolation of historical costs that will be maintained in HSSP III and costing of new planned strategies. The comparison of the projected resource envelope and the projected costs of implementing HSSP reveals a financing gap of about 24% of the expected costs. Two major investment plans, the MMAM and the HRH plan, that were developed independently without consideration of any resource envelope, contributes to this financing gap. The imbalance can be addressed by increasing the resource envelope, scaling down the interventions or adopting a slower pace of implementation of the two major investment plans. The strategic focus by MOHSW is on seeking additional resources, including attracting off-budget to on-budget development assistance.

Various DPs have expressed their commitment to continue the support to the HBF. The DPs are bound to country support programmes periods, decided by their respective constituencies. These programme funding cycles are not synchronised. Therefore each year one or more partner will have to formulate a new country programme, to be approved by its headquarters.

In recognition of the priority given to decentralisation, the importance of local level service delivery and the truly additive nature of the district basket (as there is no GOT financing mechanism that could readily match these funds), DPs have indicated their preference for using the HBF firstly to support Council Health Services. Therefore the per capita allocation to the district basket has been increased to USD 1.00 per capita from FY08/09. Sustaining this level in the future might imply that fewer funds will be available for the central basket. However, new partners joining may increase total funding, improve predictability of funding and enable increase resources for both baskets. It is estimated that 70-90 million USD will be contributed per year by 11-12 contributors.

[7] PER Update 2006 (MOHSW 2008)
[8] Costing Health Care Report, see Generic HBF Document.

Budget execution and public financial management issues

Actual expenditure has generally been lower than the budget. Budget implementation of HBF has improved significantly over the period from a low of 20% in FY00 to well over 90% in FY04. Problems of under-utilisation were caused by late crediting of the Holding Account by DPs, lack of capacity to use the funds (ignorance and human resources shortages) and cumbersome government procedures, causing considerable delays.

Tanzania has elaborated the Integrated Financial Management System (IFMS), and has rolled it out throughout central government and parts of local government. Budget preparation has also progressed, but predictability of resources to the MDAs and the appropriate timing or resource transfers are still impaired by the late approval of the budget. Disbursement delays still occur.

The HBF is included in the MTEF-ceilings provided to MOHSW, PMO-RALG and Councils for planning. DPs disburse to a USD Holding Account in BOT from which funds are released to MOFEA that in turn release directly to Councils and Ministries following the same procedures as for GOT funds. Frontloading of the HBF in the past has enabled a smooth cash-flow to Councils as disbursement of GOT funds tended to be late, often towards the latter half of the year.

Staff managers of priority programs at central level such as the National Malaria Programme, National AIDS Control Program, Health Sector Reform Secretariat and Reproductive & Child Health Unit has complained about problems encountered in ensuring the availability of critical inputs as they shifted away from project financing. They are not able to efficiently implement plans financed by the pooled funds and government funds – even when budgeted, payments take too long to process, procurements are cumbersome, committed funds are often delayed and the resulting delays mean that annually planned activities cannot meet implementation targets.

An recent study " Supporting improved PFM: Challenges to effective financing of the health sector in Tanzania" uncovered that the completeness and timeliness of releases from Treasury or DPs is generally not the major obstacle for health care funding. The main exception is the under disbursements of OC at around 80% of the budget in recent years. Noteworthy is also, that despite the perception that resources for medicines are prioritized, the completeness and timeliness of the essential drugs budget is lagging behind the overall budget performance. The shortfall causes substantial problems in the reprioritization and downward adjustment of budget plans. Such delays could be prevented by anticipating incomplete releases in the preparation of the implementation plan. Other, possibly more substantial obstacles and concerns in the effective and efficient funding of the health sector include 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.

One of the main sources of delays in execution of health programs is the overly bureaucratic procedures of the allotment of health resources, procurement processes and administrative procedures that have to be followed in order to trigger payment. Moreover while the administrative processes are cumbersome, the analysis suggests that the real constraints are formed by the institutional culture within MOHSW which has resulted in the introduction over time of numerous controls and hierarchical checks on the budgeting, allotment and spending of resources. The current processes in the health sector are bureaucratic, unnecessarily duplicative and each process involves numerous steps that could be removed. Simplification of the intra-ministerial processes, while still keeping in mind that some degree of control to ensure that public resources are used in accordance with their intended purpose, is needed. An operational manual to guide the various administrative and financial processes within the MOHSW is needed and could also form the basis of a capacity building program for ministry officials with respect to health administration.

The PEFAR LGA review of 2006 showed that the credibility of the original budget figures at the local government level is seriously undermined by changes in the block grant ceilings from central government after the approval of the original budget by the Council in earlier years. The comprehensiveness of the budget at the local level was also undermined with significant unbudgeted transfers from sector ministries. Actual expenditure figures have been affected (negatively and positively) by the poor predictability of fund flows of both donor and central government funding. In many cases funds have been received too late to spend in the current FY.

2.6. Cross-cutting issues and priority themes[9]

Gender equality

There are significant gender and other equality issues in health. In the current socio-economic situation, women are more vulnerable to health threats than men. The specific gender issues include substantial numbers of women confronting reproductive health challenges, such as maternal mortality, STIs/HIV, breast cancer, cervical cancer. The poor national maternal health is not only an indication of poor reproductive health, but also of women's low status in Tanzanian society and poor access to basic health services. More than 60% of all women feel they face big barriers accessing health care when they are sick (TGNP 2007). Only 3% of babies are delivered by C-section, which suggests that many mothers with complicated pregnancies are not getting an essential maternal health service.

The absence of gender-disaggregated data in the routine monitoring system is a severe constraint to analysis of gender equity and development of policies to address specific health needs of men and women. Such analysis is presently limited to survey data. However, the MOHSW has included as a target in its strategic plan that by 2010 gender disaggregated data should be available and used at all levels.

Strategies for addressing gender inequalities are integrated into the three MKUKUTA Clusters including Cluster 2: Improvement of quality of life and social well-being, which covers health and HIV/AIDS. Emphasis on gender is also integrated into the health sector policies (missions and objectives). The health policy mission is to facilitate the provision of equitable quality and affordable basic health services which are gender sensitive and sustainable, delivered for the achievement of improved health status. The 2006/07 MTEF for Tanzania Mainland set priorities according to 9 objectives of which included gender aspects and the planning guidelines to LGAs states the needs to take into consideration gender aspects.

While the policy framework is to a large extent in place, progress on implementation has been less convincing. A gender focal point exists in the MOHSW, but has limited capacity and budget. Despite efforts to mainstream gender into the policies and strategic frameworks, 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 FY 2008/09.

Environment

The majority of diseases found in Tanzania, especially among children under the age of five, are caused by poor environmental health conditions, e.g. malaria, diarrhoea, TB, worm infections and skin diseases. The conditions are worse in rural than in urban areas but the uncontrolled expansion of certain urban area makes the conditions in these areas equally bad. Less than half of rural households have access to an improved source of drinking water. Over 90 per cent of households report having toilet facilities – mostly pit latrines of which a considerable part does not meet hygienic standards (TDHS 04/05).

[9] For cross-cutting issues related to HIV/AIDS, see Component 3.

Water and sanitation is addressed within the MKUKUTA (Cluster 2, goal 3). In an effort to improve environmental health, the MOHSW is finalising the National Environmental Health, Hygiene and Sanitation Strategy to streamline the implementation of environmental health activities in the country. The strategy is supplemented by guidelines, i.e. national environment health implementation guidelines, waste management guideline, participatory hygiene and sanitation transformation training guidelines and occupational health and safety guidelines.

Health care waste is generated by medical facilities, and needs to be properly managed and disposed of in order to avoid public health hazards. Insecticides used to treat bed-nets need to be properly managed and disposed of. Medical care services cannot avoid producing medical waste, and there are no cost-effective alternatives to insecticide treated nets.

A Health Care Waste Management Plan developed with support from the World Bank was launched in 2004. The MOHSW's environmental health unit (under the Directorate of Preventive Services) is responsible for its implementation. The MAP included training in waste management which included instructions on separation, transport and disposal of hazardous medical waste. The National Malaria Control Program has adopted an Insecticide Management Plan (developed with support from SDC and USAID).

Human rights, democratisation and good governance:

Many vulnerable groups such as children, paupers, the mentally and physically disabled and elderly people are at the mercy of the health care system. Equity in health means a fair distribution of services, whereby all citizens enjoy similar rights of access, independent of income, gender, religion, geographic location, etc. An exemption and waiver system is in place for vulnerable groups (poor children, pregnant, elderly), but is not always understood and adhered to or even demanded. Among the operational targets of the MKUKUTA are to "protect rights of vulnerable people, including people affected by AIDS". The MOHSW Medium Term Strategic Plan correspondingly includes a target of protecting the rights of vulnerable groups by 2009, developing guidelines policies and regulations, raising people's awareness on MOHSW policies, responsibilities including their rights and obligations by June 2009 and further by 2010 creating awareness and advocacy to the general public on their rights to health services.

Democratisation within the health sector is being extended through increasing use of boards and committees at the local government and facility levels. One important part of the effort to improve governance and oversight has been the drive to establish functioning Council Health Service Boards (CHSB) and District Hospital Governing Committees in all districts and Health Facility Governing Committees in all facilities. A key element in efforts to strengthen council health services has been the effort to establish and/or strengthen the institutions and organizations crucial to governance, planning, budgeting, implementation and monitoring of local services. The Joint Annual Health Sector Review Report for 2005 noted CHSBs had been established in all councils, but more than half were not functioning. The situation may have worsened further since then.

The sector also benefits from increased civil society involvement with government as a whole, for example through input to the Public Expenditure Review process and Consultative Group meetings, and through representative participation in such fora as the TC-SWAp.

2.7. Partner coordination

In 2006, the GOT and DPs adopted the Joint Assistance Strategy for Tanzania (JAST), which is a framework to guide the management of development cooperation, including the management of external resources for the entire government and across the civil society in the country.

The coordination structures for DP collaboration with GOT is laid out in the TORs for the Development Partners Group (DPG), created in 2003. This reduces transaction costs (e.g. by cutting out duplication and ad hoc coordination) and enhances the focus on poverty reduction strategies. Sectoral DPGs have been created, e.g. DPG Health, DPG Aids, DPG Local Government.

The DPG Health includes 20+ bi-lateral and multi-lateral agencies supporting the health sector in Tanzania. The total cumulated contribution of those 21 DPs to the Health Sector in 07/08 was $280 millions, not including HIV/AIDS funding or funding from the Global Health Initiatives, etc. The DPG Health has organised itself in accordance with the JAST, with a 3 person lead arrangement (troika). As of May 2008 there were 16 active partners and 2 delegating partners. Active partners take responsibility to participate in sub-sector areas according to their distinctive competence, cf. Generic HBF document for details on DPs representation in committees

DPG Local Government (12 active DPs) collects information, supports and oversees the implementation of D by D process. DPG-LG also supports and oversees the implementation of the LGCDG system.

Health SWAp

The Health SWAp, initiated in 1999, provides the framework of collaboration among the stakeholders, MOHSW, PMO-RALG, MOF, civil society, private sector and DPs. It coordinates financing, planning, and monitoring mechanisms within the realms of MOHSW policies and strategic plans and therefore aims at creating synergies, while reducing transaction costs.

A new Code of Conduct for the SWAp was agreed and signed in 2007 by the MOHSW, PMO-RALG, the Ministry of Finance and Economic Affairs (MOFEA) and DPs in the health sector. Based on the JAST, it aims at increasing transparency, improving predictability and allocation of financing, reducing transaction costs and the administrative burden on GOT. The Code of Conduct describes the sectoral dialogue and coordination, planning and budgeting, fiduciary risks and monitoring and evaluation. It also gives guidelines for behaviour of stakeholders.

The SWAp Committee is the agreed overall body for dialogue among all stakeholders in health: MOHSW, PMO-RALG, MOF, NGOs, private sector and DPs. There is one annual planning meeting and one Joint Annual Health Sector Review (JAHSR). Topics discussed are the MTEF, the progress of implementation of the HSSP, the Public Expenditure Review and jointly agreed topics.

The Technical Committee of the SWAp (TC-SWAp) comprises representatives of the stakeholders in the SWAp. NGOs and DPs rotates representatives among the numerous entities represented. It serves as a joint monitoring body of the goals and activities of the health sector as outlined in the HSSP, MTEF and CCHPs. The TC-SWAp has an advisory role; it deliberates on technical issues; makes proposals or recommendations to senior management in the MOHSW and PMO-RALG and to the SWAP Committee meetings on what actions need to be taken to address issues of health service delivery; advises the sector on how to carry out implementation; and gets information from Ministry departments that need technical review before being submitted to the SWAp Committee.

In addition, there are several sub-committees of the TC-SWAp, including the Monitoring and Evaluation Technical Working Group (TWG), the Pharmaceutical Working Group, the Health Financing Committee, the Maternal, Newborn & Child Health Partnership, the PPP-TWG, the HIV/AIDS Committee, the Human resources for Health TWG. These sub-committees ideally comprise a range of stakeholders and provide fora for discussion of specific topics. DP participation in the relevant task force, working group or committee is expected for (i) all partners providing targeted project financing and/or technical inputs; (ii) technical experts within agencies. These sub-committees are intended to coordinate technical and policy advice, as well as financial and technical inputs. At

present it is discussed to establish a Hospital Reform TWG to replace or supplement the Hospital Reform Task Force.

Health Basket Fund

The Basket Financing Committee (BFC) is responsible for overseeing operation of the joint funding mechanism. The BFC comprises representatives of the MOHSW, PMO-RALG, MOFEA and basket-donors and is co-chaired by the Permanent Secretaries of MOHSW and PMO-RALG. . The BFC has 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 is responsible for analysing the CAG Audit report, discussing the follow up measures, monitoring their implementation and proposing special targeted audits. The Audit sub-committee reports to the TC-SWAp.

3. Strategy

Overall objective

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 National Health Policy for Tanzania Mainland (2007) and will support the overall broad outcome of Cluster Two of the MKUKUTA.

Strategic approach

The Component is designed in the context of the health sector SWAp in Tanzania Mainland and the results and experiences gained through more than a decade of Danish sector programme 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 and the JAST. The JAST recognises that a mix of modalities has its advantage.

A mix of modalities, in the form of unearmarked support as well as earmarked support and technical assistance to key areas is used. Compared to previous programmes harmonisation and alignment will be strengthened. Danida has provided sector programme support to the health sector in Tanzania for more than ten years, and in the past ten years increasingly in the form of un-earmarked funding through the HBF, cf. Figure 1. The first HSPS (1996-99) consisted mainly of earmarked support and had a regional focus in Kagera Region. Danida was among the six DPs who started the HBF. Initially, the HBF supplemented the earmarked funding, but as Danida shifted its strategy towards a more flexible programmatic approach, the majority of support was channelled to the HBF supplemented by increasingly flexible earmarked funding.

Un-earmarked support – The general advantages of the SWAp in terms of national ownership, better co-ordination of resources, less transaction cost and improved efficiency are well-known. It is also generally agreed that these benefits are further enhanced when donor funds are pooled and provided as un-earmarked funding in the form of basket funding which can be partly or fully integrated with the government budget.

The HBF is earmarked for health but is discretionary within the confines of the HSSP and the CCHPs. During its 8 years of existence the HBF has become increasingly flexible and aligned to GOT policies and procedures. The HBF is planned, budgeted, implemented (including procurement), reported and

(since 2008) audited using GOT modalities and procedures. Most of the basket funds are allocated to the districts according to the same resource allocation formula as applied by GOT block grants. Districts receive the basket funding directly from MOFEA as complement to the government health block grant to implement their individual CCHPs. A small part goes to supportive supervision by PMO-RALG and RHMTs to ensure quality of planning and reporting at LGA level. Remaining funds in the HBF are fully integrated with GOT funds, used unearmarked to finance activities in the central level budget in the MOHSW MTEF. This include co-funding the GOT budget for essential drugs and vaccines to districts and upgrading training facilities in the regions. Until 2008, a share of the basket funds was used for infrastructure rehabilitation at district level in a Joint Rehabilitation Fund, which has since been taken over by the LGCDG Health Window.

The HBF has proven to be a viable and harmonised financing instrument, which can unite a sufficient number of DPs and mobilise enough funds to make a countrywide impact on health service delivery. The creation of the HBF has been instrumental in improving donor harmonisation and alignment. The HBF has attracted more DPs, who previously funded through projects (off-budget) including UN agencies e.g. UNICEF and UNFPA. Nevertheless, the recorded volume of non-basket disbursements from DPs rose from TSH 24.7 billion in 2002/03 to 57.0 billion in 2005/06. The global health initiatives (e.g. Global Fund, GAVI) and few large bilateral programmes remain outside established coordination and alignment mechanisms. Despite progress, the MOHSW still has to accommodate the needs of such large externally supported vertical programme initiatives. HBF DPs are actively pursuing the possibility of attracting funds from USAID, Global Fund and GAVI into the HBF. This would represent a potential step forward in terms of capturing more sector funding on budget and in the MTEF and could contribute to meeting the funding gap in HSSP III, provided that new HBF partners can respect the principle of non-earmarking and aligned reporting procedures.

The advantages of sector budget support (SBS) versus HBF has been considered and discussed also in Tanzania. The basket mechanism has won a good reputation over the years and its positive effects have been regognised, i.a. in the JEHSR 2007. Thus most HBF partners have decided to continue with the HBF, but modernise it. With the new MOU of June 2008 the HBF is in fact SBS[10], with the added advantage of being pooled and harmonised with other donors contributing in the HBF rather than individual donor SBS. The strategic approach is to continue the trend of progressively shifting the Danish support for the health sector toward less earmarking by reducing the earmarked support as much as possible. Consequently, a considerable share of the HSPS financial support for implementation of the HSSP III will be provided as SBS, mainly through the HBF, but with a minor share through the LGCDG Health Window. Danida will engage actively in the dialogue with DPs providing project funding, e.g. the global initiatives, regarding their possible contribution through the HBF.

Earmarked support – While basket funding will be increased to more than 80% of the support to the health sector in Mainland Tanzania, some earmarked funding will be provided as flexible funding to support specific intervention areas in the sector plans and strategic initiatives. The focus areas for the earmarked support is selected based on GOT expressed needs and priorities; DP's division of labour; and need for flexible funding to make policies work.

[10] SBS is defined as "financial support from a donor that is channelled into the general treasury account of a recipient country where, as an integral part of the resources herein, it co-funds the national budget of a particular sector. The support is thus nominally earmarked ant it is used according to the national public expenditure management rules and procedures." (Guidelines for the provision of budget support. Ministry of Foreign Affairs. Copenhagen, September 2007). The Parliament's role is a decisive difference between budget support and parallel funding (Terminology and Aid Modalities. BFT, Copenhagen, Septermber 2005). HBF is integrated in the consolidated funds and can be allocated within the health sector at LGA and central level according to political priorities.

Within the health sector Mainland, DPs and MOHSW attempt to pursue a division of labour as regards focus of earmarked funding and policy dialogue. Stakeholders recognise the comparative advantages and strengths of the Danida support, i.e. being a strong basket partner as well as being able to provide fast and flexible earmarked funding and technical assistance for priority activities. Danida has in the past had a special role with regard to drugs, hospital reforms, 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 the development of Public Private Partnership (PPP). This is in line with preferences of sector stakeholders and the recognized division of labour between DPs and is relevant based on past experience from HSPS III. Danida has for many years been a key partner in the area of drugs. Although the drug supply situation has improved substantially, shortcomings exist. The hospital management reform initiated by MOHSW has been supported by HSPS III. Progress was initially slow, but has picked up in recent years. A review in 2008 provides valuable inputs to the planning of future initiatives. See also Chapter 5.

Danida's previous assistance to strategic initiatives and developing and adjusting health policies has been highly appreciated by GOT and other DPs. Such support has included i.a. studies on child mortality, inputs to health insurance schemes, development of new HSSP, and initial support to faith based organisations and PPP. Danida has in HSPS III provided assistance to FBOs in an attempt to strengthen PPP. Danida has recently agreed with other partners (e.g. EED and CordAid) to jointly fund the CSSC in order to provide more efficient and coordinated support. In addition, Danida has actively promoted PPP through HSPS III activities at regional and district level in the Lake Zone. See also Chapter 6.

The objective of the earmarked support is primarily to improve and refine organizational structures in terms of transparency and accountability, and to develop and implement productive management systems in specific focus areas. The focus is on service delivery and making systems function rather than on policy development. This is in line with the overall strategic direction of HSSP III. Harmonised approaches, including pooled funding arrangements, will be used where possible, e.g. when funding non-government actors.

Technical assistance – The support to HBF and the earmarked funding will be supplemented by technical assistance to capacity building in key areas to support the implementation of HSSP III. Technical assistance is at present a non-pooled resource. Harmonisation and alignment could 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 MOHSW is established (outside or within the HBF) 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.

Brief narrative summary of component

The component objective will be supported by a total grant amounting to DKK 528 million (including contingencies). The objective will be addressed by providing support in three areas:

Sub-component 1: General support to the implementation of HSSP III through the HBF and the LGCDG Health Window

Danida will increase funding through the HBF from around 60% to around 80% of Mainland health sector support. A part of the Danish funding will be channelled through the LGCDG Health Window. The implementation is guided by an MOU between HBF partners, PMO-RALG and MOHSW and an MOU between LGDCG partners and PMO-RALG. 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. Un-earmarked funding is supplemented by support in the form of TA to improve capacity in MOHSW in the medium term in certain critical areas, see below.

Sub-component 2: Support to health systems and capacity strengthening including strategic initiatives
The focus of the support will be to make policies work. Danida will with HSPS IV 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 the Lake Zone, a few initiatives to improve quality of services that have proven more successful than others can be continued or expanded. A special review after 2 years will determine how to proceed.

HSPS IV will support the monitoring and managerial systems necessary for securing 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.

The financial support is supplemented by technical assistance to capacity building in key areas, see below.

Sub-component 3: Support to strengthening the non-government health sector and public private partnership
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 monitoring and evaluation. HSPS IV will further assist in the evolution of PPP in the entire health sector (including private-for-profit) with respect to the provision of public health goods. This may include capacity development support to APHFTA.

Capacity development support
The implementation of HSSP will require technical assistance for institutional capacity building in MOHSW in areas of management, planning, financing, system implementation, monitoring and evaluation in order to improve the performance in the sector. Under HSPS IV funding TA will be provide to the MOHSW in the following areas corresponding to the Intervention Areas for earmarked funding:

- Hospital Reform Adviser (HRA)
- Pharmaceutical Services Adviser (PSA)
- Public Private Partnership Advisor (PPPA)

The HRA will be placed in the Hospital Reform Unit as counterpart to the Head of the Unit and work closely with the Department of Hospital Services/MOHSW and PMORALG as well as the HSRS, DPP, other relevant Departments of the MOHSW and other partners (e.g. CSSC). The HRA will

primarily build capacity in the areas of institutional and organisational development, including governance mechanisms, performance contracting as well as aspects of health systems analysis. Given the current lack of capacity, the adviser will also be a member of the Hospital Reform team contributing directly to the work. The HRA will participate in the Hospital Reform Task Force meetings or a sub-committee of the TC-SWAp if such is established.

The PSA will be placed in the Pharmaceutical Services Unit as counterpart to the Head of the Unit and work closely with the Directorate of Hospital Services/MOHSW, PMO-RALG, MSD, TFDA as well as other relevant Departments of MOHSW and other partners. The PSA will contribute to capacity building in strategic planning and management, monitoring and evaluation. This will involve general management support, support to strategic planning and monitoring of annual plans as will as capacity strengthening with regard to coordination of the multiple stakeholders for the implementation of the Pharmaceutical Masterplan and monitoring and evaluation of its implementation. Furthermore, the PSA will assist in the organisational development of PSU and its relation to the lower levels, including support to setting up a system for engagement with and support to the regional and district levels. The PSA will participate in the Pharmaceutical Working Group meetings.

The PPPA will be placed in the PPP Unit as counterpart to the Head of the Unit and work closely with the Directorate of Hospital Services/MOHSW, PMO-RALG, other relevant departments of MOHSW, CSSC, APHFTA and other private sector organisations. The PPPA will contribute to capacity building in policy development, strategic and operational planning and management, monitoring and evaluation. Furthermore, the PPPA will contribute to capacity strengthening with regard to coordination of the multiple stakeholders involved in the implementation of the PPP strategy and with regard to mainstreaming of PPP at all levels (central, regional and district). Finally, the PPPA will assist in the institutionalisation and further development of the service agreements. The PPPA will participate in the National Public Private Partnership Steering Committee meetings.

In addition, the following TA will be provided to the MOHSW:

- Health Policy, Planning & Management Adviser (HPPMA)
- Public Financial Management Adviser (PFMA)

The HPPMA will be placed in the Department of Policy and Planning (DPP) and be counterpart to the Director of Policy and Planning, but work in close liaison with the CMO's office. The HPPMA will primarily be responsible for building capacity in DPP with regard to general management skills, strategic planning and effectively performing its stewardship role, including assist in the development of annual plans of priorities and reporting (to Parliament, SWAp, SC, etc). The HPPMA will further assist in issues related to the HBF with the aim of improved partnership through effective coordination, management and communication in the sector as well as assistance with implementation of activities under the HSPS funded Strategic Initiatives. The HPPMA will also assume limited coordination functions in relation to HSPS IV. The HPPMA will participate in the BFC and TC-SWAp meetings.

The PFMA will provide technical assistance on public financial management to improve the capacity and efficiency in financial management, analysis and systems development in the MOHSW, in particular with a focus on three interlinked areas: objective based planning and budgeting, accounting and administrative procedures in general, and financial reporting with special focus on senior management (and DPs) needs. The Adviser will collaborate with the Budget Section/DPP; the Chief Accountant and the DPP respectively in these areas. Initially, the Adviser will be placed in the Budget section/DPP and be counterpart to the Head of the Section. The placement of the Adviser may change as the key tasks shift over time. Some advice may be needed under Component 3, but this will be limited to providing technical advice on their financial management systems and not involvement in the financial management of funds.

Draft job descriptions for the advisers can be found in Appendix 1-5.

The advisers are envisaged to be needed for up to three to five years each. Provisions are, however, made to allow for an extension of all the advisers or recruitment of new advisers in the same or a different area; a total of 25 person years of long term technical assistance is budgeted.

All advisers will work within MOHSW and with designated counterparts. They will be placed in the relevant unit and report to the Head of department. The relevance of the scope of work and job description for each adviser in view of sector development will be taken up during the annual sector reviews.

To supplement the direct financial support under the components and the long-term TA, Danida will as previously have funds available for short-term TA (corresponding to 40 person months). Some funding for training (e.g. fellowships), sector reviews and preparation of a possible next phase will be available under a budget line in the overall programme budget.

4. Sub-component 1: General support to the implementation of the HSSP through the Health Basket Fund and the Local Government Capital Development Grant

4.1. Context

Experiences and challenges

In the past ten years Danida has provided sector programme support to the health sector in Tanzania at least partly in the form of basket funding, see Chapter 2.5. The support to the HBF has initially been supplemented by earmarked funding and the allocation of long term TA to amongst other assist the MOHSW in relation to the Joint MOH and DP programming, e.g. development of principles and modalities for operationalisation of the SWAp, development of guidelines and procedures for joint sector programming, preparation of JAHSRs, preparation of annual budgets and inputs to the BFC. In HSPS II and III disbursement to the HBF depended on a set of minimum requirements to be met by GOT. In case GOT would not live up to expectations, a fall-back scenario was specified that allowed shifting the balance between earmarked and un-earmarked funding. The fall back option was, however, never used.

The success of the HBF is well-recognised. The devolution of responsibilities for health planning and management of health facilities to LGAs – supported by financial resources (HBF and GOT Block Grants) has made a difference in the health sector and contributed to improvements in service quality at health facility level (JEHSR 2007). The HBF is considered one of the major factors in improving the quality of the CCHPs, because the funding provided an important incentive to the CHMTs (JEHSR 2007). The introduction, in 2000, of resource allocation criteria for the HBF, taking into account population, remoteness, poverty and disease burden and subsequent use of similar criteria for the government block grant, cf. Chapter 2.5, contributed to a more objective, equitable and transparent allocation of resources. The HBF has also helped to strengthen the capacity at central level to supervise and support regions and districts to implement their health plans.

In view of the increased project funding from global health initiatives and other DPs a key challenge is to convince these of the advantages of the HBF. The recent very positive independent external review of the health sector development and the role of the HBF (JEHSR 2007) presents an opportunity for the HBF partners to proactively seek to incorporate external financiers predominantly operating in a project mode. The ability to attract and retain support to the HBF is likely to be influenced by the

performance of the health sector, the successful implementation of health sector reforms and the ability to provide adequate documentation for progress that will allow agencies that would normally earmark funds for certain focus areas to join as they can identify results in their preferred priority areas through the sector monitoring and reporting (i.a. child survival, human resource availability).

The implementation arrangements for the HBF have been developed over almost a decade and have been working fairly well. As GOT has developed better mechanisms for planning, budgeting, monitoring and evaluation, the HBF has been increasingly integrated into government systems. HBF funds are managed using GOT systems, accounted for as part of MOHSW's voted expenditure and processed using GOT's IFMS. The HBF accounting follow GOT financial management procedures. Until 2007, however, separate accounting took place, allowing for special auditing of basket funds. The increased transaction costs was a burden on the district staff in particular. It has been agreed that with improved government auditing capacity (in numbers as well as skills of personnel), CAG audits of the entire budget – including the HBF – will be applied under the assumption that audits will be timely.

There is still room for improvement in the GOT system. CCHPs are of varying, but increasing quality. The technical progress reporting by Councils has been weak. The government reporting system through PMO-RALG is skewed towards financial reporting. Routine information systems in the MOHSW (especially HMIS) are not providing timely and reliable information. The quality, timeliness and reliability of the technical and financial progress reporting has to increase. Continued progress in harmonisation with GOT systems is a challenge. At the same time the solicitation of support to the HBF from the global initiatives and others might require some compromises on reporting and management which would increase transaction costs in managing the HBF, but such compromises could potentially reduce overall transaction costs for the GOT health sector.

The biggest advantage of the HBF has been its predictability in terms of the Councils knowing precisely how much funding was coming. The approval of disbursements by the BFC has been delayed – often simply because of scheduling conflicts, but also due to delays in preparing reports, which in turn causes delays in disbursements to councils. Fixed dates for approving disbursements and clear agreement on the reports required to support approval of disbursements by the BFC should lead to improved availability of funds at the Council level. At the same time delays in disbursement due to bureaucracy in the MOFEA have to be minimised.

Concerns among DPs and programme staff about cumbersome ministerial procedures and delays in release of funds for implementation of activities are barriers for attracting more funds to the HBF., cf. Chapter 2.5.

The JRF basket funded rehabilitation of 40 % of the publicly owned primary health facilities during its 4 years of existence (2004-8). Problems with infrastructure prevail and affect the retention and attraction of human resources at peripheral level, with negative effects on service delivery. Problems include shortage of quality and accessible health care facilities (dispensaries and health centres), lack of medical equipment and lack of adequate staff housing in good repair. The JRF as a separate funding flow has been discontinued in 2008. It is the government policy that the LGCDG system will be the primary modality for local infrastructure financing. GOT and DPs have agreed to establish a Health Window within the LGCDG system to channel earmarked health-specific development funds to LGAs for infrastructure. The LGCDG Health Window will provide funding to LGAs to enable the construction and rehabilitation of health centres and dispensaries in support of the MMAM and consistent with the CCHPs. A key challenge will be to ensure that adequate funding and technical capacity is available and that the pace of infrastructure rehabilitation and development is tailored to the available resource envelope and, equally important, is effectively coordinated with human resource and drug availability.

Key stakeholders

The Department of Policy and Planning (DPP) in MOHSW is responsible for coordination of the formulation of policies and guidelines and the preparation of the annual MTEF plan for MOHSW headquarters, departments, agencies and institutions directly under the ministry, of which the basket funding for centrally budgeted activities are part and parcel. The Director of DPP heads the Audit Sub-committee of the SWAp.

The Health Sector Reforms Secretariat (HSRS) within the DPP is responsible for the coordination of the implementation of the HSR and also functions as secretariat for the SWAp coordinating mechanisms including the HBF. The HSRS is responsible for invitations to meetings, minutes, and other relevant documentation, including the documentation to be provided to HBF partners as specified in the MoU of the HBF. The secretariat is responsible for the technical and financial progress reports for SWAp committees and BFC. It produces summary reports of CCHPs, and Council progress and financial reports in collaboration with the PMO-RALG, assisted by the RHMTs.

PMO-RALG is responsible for supervision and support to the LGAs, including development of guidelines for planning and budgeting for the LGAs and for the implementation of the LGDG system. Assessments and summary overviews of the CCHPs and funding proposals are produced together with the MOHSW. PMO-RALG is responsible for overseeing the quarterly and annual reporting as part of the Councils' technical and financial reporting obligations. PMO-RALG is responsible for the reporting to the MOFEA and sectoral ministries, when applicable. PMO-RALG is responsible for the proper performance of the RHMTs and reports to the BFC on budgets, plans and implementation by RHMTs.

The Regional Health Management Team (RHMT) consists of the Regional Medical Officer and a small team, under the Regional Administrative Secretary, complemented with experts from the regional hospital. The RHMT is responsible for the supportive supervision of Council Health Management teams in the Region. The RHMT provides technical support to the CHMTs where necessary. The RHMT has a task in scrutinising the CCHPs, as well as the quarterly and annual technical reports by the Councils.

The LGAs are responsible for formulation of the CCHPs. The CHMT produces the draft plan and budget and submits it to the Council Health Services Board for approval. Thereafter, the plan is incorporated in the Council annual plans and approved by the Full Council. The CHMT is responsible for implementation of the planned activities and reporting. The Council Administration is overseeing the implementation and reporting and is responsible for the financial management of the funds.

DPs collaborate in the BFC and in the SWAp committees, cf. Chapter 2.7. The day to day management of the basket is ensured by a Basket Coordinator (on rotation).

4.2. Strategy

The main strategy is to support the implementation of the HSSP III by ensuring flexible un-earmarked funding for the health sector both by providing the majority of the Danish funding for the health sector as un-earmarked funding and by using the HBF modality and the LGCDG Health Window.

The support to the implementation of the HSSP III through the HBF will be based on the agreed HSSP III including milestones, indicators and targets. An MOU signed by GOT and partners will specify the common management arrangements for the HBF. Furthermore, support to the LGCDG Health Window, will follow the principles, systems and procedures as outline in the 2008 Letter of Agreement for the LGCDG system and as contained in the 2008-2013 MOU between the GOT and DPs who are supporting the LGCDG system.

The provision of un-earmarked funding rests on the basic assumptions that MOFEA, MOHSW and PMORALG will make all reasonable efforts to facilitate successful implementation of the HSSP, in

particular

- make commitments to the health sector that are consistent with the MKUKUTA and the Sector's demonstrated capacity to perform;
- contribute adequate financing to the Programme per the MTEFs of both MOHSW and PMORALG, and the Comprehensive Council Health Plans of all Councils in the Country;
- ensure that development partner financing is reflected in the plans and budgets of the GoT, and that the pooled financing is managed in accordance with the implementation arrangements described below;
- promptly inform the Development Partners of any condition (including theft or misuse of funds) which interferes or threatens to interfere with the successful implementation of the Programme.

Danida will actively participate in the policy dialogue in the sector. The dialogue in the sector will include government allocations to the sector, timeliness and quality of public expenditure management; contents, comprehensiveness and quality of sector policies and implementation plans, in particular with regard to addressing key challenges, implementation capacity and the sector expenditure plans, including the pro-poor focus and gender sensitivity. Furthermore, in line with the division of labour between DPs, Danida will in the policy dialogue have particular focus on hospital reforms, the drug chain and private-public partnership.

The basket pooling mechanism is the most harmonised and aligned mode of funding, which can unite a sufficient number of development partners and mobilise enough funds to make a countrywide impact on health service delivery. Danida will participate actively in the dialogue with DPs who are currently using only the project funding modality in order to mobilise their use of HBF.

The experience over the last ten years has shown that improvement of GOT procedures as well as of harmonisation and alignment is an on-going process. Therefore, procedures should be adapted and simplified where and when possible. The further improvement of existing procedures, the further integration of the HBF into government procedures and the adjustments that may be needed to enable DPs that would normally provide project funding are likely to require capacity development in areas of financial management, technical and financial reporting, monitoring and follow up. Similarly, capacity building in health policy and systems analysis, operationalisation and management of health sector reforms will be required to improve the performance of the sector and enable MOHSW to provide inputs for an informed policy dialogue with DPs. Therefore, in parallel to the increased funding for the HBF, long-term technical assistance will be provided in the areas of financial management and health sector management and strategic planning.

Danida is confident that GOT as before will honour its commitments as stated in the HSSP III. In the unlikely case that problems prevent Danida from channelling funds through the HBF due to non-compliance with key assumptions listed above, Danida will have the option to revert to earmarked funding. The specific details of such earmarking will be decided depending on the circumstances. Such a decision will not be taken without a formal consultation between MOH, PMO-RALG and DPs contributing to the HBF. Discussions would include the reasons for falling short of meeting agreed requirements and the need for mitigating actions.

4.3. Objectives, outputs and main activities

This component will provide direct financial support to the implementation of the HSSP III through the HBF and the HSDG. The overall objectives for this component therefore coincide with the objectives of HSSP III, see Chapter 2.4, while the immediate objective is to enable the health sector to achieve its objectives.

The outputs and activities are those defined by HSSP III and operationalised in the annual MTEFs and CCHPs that are approved annually following the procedures agreed in the MOUs.

4.4. Inputs and budget

The inputs from Danida will consist of 416.5 million DKK for the implementation of activities under the HSSP III, see Table 1. In addition, Danida will provide funding for long term-technical assistance in the areas of financial management and health sector management and strategic planning.

Table 1. Indicative budget for Sub-Component 1.1

	FY starting:					
	2009	**2010**	**2011**	**2012**	**2013**	**Total**
1.1 Support through HBF	60.0	64.0	75.0	82.0	85.5	366.5
1.2 Support through HSDG	10.0	10.0	10.0	10.0	10.0	50.0
Grand Total	**70.0**	**74.0**	**85.0**	**92.0**	**95.0**	**416.50**

Note: Virement between budget lines is permitted. TA budget is combined for sub-components, cf. Chapter 7.

4.5. Management and Organisation

The implementation procedures will be the implementation arrangements agreed upon with MOFEA, MOHSW, PMO-RALG and DPs participating in the HBF and the LGCDG Health Window as stipulated in the MOUs for the HBF covering the period July 2008 to June 2015 and the 2008-2013 MOU signed between the GOT and DPs who are supporting the LGCDG system. In addition to the HBF MoU, a "Side Agreement" is made and signed yearly by the HBF Partners. It defines the priorities for the year to come, the level of contribution by the DPs, as well as possible amendments to the MOU. The MOUs outlines in detail the roles, responsibilities and obligations of all stakeholders and describe the implementation arrangements, including disbursement, procurement, audits and reporting.

No separate steering committee for HSPS IV sub-component 1.1 will be needed.

The TC-SWAp oversees the planning, budgeting, monitoring and evaluation activities in the SWAp, cf. Chapter 2.7. Day to day management of the SWAp process is conducted by the MOHSW and PMO-RALG leadership, in regular consultation with the Troika (chair of the DPG-Health).

The BFC is responsible for overseeing operation of the HBF. This involves determining the per capita amount to be allocated to the Council health services; approving the release of resources against the HSSP, MTEF and CCHPs; and ensuring that the use of basket resources follow agreed financial, administrative and management procedures.

The LGCDG System Steering Committee is responsible for overseeing the general and financial management of the LGCDG system including the Health Window. The Technical Committee of the LGCDG System is responsible for overseeing the operation of the Health Window at the technical level and to make recommendations to the PS and the Steering Committee. A sub-committee to start the implementation of the Health Window within the overall LGCDG management will be set up.

4.6. Financial management and procurement

The mechanisms for flow of funds, financial management and procurement will follow the agreements of the MOU(s) or later amendments to which RDE is signatory.

Planning and budgeting

MOHSW, PMO-RALG and CHMTs are responsible for developing the MTEF each year according to the procedures stipulated in the GOT budget guideline. MTEF priorities are expected to be shared with

DPs for dialogue. Well in advance and according to deadlines agreed in the MOUs the RDE will notify MOHSW and PMO-RALG of the total amounts that will be committed for the following year.

Disbursement
Once the MTEFs and CCHPs have been approved, disbursements can be made to the HBF USD Holding Account at the Bank of Tanzania (BOT). The annual amount disbursed by RDE will be the amount specified in DKK in the annual plan converted into USD according to the exchange rate valid at the time of disbursement. The funds for the LGCDG Health Window will be deposited into the LGCDG Common Basket Fund (CBF).

Disbursements into and releases from the Holding Account to the Exchequer is conditional on receipt of documents as agreed in the respective MOUs to which Danida is signatory.

The MOFEA manages the USD holding account for the HBF and the CBF in the BOT and is responsible for timely and correct onwards disbursement of funds to the Councils and MOHSW and PMO-RALG. The MOFEA makes quarterly transfers to the Council Health Accounts on request of PMO-RALG and notifies PMO-RALG of transfers made. PMO-RALG in turn informs the HSRS/MOHSW

Procurement
For procurement, the laws and regulations of the GOT apply, as laid down in the Public Procurement Act. GOT will develop an annual procurement plan, in draft form to the BFC in May and a final version to the Audit Sub-committee in August. The Government provides the Audit Sub-Committee with quarterly progress reports on procurement. For large procurements (above thresholds defined in the MOU), the World Bank's office conducts prior review, with on-the-job training of the procurement unit of MOHSW.

Accounting and auditing
Accounting and financial reporting will follow the procedures established in the MOUs. The National Audit Office (NAO) performs annual audit of the LGA and MOHSW accounts (including HBF funds and CBF funds) and submits reports to the MOHSW and PMO-RALG. Government procedures for timing audits apply. The National Audit Office can subcontract qualified private audit firms if deadlines cannot be met. A DP in the BFC may request a special audit, when a particular risk has been identified.

The HSRS will ensure that the Audit sub-committee of the SWAp is informed about audit issues without delay. The Audit Sub-Committee tables a summary and issues for follow-up to the TC-SWAp.

4.7. Monitoring, reporting, reviews and evaluations

The mechanisms for monitoring, reporting, reviews and evaluations will follow the agreements of the MOU(s) for the HBF covering the period July 2008 to June 2015 and the 2008-2013 MOU signed between the GOT and DPs who are supporting the LGCDG system or later amendments to which RDE is signatory.

The indicators, targets and milestones for achievement will be those of HSSP III and the MKUKUTA, cf. Appendix 10. Danida will participate in the development of the indicators, targets and milestones.

Quarterly and annual technical and financial progress reports are produced by PMO-RALG and MOHSW, in line with GOT requirements. LGAs will include the LGCDG Health Window in their overall technical and financial monitoring system. The CHMT will include all health-related LGCDG

spending in the health sector technical reporting as outlined in the CCHP guidelines. The reports are summarised (if necessary) and presented by the HSRS to the TC-SWAp. The TC-SWAp can forward the reports to sub-committees for further discussion or to the plenary SWAp committee for information. The audit sub-committee of the SWAp will discuss quarterly income and expenditure statements for the Holding Account.

The JAHSR Meeting during the third quarter of the fiscal year discusses implementation progress and budget performance. This meeting also discusses minimal requirements for disbursement and ways to avoid delays in disbursements as well as milestones for the coming year. Danida will participate in the JAHSRs, but will reserve the right to undertake own reviews should it be necessary.

The partners in the HBF will meet once per year with the political leadership in the MOHSW to exchange views on the functioning and future direction of the basket fund.

5. Sub-component 2: Support to health systems development and capacity strengthening

5.1. Introduction

Danida has in the past supported a diversity of aspects of capacity development for district quality services. In HSPS IV the Danish support will focus on supporting health systems development and capacity strengthening in three intervention areas of big complexity and challenges for improving the quality of services at district level, cf. Chapter 3:

1) Hospital reforms
2) Drugs management and use
3) Strategic initiatives

The support in these three areas will complement each other in several ways. For example, rational use of drugs is addressed in relation to drug management and use, but is also an important aspect of hospital management for effective use of resources and quality of care.

Below each intervention area is presented with regard to context, strategic principles, objectives, outputs and main activities and inputs. Following that the sub-component inputs and budget as well as implementation arrangements are presented.

5.2. Intervention area 1: Hospital reforms

5.2.1. Context

Issues and challenges

Much of the success of the health system in Tanzania arises from its commitment to the primary health care approach. This approach includes a clear and essential role for hospitals both as the location of expertise to deal with complex conditions, and as the source of technical expertise for lower levels of service provision.

With the aim of ensuring quality, equity, efficiency, affordability and financial viability of referral and regional hospitals, a comprehensive and ambitious plan for hospital reform was laid out first in the POW (1999) and later in HSSP II (2003). The strategies included devolving management authority, broadening financing options and strengthening of financial management, strengthening planning and management, increasing efficiency, improving infrastructure and concentrating on provision of referral

services. A five year implementation plan including a number of concrete steps were developed. Guidelines for reforming regional and district hospitals were, however, issued in 2005 only.

The referral health care system is still not functioning optimally. Many regional hospitals are not providing regional level referral services due to constraints such as lack of management skills, inadequate resources and poor infrastructure. Low standards of care prevail. Service delivery is characterised by low level of efficiency, effectiveness and value for money. Poor and vulnerable groups have reduced access to hospital services.

There has been little progress in improving the governance structure or management practices at hospital level. Management capacity has improved somewhat, but is still very limited and little progress has been made on quality improvement and performance management. Although budgets for regional hospitals have increased and the revenue base has been broadened (user fees, private wards, insurance), they remain under-funded and experience major shortages of qualified staff and drugs. (Naylor et al 2008; JEHSR 2007)

A review in January 2008 of the HSPS III support to hospital reforms pointed to a number of challenges for hospital reforms. A key challenge for the reforms has been the lack of attention to the organisation at regional level (Naylor et al. 2008). There are clear structural and accountability problems at the regions and the regional hospitals that needs to be addressed. Governance arrangements are in place for the National Referral Hospitals and clear chains of accountability and decision-making structures for district hospitals are part of the LGA governance arrangements. At the regional level the lack of clear division of responsibilities between the MOHSW and PMORALG including absence of an agreement about decision processes and resources contributed to stalling the reform process. The lack of autonomy for the regional hospitals, including the lack of establishment of Hospital Boards, the limited authority of hospital managers to make decisions and HMTs being dependent on the RAS discretion for resources as well as the dual accountability of RRMTs created problems.

Fragmentation and lack of coordination of efforts seem to prevail. Over the last couple of years, for example, various projects by various organisations have, in agreement with MOHSW/PMORALG but largely uncoordinated, introduced computerised financial packages at district and regional hospitals aiming at improving financial management. The recent establishment of a Hospital FAMS Working Group with the objective of establishing a national policy and strategy for implementation of FAMS at various service levels is addressing this issue.

The challenges also include inadequate resources such as skilled staff, staff mix, financing, drugs and supplies, equipment, communication and infrastructure, the latter partly due to poorly functioning PPM systems. There are weaknesses in health care financing as regards cost recovery, access to internally generated funds and implementation of exemptions.

The capacity in terms of skills and functioning systems remains a challenge. There are inadequate managerial skills of HMTs in planning, management, human resource management, financial management, patient care management systems, stock control and weak management accountability for results. The system capacity for provision of quality services is also negatively affected by inadequate staff motivation, morale and attitudes of staff and inadequate quality control and poor supportive supervision of staff.

The importance of hospital reform and performance improvement of hospitals remains very high (JEHSR 2007) and it remains a high priority to both MOHSW and PMO-RALG and a key strategy in the HSSP III. Strengthening of management of hospitals will contribute to the strengthening of the referral system and better use of health resources. The level of attention and investment in hospital reforms will, however, have to improve to achieve this.

Hospitals are complex organisations that do not lend themselves to quick solutions; reforms need to be taken forward over a number of years and require a balance of various interventions (Naylor et al. 2008). Nevertheless, it is a concern that the progress made in reforming hospitals has been slower than had been anticipated and could be expected.

The review of the HSPS III support identified the main constraints for HSPS III progress as a too narrow HSPS III implementation strategy (over-emphasis on training rather than organisational development, lack of mechanisms for spreading good practices and too little attention to the overall policy framework and legislation), inadequacy of dedicated resources in Department of Hospital Services (DHS) and an ineffective Hospital Reform Task Force (HRTF). (Naylor et al 2008)

Since the review in January 2008, several steps have been taken that improve the situation. The staff allocated to hospital reforms has been increased, a guiding document spelling out the different roles and responsibilities of the RHMTs, RRHMTs and the Hospital Boards have been approved. The HRTF is meeting regularly and providing guidance on reform issues. An allocation in the MOHSW MTEF has been made to supplement the Danida funds, and the OC budget for regional hospitals has been further increased and budgeting authority given to the regional hospitals. The above-mentioned FAMS working group has been established. The National Health Services Act to provide for regulation of delivery of health care services and to provide for strengthening of health facilities governance at all levels has been drafted.

The strategic objectives formulated in the HSSP III to address the challenges for referral care are:

1. To increase access for patients in need of advanced medical care
2. To improve quality of clinical services in hospitals
3. To improve management of the hospitals through implementation of the Hospital Reform Programme
4. To strengthen hospital governance

Key stakeholders

MOHSW/DHS/Hospital Reform Secretariat - MOHSW is the lead ministry for hospital reforms, where the responsibility lies with the DHS. Although the DHS has been strengthened since the review in January 2008 (Naylor et al 2008), the DHS remains inadequately staffed for the tasks required including undertaking the reform leadership. It is still a question whether the capacity in terms of skill mix and staff numbers of the HRS as well as organisation and systems matches the responsibilities. The commitment of DHS will be essential for successful implementation of the support to hospital reforms.

PMO-RALG/Regional Health Management Teams: Recently, agreement has been reached regarding the role of the RHMT within the Regional Secretariat (HSPS 2008). The RHMT with technical support from JICA and financial support from the HBF will play an active role to back stop the RRHTs, the CHMTs and the DHTs in the reform process. The capacity at regional level to support hospitals at regional and district levels is limited so they will need to be assisted by level 3 hospitals to do this.

The Hospital Reform Task Force (HRTF) was created to ensure the involvement of both the stakeholders and key co-opted experts in guiding the reforms. The HRTF until recently has been ineffective with only annul meetings held. It has not been clear whether the role is to guide the process or to implement the reforms because the task force had no Terms of Reference to guide its operations. TORs were prepared in Janury 2008. The HRTF is a key body needed to guide implementation of hospital reforms. However, it needs to have regular meeting and sufficient support in order to function well. In future, the HRTF may be transformed into a sub-committee of the TC-SWAp.

Development partners – Denmark is the designated lead on hospital reforms according to the agreed division of labour between DPs. Only few DPs are involved in hospital reforms. Apart from Denmark others are mainly involved in one or two specific hospitals.

5.2.2. Strategy and guiding principles

The areas of support in this intervention area recognizes the priority areas in the "Guideline for reforming hospitals at regional and district level" as well as in the "Functions of Regional Health Management Team, Regional Referral Hospital Board, and Regional Referral Hospital Management Team" (MOHSW/PMORALG 2008) describing new roles and responsibilities of the Regional Health Management Team (RHMT) and the Regional Referral Hospital Team (RRHT). The HSPS IV funding and TA will support the HSSP III Strategy 2: Referral Hospital Services Strategy. Furthermore, the findings of the recent reviews of the Hospital Reforms sub-component of HSPS III will be taken into account in the future planning of activities.

A phased approach will be adopted in which the Danish funding initially will concentrate in a few areas to achieve most impact. Ownership, governance, accountability and sound management are key to the hospital reforms. The initial focus will be on strengthening the regional level in these key areas through the establishment and development of functioning hospital boards, implementation of financial management systems, and continued strengthening of hospital management capacity without which there would hardly be any incentives to make the hospital boards function. Simultaneously, to enable the provision of more visible/tangible results of hospital reforms, one or two concrete initiatives to improve quality of services can be considered for support based on lessons learnt from the more successful initiatives in the Lake Zone, e.g. either strengthening of ICU, emergency reception centres, specialist outreach services or maintenance. The main focus of the support will be strengthening of the national level to lead the hospital reforms at regional and district hospitals, mainly through technical assistance.

HSPS IV support such activities that cannot be considered routine activities. Routine activities and large capital investments are assumed to be implemented by MOHSW or PMORALG through the MTEF using GOT or HBF. The areas of support will be interventions of crucial importance for the progress of hospital reforms and at risk of not being sufficiently attended to due to resource constraints or lack of recognition of its complexity and corresponding resource needs. Focus should be on systems and capacity development. The support may be targeted at both public and private hospitals.

The MOHSW will have the full responsibility for the implementation of hospital reforms. HSPS IV will only provide supplementary funding and TA to support the overall joint plan for implementation of hospital reforms. It is assumed that due commitment from MOHSW will be given and that MOHSW will continuously provide the necessary leadership and full-time human resources to see the reform activities through. A review of the progress in hospital reforms will be undertaken after 2 years. Based on the review it will be decided whether and how to continue supporting hospital reforms with earmarked funding.

5.2.3. Objectives, outputs and main activities

HSPS IV objective: To support the HSSP Referral Hospital Services Strategy by supporting the implementation of hospital reforms with focus on hospital management training, hospital management systems strengthening, institutional development and clinical quality improvement.

The expected output of the HSPS IV support is

Output 2.1: Improved hospital management capacity, governance arrangements and quality of care at the level of regional and district hospitals.

The earmarked funds for capacity strengthening together with funds from GOT and HBF and TA is expected to contribute to the strategic objectives of the HSSP Referral Hospital Services Strategy.

Main activities: Activities would generally be selected for implementation in accordance with the guiding principles outlined above. While in the beginning it is foreseen to focus on few areas and activities, activities can, assuming that the support remains throughout the programme period, include the following (grouped by indicative sub-outputs; * indicates activities suitable in the initial phase):

a) Improved systems for increased access for patients needing advanced care

- Further development of the system for provision of outreach specialist services including a strategy for roll-out based on the follow up and evaluation of the roll out mechanisms for outreach specialist services
- Implementation and refinement of a referral strategy
- Systematic follow up on experiences with new initiatives for strengthening the referral system, e.g. the designation of CCBRT as regional referral hospital

b) Improved systems for patient care management and clinical quality improvement based on agreed performance measurement milestones

- Establishment of QA committees, establishment of standards and quality improvement teams, development of tools to measure progress and training in quality improvement
- Development of system for clinical and managerial supervision
- Provision of skills to HMTs on human resource management (recruitment, preparation of job descriptions, staff appraisal, disciplinary procedures, effecting disciplinary action)
- Development of feedback mechanism for systematic use of results of clinical audits, maternal deaths reviews, community surveys etc for improvement of quality of treatment, nursing and patient care
- Development and testing of a performance measurement system and links to service agreements

c) Improved hospital management capacity (skills and systems development)

- Training of hospital management teams in general management skills and on preparation of long term business and annual plans including follow-up and support on site *
- Set up a system for and facilitate regular monitoring of implementation of business plans by the RHMT/DHS/HRTF
- Development of a workable system for regular supportive supervision and mentoring by level 3 hospital managers to level 2 hospitals, by level 2 hospital managers or well-performing mission hospitals to level 1 hospital managers and peer reviews among hospitals of the same level
- Strengthening financial management systems including the internal organisation of financial accountability within the hospital *
- Establishment of preventive maintenance systems in hospitals

d) Improved governance arrangements for regional hospitals

- Assist in orientation of DEDs RASs, hospital boards and hospital governing committees on hospital reforms and their expected roles and responsibilities to support the hospital teams
- Assist in the establishment and development of functioning hospital boards *
- Capacitate HMTs to promote delegated management within the hospital to improve efficiency
- Build capacity on effective ways of promoting community participation (suggestion boxes, community surveys, exit interviews)

5.2.4. Inputs

GOT funds, HBF and earmarked funding will jointly contribute to the achievement of the objectives and targets of the HSSP Referral Hospital Services Strategy. The indicative budget allocation from HSPS IV for this intervention area is 20 million DKK.

In addition funding is set aside for one long term Hospital Reform Adviser (HRA) throughout the program period to assist the Hospital Reform Secretariat in capacity building, cf. draft job description

in Appendix 3. MOHSW will provide office space and ensure that counterparts are appointed and available to work with the HRA.

5.3. Intervention area 2: Drugs management and use

5.3.1. Context

Issues and challenges

Danida has supported drug supply management and cost-effective, rational use of good quality drugs at district level for more than a decade. The Danish funding and TA has provided broad support to the sub-sector, but has been particularly substantial in relation to the MSD. The support has been successful in the development of a relatively well-functioning organisation with a professional management. Bottlenecks in the drugs supply chain still exist and need to be addressed.

Overall, there has been an improvement in the supply of pharmaceuticals and medical supplies in public health facilities in recent years (Drug Tracking Study 2007, JEHSR 2007). Nevertheless, drug supply is still reported to be erratic and with frequent stock-outs occurring at district level and below. Challenges arise at several points along the drug chain, from policy level to end user. A targeted approach to improvement is hampered by the fact that no monitoring of the flow of funds and commodities all the way from the DMO to health facilities and information flow from facilities to DMO (and back to MSD) is presently taking place.

The sector is still guided by the outdated National Drug Policy (NDP) of 1991. The new NDP has been delayed but will be finalised in August 2008. A Pharmaceutical Master Plan for its implementation is expected before June 2009.

Spending on essential drugs and supplies in the public sector increased by 150% from FY 2002 to 2005, but the disbursement of funds has been irregular with not more than on average 75% of approved funds released – with the lowest % released for the primary health facilities (Drug Tracking Study 2007). The time span between release of funds from MOFEA to deposits appearing in health facility MSD-accounts can be considerable (up to more than 3 months). The sources for essential drugs in Tanzania include internal resources such as the GOT, NHIF, CHF and user charges. Vertical Programmes are financed by GOT and a range of external partners. Less than half of drug spending in 2005/06 was for essential drugs, of which half was spent at district level. Vertical programmes account for an increasing share of spending, reaching two thirds of MSD sales in 2006-07, thereby increasing the risk of distorting the relative distribution of drug spending.

Equitable and gender sensitive access to pharmaceuticals and medical supplies in health facilities at prices that are affordable also to poor and vulnerable groups is still a challenge. A drug budget allocation formula taking into account equity issues will be implemented in FY 2008/09. The ADDO system was introduced to support availability of good quality essential drugs in private drug stores close-to-clients in rural areas to treat common diseases (e.g., anti-malarials, impregnated bed nets, family planning products, IMCI drugs, ORS, condoms etc). The on-going roll out has been slow and relatively expensive and a new strategy for training of dispensers has been developed and are being implemented.

The move from push to pull system for around 4000 lower level health facilities that started in 2003-04 and expected to be completed in 2008 has been a cumbersome process. The shift to the indent system requires forecasting and quantification of needs at district level. The capacity to do so in public health facilities at all levels is low. MSD is overloaded with logistics for parallel programmes. The Logistics Management Information System is weak. Storage conditions in some health facilities are poor. Shortage of qualified staff is critical. Inadequate functionality of the transport system at district level is affecting distribution of pharmaceuticals and medicines supplies and supervision.

Irrational use of drugs is a risk to patient health and leads to inefficient use of resources that contributes to lack of drugs when needed. Although Management tools have been developed and training has been undertaken but the present strategy has not been very effective and needs to be reviewed and changed. There were no interventions on rational drug use (RDU) at hospital level, during the implementation of HSPS III. Rational drug use has improved at dispensary and health centre level, but is still unsatisfactory at hospital level in both the public and private sector. Inadequately functioning hospital therapeutic committees have contributed to the lack of progress in rational drug use in the hospitals. An INRUD survey was undertaken in 2008 and will guide the strategy development for targeted promotion of rational use of drugs in the coming years. Supervision of drugs management remains limited partially due to the shortage of pharmaceutical staff at regional and district level, but also due to the absence of a systematic approach to supervision. RDU is seen as a pharmacist issue not a management issues requiring to be addressed broadly because pharmacists cannot deal with prescribers who are not supervised by a pharmacist.

Sub-standard and counterfeit pharmaceuticals circulate in the market. Availability of private sources of pharmaceuticals and medical supplies mostly in rural areas is inadequate. Capacity of the local pharmaceutical industry is low and accounts for only 30% of the national requirements. In accordance with the Abuja Declaration Tanzania aim at having 50% of essential drugs produced domestically. This is however also a question of quality, effectiveness and safety and will put increasing demands on PSU for setting guidelines and TFDA for quality control systems. Private production capacity is low in terms of quality and quantity.

The challenges for improving pharmaceutical services in the public and private sectors include:

- Inadequate financing for provision of essential pharmaceuticals, medical supplies, equipment and vaccines at all levels
- Irregular availability of pharmaceuticals, medical supplies and equipment in supply chain system
- Inadequate qualified and skilled human resources for the pharmaceutical sector at all levels
- The tracking of supply, quality and use of medicines and operational research in pharmaceutical services is not adequate at all levels
- Inadequate control of quality, safety and efficacy of pharmaceuticals, medical supplies, medical equipment, traditional and alternative medicines in both public and private sectors
- Inadequate capacity for domestic production of pharmaceuticals, accounting for only 30% of the national requirements compared to the Abuja target of 50%
- Inadequate outlets and high prices of pharmaceuticals and medical supplies in the private sector in rural areas. Affordability of pharmaceuticals and medical supplies especially to the poor and vulnerable groups is a challenge
- Lack of coordination and harmonisation of financing in vertical and parallel programs.

Key stakeholders

MOHSW/PSU - is responsible for policy level decisions, development and oversight of policies and guidelines and their implementation. The PSU is also responsible for ensuring an appropriate allocation of resources to health facilities for drugs; ensuring timely transfer of funds to the district accounts with MSD as well as of budget information to the districts; ensuring that MSD performs according to the MSD Act of 1993; assisting to capacitate the health facilities to quantify drugs requirements; establishing effective strategies for improving rational drugs use; and establishing effective drug management and monitoring systems at health facility level. The staffing and operational capacity in PSU is however limited. Most posts for pharmacists at regional and district level are vacant. Due to limited resources, the PSU is unable to function effectively and the shortage of pharmacy related staff in the regions and districts incapacitates PSU from carrying out its tasks.

MSD - is the exclusive supplier of medicines to public health facilities and currently classified as an autonomous government department under MOHSW MSD is responsible for the procurement, storage and distribution of pharmaceuticals up to the district level. Despite recently being rated one of the best in Africa[11], MSD is still facing challenges in meeting the requirements of its customers. In 2007 MSD started to implement its Medium Term Strategic Plan (2007-2013), which is addressing issues such as the inefficiencies of its computer (ORION) system, a procurement process that is lengthy and coupled with long lead times and stock management, the need for a quality assurance system; the introduction of a Budget Based Ordering system, whereby the regional and district hospitals place orders based on their available budget with MSD. Integration of the vertical programmes into the Integrated Logistics System developed for the indent system (to be completed in 2010) is also a challenge. MSD has an aging transport fleet and a drastic shortage of storage space. As a result, MSD is not able to fully respond to the needs of its customers and health facilities continue to experience stock outs of pharmaceuticals and medical supplies.

TFDA - established in 2003, is the regulatory body responsible for ensuring the quality, safety and efficacy of drugs, foods and cosmetics available for consumption in Tanzania and conducts inspections of private and public drug outlets. TFDA is responsible for the roll out of the ADDO. To speed up the roll-out there is need to develop a system to quality assure the training as well as a quality assurance system for the quality at outlet level. This will require decentralisation of regulatory functions to the regions and council level. TFDA further has a role in education of the public in rational use of drugs. Recognising the need to focus more on the quality in public sector as well as the quality of products at end use, i.e. not just at the top of the supply chain at MSD, TFDA in 2006 launched a QA program using mini lab kits and training inspectors to do initial screening in selected regions. This system still needs strengthening to become functional.

RHMTs, RMOs, Regional Pharmacists, CHMTs, DMOs and District Pharmacists - play a crucial role in the facilitation of ordering and distribution of drugs to facilities as wells in the supervision of the use of drugs.

DPs - participate in the Pharmaceutical Sub-Committee of the TC-SWAp. Its mission is to provide sound advice and technical support for sustainable improvement of the Pharmaceutical sector so as to realise the overall objective of the National Medicine Policy.

5.3.2. HSPS IV Strategy and guiding principles

The HSSP pharmaceutical strategies outlines key objectives, expected results and indicators. HSPS IV will support the implementation of the HSSP Pharmaceutical Strategy with flexible earmarked funding for capacity development (of human resources as well as systems) needed to improve the drug chain with a focus at the district level. The capacity development will mainly be provided as support through three key institutions, e.g. PSU, MSD and TFDA.

The selection of activities will be in line with the HSSP, the new NDP and pharmaceutical master plan as well as the MSD Mid Term Strategic Plan. Furthermore, the activities may be follow-up or respond to special studies undertaken, e.g. the on-going (July 2008) consultancy to set up a regular quarterly monitoring mechanism of flow of funds, commodities and information from MOFEA to the peripheral facility level and back. HSPS IV will support the various strategic plans as operationalised in the annual operational plans.

Assistance will be given with particular focus on development activities of key importance for getting the entire drug chain to function. To address the lack of availability of drugs at the health facility level it

[11] MSD Medium Term Strategic Plan, the Drug Tracking Study and the Public Expenditure and Financial Accountability Review of MSD.

is essential to strengthen the entire drug chain both 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 and monitoring and evaluation of parts of the chain. HSPS IV will support the monitoring and managerial systems necessary for securing essential drugs and supplies with focus at the district level as well as the rational use of such provisions.

HSPS IV will support activities which cannot be considered as routine activities which should be financed by GOT or HBF. Activities supported would typically include development, testing and implementation of systems to a level where it is functioning and can be rolled out using GOT or HBF funds; exploring and testing of innovative ideas that may be difficult to fund in a resource constrained setting; and activities where flexible funding can contribute to benefit from opportunities that suddenly arise.

The focus in HSPS III has to a large extent been on the strengthening of TFDA and MSD and less on PSU itself. However, PSU is inadequately resourced for its optimal functioning. Although the staff strength has increased in recent years PSU has many tasks and the workload and content do not match the capacity of staff and systems available in the unit. A consultancy in 2008 has assessed PSU capacity and recommended ways forward for capacity strengthening.

5.3.3. Objectives, outputs and main activities

HSPS IV Objective: To support 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.

The expected output of the HSPS IV support is

Output 2.2: Drug chain strengthened and better able to deliver affordable quality drugs at the district level when needed

The earmarked funds for capacity strengthening together with funds from GOT and HBF is expected to contribute to most of the strategic objectives for the area of Pharmaceuticals specified in the HSSP III. The attainment of the strategic objectives regarding pharmaceuticals in HSSP III will require a combined effort by key stakeholders. HSPS IV will support improvement of the capacity of PSU to match the responsibilities vested with PSU by GOT, of MSD to ensure availability of drugs at MSD-end user level and of TFDA to undertake its regulatory functions to ensure access to quality drugs.

Main activities: Activities would generally be implemented in accordance with the guiding principles outlined above and may include, but not necessarily be limited to the following (grouped by indicative sub-outputs):

a) Improved adequacy, timeliness and coordination of financial resources available for essential pharmaceuticals and supplies at all levels
    - Review processes in MOHSW and develop systems for timely disbursement of financial resources district health services and hospitals for essential medicines, medical supplies, vaccines and equipment
    - Develop policy and guidelines regarding coordination and harmonisation of resources available for pharmaceuticals and medical supplies
    - Develop systems and processes for better coordination of chain management irrespective of funding modalities
    - Development/adjustment of management systems that will facilitate the harmonisation of chain management between various programme modalities (government, vertical and parallel programmes)

b) Improved capacity to supervise, monitor and evaluate the implementation of the NDP and the national requirements for pharmaceuticals
   - Develop and implement a monitoring and evaluation system including feedback mechanisms for resolving emerging issues and challenges
   - Strengthen the institutional capacity at the central level to guide and steward the sub-sector development and to supervise, monitor and evaluate the performance in the sub-sector and the regional offices.
   - Strengthen pharmaceutical capacity at regional offices through training regional pharmacists to coach district pharmaceutical supervisors, and accompany them for dedicated pharmaceutical supervisory visits to each health facility
   - Develop basic tools for supportive supervision of the pharmaceutical sector at district level based on the NDP and Pharmaceutical Master Plan
   - Develop a pharmaceutical supervision system at district and regional level which will enable health authorities to provide adequate pharmaceutical supervision to the health facilities, government, NGO and private, under their supervision.
   - On the job capacity building of staff with pharmaceutical responsibilities to manage, order, forecast and quantify drugs and medical supplies at district level.
   - Undertake small scale operational research to determine ways of improving pharmaceutical services.

c) Improved drug procurement, storage and distribution systems for delivery of quality essential drugs to districts
   - Develop plans for and follow up on implementation of the ICT system in MSD
   - Strengthen the capacity of MSD in stock management
   - Develop a new quality assurance system for MSD and strengthen the present quality control unit
   - Implement a zonal specific decentralisation plan for MSD targeted to the different needs
   - Undertake a thorough review of the barriers in the roll out of the integrated logistics system (ILS) and develop an implementation plan in collaboration between MSD and PSU (responsible for training, supervision and follow up)
   - Continue support to capacity development of the senior management, in leadership and team building skills

d) Control of quality, safety and efficacy of pharmaceuticals in the public and private sector strengthened
   - Develop a decentralised system for quality control and accreditation for both public and private facilities
   - Evaluate the training programme for ADDO dispensers
   - Develop and test basic training of owners in business management & development of microfinance/loan schemes
   - Develop pricing policies and guidelines for ADDOs
   - Develop a system for monitoring and evaluation of the ADDO programme
   - Develop strategy for promoting domestic production of quality pharmaceutical supplies
   - Develop system at TFDA for quality control and accreditation of domestic producers of pharmaceuticals.

e) Increased rational drug use
   - Develop a new strategy for addressing rational use of drugs

- Revive and capacitate hospital therapeutic committees
- Strengthen capacity of RHMTs, CHMTs and health facility in-charges to supervise and intervene for improved rational use of drugs
- Build capacity in regional and district offices to support and stimulate rational drug use activities at facility level
- Develop system for monitoring and evaluation of rational use of drugs

5.3.4. Inputs

GOT funds, HBF and earmarked funding will jointly contribute to the achievement of the HSSP strategic objectives. The indicative budget allocation from HSPS IV is 20 million DKK. In addition, funding is set aside for TA.

One long term Pharmaceutical Services Adviser (PSA) is allocated to assist PSU in capacity building, including systems development, at central, regional and council level, cf. draft job description in Appendix 4. MOHSW will provide office space and ensure that counterparts are appointed and available to work with the HRA.

Need for short term TA is envisaged in such areas as development of the ICT systems, QA system and stock management. Further it is envisaged that continuing and recurrent technical support to capacity development of the senior management, team building and leadership skills, will be needed.

5.4. Intervention area 3: Strategic initiatives

5.4.1. Context

The major share of HSPS IV funds goes to the joint basket fund. The basket fund directly supports central level operations in accordance with the six year HSSP III and the annual MTEF allocations and district health services as outlined in the annual CCHPs. However experience from HSPS III has demonstrated that these systems leave little room for the sector to respond quickly to new and developing issues and challenges as they arise. Experience throughout HSPS III has shown the importance of having flexible funds available to support arising needs in terms of initiation of new activities, short term TA, reviews and workshops. Areas supported in HSPS III include PPP zonal private/public partnership steering group, support to interfaith forum, support to CSSC and to the development of NCD strategy.

Rigidity in the public financial management system still remains and many opportunities that arise cannot be responded to in a timely manner. The many opportunities and issues arising from the Local Government Reform and the increasing involvement of the private sector are further adding to the need for such a flexible funding mechanism. In order to counter unnecessary delays in ensuring sustained development and implementation of the health sector reforms there is a need for continued flexible financial and technical support to strategic initiatives. Thus a small share of the budget will be reserved to facilitate strategic initiatives at the request of the MOHSW or PMO-RALG, as well as other major players, e.g. from the private sector.

5.4.2. Strategy and guiding principles

While the government is definitely committed to support priority strategic initiatives the rigidity of the government budgeting and planning systems as well as the scarcity of resources may result in some areas not receiving optimal funding, neither in terms of timeliness to respond to opportunities that arise nor in sufficient amounts to ensure quality development. The same applies to key private sector organisations and systems and cross cutting areas that do not fall under other components and that may be at risk of not being allocated sufficient funds.

The aim of this component is to provide timely, flexible support in areas where windows of opportunity open, but at the same time to ensure that this type of support maintains a clear focus, namely improved quality of service delivery and making systems function. This is in line with the overall strategic direction of HSSP III.

Besides government institutions, research institutions and key private sector organisations with a sufficient broad insight and constituency have a role to play in the ongoing policy discussions and developments within the health sector and will be eligible for support. This is in line with both the government's and Danida's view of a pluralistic health sector.
In general, this component is not intended for routine activities or scaling up of already piloted interventions. The support should be based on applications from the eligible departments and organisations for support to develop innovative means of addressing the identified issues.

Only activities in line with the overall objectives and components of this programme, and hence HSSP III, can be supported. This could also include special initiatives addressing cross-cutting issues, for example gender, patient rights, vulnerable groups like mentally and physically disabled..

5.4.3. Objectives, outputs and main activities

HSPS IV Objective: To support improvement and refinement of health system structures and delivery of quality health care services through exploration of efficient interventions, policy and strategy formulation and development and implementation of productive and efficient management systems in specific areas of focus in line with the overall objective of the programme.

Output 2.3: Strategic initiatives have been taken and outputs achieved according to expectations specified in the planning of these initiatives.

Main activities: Activities can include but will not be limited to:

- Assessment of existing organizational, managerial and systemic structures in both public and private sector
- Development of revised organizational and managerial systems for both the public and the private health sector
- Assist in developing key policy areas for public as well as key private sector organisations
- Assist in the operationalisation of policies, e.g. the translation of policies into concrete implementable activities
- Dissemination of policy views
- Support to initiatives on cross-cutting issues
- Support to inter-ministerial collaboration particularly between MoHSW and PMO-RALG

5.4.4. Inputs

The indicative budget allocation for Intervention Area 3 from HSPS IV is 10 million DKK. The funding may be used for, but not necessarily be limited to, funding of short term TA, operational research, training, workshops, study tours, publications and dissemination hereof. Under special circumstances equipment can be funded provided financing of replacement and recurrent cost is secured.

The HPPMA will allocate a part of his/her time to assist in the development of strategic initiatives.

5.5. Budget

The inputs from Danida will consist of 50 million DKK in funding for implementation of activities under sub-component 2, see Table 2. In addition, Danida will provide funding for up to 10 person

years of long term TA in the area of Pharmaceutical services and Hospital reforms, cf. total component budget in Chapter 7. The long term TA in health sector management and strategic planning will also provide some assistance in relation to the Strategic Initiatives. Furthermore, funds are set aside for short term technical assistance.

Table 2. Indicative budget for Sub-Component 2 in million DKK:

	FY starting:					
Outputs	**2009**	**2010**	**2011**	**2012**	**2013**	**Total**
1. Hospital reforms	4.00	4.00	4.00	4.00	4.00	20.00
2. Drug chain strengthened	4.00	4.00	4.00	4.00	4.00	20.00
3. Strategic initiatives	1.00	2.00	3.00	2.00	2.00	10.00
Grand Total	**9.00**	**10.00**	**11.00**	**10.00**	**10.00**	**50.00**

Note: Virement between budget lines permitted

5.6. Management and Organisation

Oversight and Decision-making Structures

The MOHSW, represented by the Permanent Secretary (PS), will be overall responsible for the implementation of Sub-Component 2.

As there is a need for an oversight and decision-making forum for the earmarked support, a Steering Committee (SC) for the earmarked support to the health sector Mainland will be formed, although its activities will be kept to a minimum. The SC will consist of representatives of implementing partners and RDE. Composition, mandate, tasks and working arrangements are described in Appendix 6.

All activities foreseen under Sub-Component 2 will contribute to the implementation of HSSP III. They will be identified during the routine annual departmental planning and be an integral part of the MTEF. Each year MOHSW and RDE will agree on the annual plan and budgets for the earmarked funding. To the extent that activities are included in the MOHSW MTEF such work plans may be extracts from the MTEF. DPP/MOHSW is responsible for developing and presenting its overall annual work plan and budget, including the Danida earmarked support for activities implemented by MOHSW, for discussions in the Technical Committee of the SWAp (TC-SWAp). The MTEF is discussed yearly between MOHSW and DPs. MOHSW produces quarterly and annual progress reports. The DPP is responsible for adequate technical and financial reporting. The long term TA within each area will assist in improving the current reporting.

The Joint Annual Health Sector Review will assess implementation of the MTEF including the earmarked components, but cannot be expected necessarily to go into much detail with all aspects of activities earmarked by individual donors. Therefore, in conjunction with the Joint Annual Health Sector Review Meeting, the RDE and MOHSW/PMO-RALG will be responsible for undertaking a brief (1-2 days) Annual Programme Review (APR) of the earmarked support (sub-component 2 & 3).

The APR will recommend to the SC adjustments to HSPS IV as necessary in view of the sector development. At the same time the need to reallocate funds between the budget lines will be assessed.

Daily Management

All earmarked activities will be reflected in the annual work plans. The PS may delegate day-to-day management to senior staff of the responsible department/organization with direct responsibilities for coordination and implementation of the activities.

Intervention Area 1: Support to hospital reforms – The Director of DHS will be responsible for the coordination of the implementation of the HSSP III Referral Health Care Strategy and the Guideline for hospital reforms. Overall direction will be provided by the Hospital Reforms Task Force (HRTF). This function may be taken over by a hospital reform sub-committee under the TC-SWAp, if and when it is formed The Head of the Hospital Reforms Secretariat (HRS) under the DHS will be responsible for the day-to-day management and implementation of activities. HRS will in liaison with the other organisations involved, through the HRTF, prepare annual work plans for the implementation of hospital reforms reflecting all inputs, including management activities, external technical assistance and activities to be supported by HSPS IV within this intervention area. These plans will be part and parcel of the annual planning for HSSP III and therefore be clearly aligned with the objectives for hospital reforms in HSSP III and using same indicators. The plans will include time tables, inputs and anticipated outputs with defined indicators.

The DHS will prepare an annual progress report for implementation of the hospital reforms, including Danida earmarked activities, which will be presented at a HRTF meeting and copied to the SC.

Intervention Area 2: Drugs management and use – The Director of DHS will be responsible for the coordination of the implementation of the HSSP III strategic objectives regarding pharmaceuticals and the Pharmaceutical Master Plan. PSU will in liaison with the other organisations involved, i.a. MSD, TFDA as appropriate, prepare annual work plans for its implementation, including activities to be supported by sub-component 2. These plans will include time tables, inputs and anticipated outputs with defined indicators.

The PSU will prepare an annual progress report on the implementation of the HSSP III Pharmaceutical Strategy and the Pharmaceutical Master Plan, including Danida earmarked activities, which will be presented to the Pharmaceutical Sub-Committee of the TC-SWAP and copied to the SC.

Intervention Area 3: Strategic initiatives – The CMO will be responsible for the coordination of the implementation of the Strategic Initiatives. The support to strategic initiatives should be based on proposals to the CMO from the eligible departments and organisation for support to develop innovative means of addressing the identified problems.

The specific activities including TOR will be developed by the implementing department / institution or technical working group.

The implementation of the activities, will be the responsibility of the requesting institution/unit. All consultants/TA will report to the institution/department responsible for the implementation of the activity.

The DPP will strive to ensure that activities are included in the annual work plans and budget of the involved department whenever possible and will prepare annual progress report for activities in this intervention area.

General

The responsibility for daily management of the implementation under each intervention area should be delegated to the units that would normally be responsible for implementation of such activities in the MOHSW departments, agencies and institutions directly under the ministry. E.g. the Director of MSD would be responsible for the implementation of activities related to MSD, the Director of Human Resources would be responsible for the implementation of certain capacity building elements, etc.

Within each intervention area the responsible coordinator will include progress on Danida assisted activities in the departments' periodical progress meetings. These meetings are expected to be held at least quarterly to monitor the progress on the implementation of the annual plan, discuss problems and bottlenecks and agree on the way forward. These meetings should be minuted and copied to the chairs of the SC.

In addition, the MOHSW 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 assisting in instilling good management practices.

The earmarked support will be relatively less in HSPS IV. The administration will be integrated in the procedures of the MOHSW. Procedures and regulations for the implementation will be described in a separate manual.

5.7. Financial management and procurement

A Procedure Manual for the implementation of HSPS IV Component 1 programme activities will be developed before the start of HSPS IV and approved by the SC. The Procedures Manual will describe details of the financial management and procurement of goods and services.

Planning and budgeting

The MOHSW (and its agencies) is responsible for proposing annual work plans and budget for the earmarked funds based on the HSSP as part of the annual MTEF planning exercise. Planning and budgeting for the earmarked funds will follow the normal government procedures and time lines for development of work plans and budgets and be fully integrated in the MTEF. The work plan and budget will be discussed and approved by the SC. The component work plans and budget for the first year of HSPS IV will be developed under HSPS III and may only figure in the MTEF 09/10 with one line.

Disbursement and flow of funds

A designated bank account will be established in BOT. Based on approved annual work plans, RDE will disburse funds bi-annually based on a request from MOHSW. Funds will be transferred from RDE through the MOFEA to MOHSW and deposited on the designated account in BOT. The use of funds from the BOT account will follow normal MOHSW procedures. Disbursements will depend on financial reporting on previous periods.

Procurement

In case of procurement of national consultancy services or other procurement, the GoT procurement procedures will be applied unless the MOHSW request the RDE to apply Danida procedures.

For international consultants the RDE will contract through Danida Copenhagen, Danida's procedures and regulations will apply. Payment will be made directly by Danida in Copenhagen to the consultant according to a contract between these two parties. Goods and services paid for directly by Danida are considered to be grant-in-kind assistance. Procurement of TA through a TA pool, should such be established and joined by Danida, will follow other rules agreed between partners.

Accounting and auditing

The PS MOHSE will be the responsible accounting officer. The MOHSW Accounts Unit will be responsible for the accounting and financial reporting. The management of funds received from Danida will comply with the Danida Guidelines for grants through Government and Para-Statal Organisations and NGOs, which will be laid down in the Procedures Manual. The Chart of Accounts will be compatible with the MOHSW accounts and also set up in a way that necessary financial reporting for implemented activities can be generated.

If necessary the RDE will on a quarterly basis inform the MOHSW Accounts Unit about direct payments for technical assistance and other items, booked by MOFA, Copenhagen, on the individual budget lines.

At the end of the financial year earmarked funding will be audited by the NAO as part of the NAO audit of MOHSW books. The audit will have a special note for the Danida funds. The audited financial reports including a management letter will be made available to the PS/MOHSW and RDE no later than 6 months after the end of the financial year.

5.8. Monitoring, reporting, reviews and evaluations

The activities will be monitored by the MOHSW as part of the monitoring of the MTEF implementation. MOHSW will prepare quarterly financial statements and half-yearly progress reports on physical progress. Results will feed into the Joint Annual Health Sector Review (JAHSR) . The technical progress will further be reviewed annually in connection with the JAHSR of the support for the HSSP. In the second year of HSPS IV a Joint MOHSW-Danida Review will be undertaken to critically review progress, obstacles and needs for adjustment of sub-component 2.

Danida will, if the need arises, carry out any supervisory visits, reviews or evaluations it finds appropriate. This decision will be taken in consultation with the MOHSW and PMORALG as well as the other partners in order to minimise administrative burdens on the MOHSW and maximise benefits to the sector. Such independent reviews and evaluations will be an exception and are not expected to occur frequently.

6. Sub-component 3: Support to strengthening the non-government health sector and public private partnership (PPP)

6.1. Context

Issues and challenges

In Tanzania about 40% of health services are provided by the private sector, including FBOs, CSOs, NGOs and the private for profit providers (PFP). In the past, the private sector has been mainly represented by FBOs but since 1991, the private-for-profit health providers have been growing rapidly particularly in the urban areas. While the PFP health sector mainly provides curative services in urban areas, the FBOs provide curative and preventive services in the rural areas, complementing similar services provided by the GOT. Many of the FBO facilities have training schools attached to them. Legislation and regulation exist, e.g. for licensing of private health service providers and accreditation for service delivery at certain level. Regulations are, however, not systematically applied and has room for improvement.

The FBO sector is financed through a variety of resources including subsidies from the government, user charges and insurance, contribution from DPs and other external resources. FBO hospitals designated as District Designated Hospitals (DDH) are, however, funded on the same basis as district hospitals. Reductions in funding from traditional core partners abroad and within Tanzania combined with insufficient subsidies by the GOT, however, impose increasing financial constraints. In effect, most FBO health facilities at all levels of the referral chain face serious difficulties to sustain themselves. A most notable problem is the increasing difficulty for most FBO health facilities in attracting and retaining professional staff. This, and the increasing dependency on user fees has severe and critical effects on access to care and public health effects.

The PFP sector is mainly financed by charges and health insurance. In some instances, PFP providers receive resources from the government, e.g. some districts provide MCH supplies to selected PFP providers for delivering specific essential services like MCH, other examples are the provision of TB drugs for DOTS and provision of VCT services in combination with provision of ART.

The National Health Policy (June 2007) acknowledges the complementarity of the private sector in health service provision, as well as the existence of areas of weaknesses in the private sector as well as in the collaboration with the private health sector. One of the objectives of the National Health Policy is to improve participation of the private sector in improving access to health services at all levels. This is being pursued through the adoption of a specific PPP strategy in the HSSP.

At National level a PPP Steering Committee has been established and, at a limited number of zones and Regions, PPP fora have been initiated with varying levels of success and impact. However, there is little coordination and linkages between the National PPP Steering Committee and the zonal and regional PPP fora. The fora lack formal mandate to take concrete actions on issues raised. At District level a number of institutions have been initiated (e.g. CHSBs and Facility Governing Committees) with the aim to improve popular governance structures which include private sector involvement. At the end of 2007, the MOHSW, the PMORALG, BAKWATA, CSSC and APHFTA finalised a template for a Service Agreement governing the health service provision between an individual service provider and the (local) government. This template is currently being introduced and will possibly replace current financing mechanisms between government and health providers such as the DDH arrangement, by moving from institution-based to service-based financing.

Though there has been a considerable emphasis on the need to implement the PPP strategy, and despite some stand alone PPP initiatives and successes, in general a meaningful and sustained improvement in health outcomes as a result of improved dialogue, collaboration and partnership has not been achieved. The MOHSW has not been convincing in its role as steward and regulator of PPP. There is general inadequate conceptual recognition and understanding of PPP and of the objectives that PPP is really intended to play in the health sector at all levels. The private sector is often regarded as a separate competing system rather than a complementary element in one health care system next to the government. This is not only the case at the national level, but also at the regional, district and village levels. While the concept and the relevance of PPP may be slowly getting more attention and understanding among stakeholders in the health sector, practical implementation of PPP is still very limited. Mainstreaming of the PPP strategy in the design, implementation and M&E of health policies is only at very premature levels and there is no specific strategic plan for the implementation of PPP.

Whilst the capacity of the MOHSW to conceptualise and operationalise the PPP strategy is limited, the capacity of FBOs, CSOs, NGOs and PFPs to use the PPP strategy to comprehensively understand and jointly address the main issues affecting the health sector in partnership with the MOHSW is equally limited. Not only are the non-government stakeholders in health fragmented along ideological and denominational lines, they also lack organisational and institutional capacity to advocate and implement change. While some marked improvements can be seen over recent years in development of umbrella organisations such as CSSC and APHFTA, their main presence and influence is largely at national level. Regional and district representation of CSSC and APHFTA, although developing, is only at a premature stage and at present has little capacity to drive a meaningful PPP agenda or to set an enabling PPP environment in support of their respective members at the operational levels.

The HSSP III aims to ensure a conducive policy and legal environment for operationalisation of PPP by putting in place national PPP policy and legal frameworks, which enable PPP at national, zonal, regional and district level; to ensure effective operationalisation of PPP by establishing PPP forums at national, regional and district level that are functional for joint planning, implementation and monitoring and evaluation of health services; and to enhance PPP in the provision of health and

nutrition services. The enhancement of PPP will result in the participation of the private sector in the formulation of the CCHPs in all districts; in a rational allocation of health funds to public and private providers using service agreements and based on competencies and performance; in maximum involvement of private providers in health programmes through service agreements; in mechanism for optimal mutual utilisation of human resources for health in public and private facilities; and in increased motivation to increase the availability of fortified foods.

Danida has in HSPS III provided assistance to Faith Based Organisations in an attempt to strengthen the public private partnership. Danida has recently agreed with other partners to jointly fund the CSSC in order to provide more efficient and coordinated support. In addition, Danida has actively promoted PPP through HSPS III activities at regional and district level in the Lake Zone.

Key stakeholders

The development of PPP requires that the MOHSW has capacity to engage on behalf of the public sector, but also that the private sector providers are organised in umbrella organisations or representative bodies that can represent their views and engage in communication with MOHSW on PPP issues. A previous technical review of the PPP (HERA 2005) identified umbrella organisations that had the potential to become such representative organisations for the FBOs and the PFP sub-sectors.

MOHSW/PPP Unit –The capacity of the MOHSW to take on its stewardship role, to develop PPP, PPP policy and strategies, to voice the view of all health service actors, to develop required tools, to mainstream PPP through collaboration with other MOHSW departments and to ensure that private sector is taken into account in all relevant health strategies is very limited. The PPP Unit is placed under the Directorate of Hospital Services. It has recently been separated from the private hospital registration desk. Until recently the person in-charge of the PPP desk was also tasked with other time consuming responsibilities, but recently new staff has been appointed. If MOHSW is not strengthened in its stewardship role at national level, little can be expected at regional and district level, where most officers wait for instructions and guidelines before engaging in PPP arrangements at their respective levels and where the institutions created at district level and potentially a proper vehicle to move PPP (eg DHSBs, HFSBs) are mostly not functioning as planned. Progress in the PPP stewardship role will require that the priority given to this area is reflected in the allocation of staff time and resources, e.g. the staff responsible for PPP should be allocated to work full-time in a PPP Unit with clear mandates. There is a need for the PPP unit to be more focused by defining clearly what it is possible to address in the next five years by having a strategy in place.

CSSC – Christian Social Services Commission (CSSC) is an Ecumenical Body jointly established in 1992 by the Christian Council of Tanzania (CCT) and the Tanzania Episcopal Conference (TEC). The main responsibility of CSSC is to facilitate the delivery of social services with focus on Education and Health. Health services facilitated by CSSC account for 607 health facilities, including 87 hospitals, 68 health centres and over 452 dispensaries. In addition, CSSC has been instrumental in developing the Tanzania Inter-Faith Forum (TIFF) and currently houses its secretariat.

Some of the obstacles that impacted on the work of CSSC include: inadequate involvement of TEC and CCT members and other stakeholders in planning; low contribution from church institutions; lack of a sound resource mobilization strategy; weak management systems; inadequate funding to implement planned activities; inadequate communication and lack of monitoring and evaluation system. In view of ongoing reforms (and decentralisation) in the educational and health sector, CSSC organised itself on a "zonal basis", creating 5 so-called Zonal Policy Forums. These are still to become truly functioning. There is a need to continue strengthening the Zonal Policy Forums and establishing strong

technical support to zonal structures, dioceses, church education and Health Institutions through decentralized coordination of policy debates, participation in health planning and management.

Strategic analyses which focus on critical issues and will provide strategic direction for CSSC has been or are in the process of being undertaken. CSSC has in place a Five Year Rolling Strategic Plan which has helped CSSC reposition itself to become a more effective and efficient instrument for carrying out its core functions of policy advocacy work, lobbying and capacity building especially with regard to the key areas of human resources development, equitable distribution of resources, physical infrastructure, equipment, drug availability etc., all of which are critically essential elements in attaining equitable access to quality social services delivery. The Strategic Plan is an important tool for resource mobilization domestically and internationally. Furthermore, it provides a basis for coordination, communication, joint implementation, monitoring and evaluation.

CSSC's core budget is financed by mainly church-related donor agencies abroad, with other sources contributing to specific programmes (such as rehabilitation of schools and health units). Cordaid and EED are key development partners, whom Danida has joined in the support to the implementation of CSSC's strategic plan.

APHFTA – In 2006, the Association of Private Hospitals in Tanzania (established in 1994) re-constituted itself into the Association of Private Health Facilities in Tanzania (APHFTA), an umbrella membership-based organisation for PFP providers. Health facilities eligible for membership include hospitals, health centres, dispensaries, laboratories, pharmacies, specialised clinics, nursing homes, physiotherapy centres among others. The present membership is almost 350 from among a potential base of more than 3,000 providers, i.e. about 10% coverage. The organisation is governed by a board of directors and trustees. The organisation has a National secretariat with 8 key staff and 6 Zonal branches.

The mission is "to provide a forum for private health care providers and the private health sector for advocacy, administration, knowledge-sharing and networking, among themselves and with the government and to establish linkages with the community that will contribute towards poverty alleviation." APHTA has developed a Strategic Plan 2005-10 containing 7 strategic objectives among which are to complement the provision of public sector health care services; to increase accessibility and availability of quality medical supplies at competitive prices; to strengthen and maintain the high standard and professional competence in the private health sector. A mid-term evaluation of APHFTA's Strategic Plan is planned for the fall 2008. This evaluation will provide directions for the remainder of the plan period and are likely to include a costing of the remaining and new activities.

APHFTA is actively involved in various public private partnership initiatives, at district and regional level as well as in the policy dialogue at central level. Members pay membership contributions. APHFTA has previously received some funding from DCI for organisational strengthening and capacity building and have received project funds from MSH/USAID, Global Fund – Round 4 (through NACP), World Diabetes Foundation and others.

Professional associations - The number of associations of medical , clinical and nursing professionals exceeds 20, some of which are very limited in size (HERA 2005). Their objectives include upkeep of professional standards of ethics and conduct; representation and promotion of professional interests. Although, the professional associations could potentially play an important role in relation to setting and maintaining standards also in the private sector through effective self-regulation, they do not presently play such a role.

National Public Private Partnership Steering Committee (NPPPSC) includes members of MOHSW, PMORALG, APHFTA, CSSC, BAKWATA, representative for Professional Association, TGPSH and Danida. TORs have been developed. The NPPPSC is a forum for facilitating the operationalisation of

PPP at all levels, coordinating of public and private stakeholders for organised participation in policy dialogue, support development of contractual arrangements and enforcement of legal arrangements, networking.

6.2. Strategy and guiding principles

The HSSP Public Private Partnership Strategy outlines key objectives, outputs and indicators. Successful implementation of the PPP strategy requires that both the MOHSW as well as the private sector is well-organised and committed and have the capacity to take on their responsibilities. HSPS IV will assist in strengthening its main stakeholders through capacity development (skills and systems) with focus on organisational development of key partners and institutional strengthening of the health system to improve the quality of the policy dialogue and to improve policies to improve and facilitate participation of the private sector in increasing coverage and provision of quality public health goods. The latter will require capacity with regard to contractual arrangements as well as with regard to regulation, quality improvements, supervision and monitoring and evaluation.

As a key starting point, there is a need to support the MOHSW to review the operations of the PPP unit vis-à-vis expected mandate including the development of a plan to address of the current bottlenecks that are making it difficult to promote PPP such as legal framework gaps, current administrative arrangements, mind set of those tasked with promotion of PPP and expounding guiding principles of PPP at policy level The MOHSW will need to be assisted to strengthen its role as regulator and steward especially in areas of regulation (registration, licensing and accreditation and quality assurance). There is a need to move away from the present perception of three different parallel systems (Public, FBO and PFP) towards one health system with different actors that should be enabled to provide quality health services for public benefit.

Next to support to MOHSW, the FBO and PFP providers will be facilitated to organise them selves into effective representative bodies to facilitate communication and coordination with government. through support two main representative bodies, one for the FBOs and one for the private for profit providers. It is assumed that this approach will lead to a conducive environment for PPP and a better understanding, organisation and rationalisation of a holistic and pluralistic health care system in which public and private stakeholders will relate better to provide public health goods in a more complementary fashion. As such the strategy will contribute to overcome the current fragmentation in the health care system. Operational research will be applied as a distinct strategy to document lessons of the anticipated impact of improved public private relation (e.g. contracting) and to guide evidence based policy dialogue and formulation.

HSPS IV will assist in strengthening of CSSCs national and decentralized capacity particularly with respect to enhancing quality improvements of services provided by its member institutions, including CSSC providing support in local negations on institutional based service agreements through the CSSC central Zonal, Regional and District forums. In order to realise this, the CCT and TEC will need to agree to entrust CSSC with a firm mandate to liaise with non Christian FBOs and engage a working relationship with MOH to promote PPP.

HSPS IV will support non-routine activities implemented by GOT. Activities supported would typically include development, testing and implementation of systems to a level where it is functioning and can be rolled out or skills development based on an institutional needs assessment, assisting with set up of committees to facilitate PPP. Specific innovative PPP projects may be supported with flexible funding under certain well defined criteria, including support tour visits to neighbouring countries to explore on the best practice in PPP. Finally, there may be activities where flexible funding can contribute to benefit from opportunities that suddenly arise. Support to private sector organisations may be provided as core

funding for implementation of strategic plans, preferably in a pooled funding arrangement with other DPs. Such funding will not be restricted to non-routine activities.

HSPS IV will mainly support the key players in the implementation of the HSSP PPP Strategy, e.g. MOHSW PPP unit, PMO-RALG directorate of local government that is supposed to promote PPP at regional and council level, CSSC and APHFTA. The bulk of the support will be provided to strengthening of CSSC. Given the weaknesses of the current set up in MOHSW for PPP and the present lack of implementation capacity, support to the MOHSW PPP unit while urgently needed would require a demonstrated commitment by MOHSW to dedicate sufficient staff time and other resources.

The HSSP PPP Strategy underscores the importance of participation of non-state providers and CSOs for increasing access to health services, and the need to stimulate private providers to step up service provision to vulnerable groups and in remote areas, while also taking into account the distinctive competencies across the sector. NGOs/CSOs often have a more comprehensive and community oriented approach, which may not fit directly with the service agreements developed for FBOs and PFP providers that are in many ways more like the government providers. HSPS IV support under sub-component 3 could be used to facilitate PPP with one or two NGOs, which have special competencies in targeting vulnerable groups, with a view to developing a mechanism for partnership with NGOs that could be replicated in other areas. One NGO that could be considered is Comprehensive Community Based Rehabilitation in Tanzania (CCBRT), the largest provider of disability and rehabilitative services. Community based rehabilitation is the guiding principle of CCBRT's work. CCBRT opts to provide physical rehabilitation through medical care at the CCBRT disability hospital. It also supports patients so they can become socially and economically empowered, promotes and protects human rights and assists in the social inclusion of persons with disabilities into their local communities through CCBRT community programmes. Furthermore, CCBRT has recently signed a MOU with GOT through MOHSW for the existing disability hospital to be upgraded to become the Designated Regional Hospital of Dar es Salaam. This may provide valuable experiences on operationalisation of PPP.

The private sector organisations will be supported based on their Strategic Five Year Plans (or similar) and annual work plans. An annual budget will be negotiated and agreed prior to each year for Danida funds to support the execution of the work plans. Limited basic equipment and supplies can be provided under special circumstances where there is clear and evident justification. Support will preferably be rendered as harmonised core funding.

The support to private health sector institutions/organisations is intended to be availed as budget support, preferably jointly with other partners, based on a mutual agreement and with the requirement of financial and narrative reporting on all aspects of their activities as done in their general annual report for supporting partners.

6.3. Objectives, outputs and main activities

HSPS IV Objective: To support the implementation of the HSSP PPP Strategy with a focus strengthening the relationship, collaboration and partnerships between public and private stakeholders in the health sector for increased coverage, equity and quality of health services.

The expected output of the HSPS IV support is

Output 3.1: Improved policies, regulation and actions for private health sector involvement in the health sector, including institutional development and capacity building of MOHSW

Output 3.2: Improved relevance and functionality of PPP co-ordination fora, including institutional development and capacity building of MOHSW, CSSC and APHFTA

Output 3.3: Improved PPP arrangements at zonal, regional and district level

The earmarked funds for PPP together with funds from GOT and HBF is expected to contribute to the overall strategic objective and most of the specific objectives of the HSSP PPP Strategy.

Main activities: Activities would generally be selected for implementation in accordance with the guiding principles outlined above and can include but will not necessarily be limited to the following

a) MOHSW capacity for policy development, regulation and coordination strengthened

- Formulate national PPP policy, strategic framework and operational plans
- Assist in PPP policy development, regulation, legislation, harmonisation and advocacy in relation to human resources, health financing, accreditation, health planning and governance, including specification of clear roles for RHMTs and CHMTs.
- Assist in analysis of capacity of the MOHSW/PPP unit compared to its mandate and responsibilities and review the organisational set-up of PPP desk;
- Facilitate institutionalisation of service agreement to improve involvement of the private sector in the delivery of health services thus improving PPP
- Evaluate, develop and facilitate coordination and monitoring mechanisms at all levels to promote PPP
- Initiate, facilitate and evaluate specific PPPs to directly improve coverage and quality of health services, e.g. EHP, TB, NCDs, special diseases, drug supply, CCBRT etc.
- Build capacity of regional and LGA health management teams and boards for PPP mainstreaming

b) Institutional development and capacity building of CSSC for health policy development, advocacy and engagement with government

- Initiate and facilitate specific PPPs to directly improve coverage and quality of health services, e.g. EHP, TB, NCDs, special diseases, drug supply etc.
- Strengthen capacity and institution at Zonal, regional and district level to be effectively represented in decision-making for a of RHMT, CHMT and health governance institutions
- Develop system for self-regulation e.g. peer reviews, participating in monitoring and supervision with regional and council management teams
- Document micro lessons for macro policy development

c) Institutional development and capacity building of APHFTA

- Develop system for self-regulation, e.g. peer reviews, participating in monitoring and supervision with regional and council management teams
- Initiate and facilitate specific PPPs to directly improve coverage and quality of health services, e.g. EHP, TB, NCDs, special diseases, drug supply etc.
- Conduct studies to define, identify and document private for profit health providers and services
- Strengthen capacity and institution at Zonal, regional and district level
- Document micro lessons for macro policy development
- Develop a strategic plan from 2011

d) Policy development/Operational research:

- Operational research on capacity, utilisation and community contributions to financing of private providers (FBO/PFP)
- Study on financing of FBO hospitals

- Mapping health facilities; (consolidated mapping taking advantage of existing exercises undertaken by PMORALG, MOHSW, CSSC, including development of tools to use the information)
- Mapping of existing PPP arrangements: (e.g contracting, leasing, voucher, pp competition, global PPPs, etc.)

6.4. Inputs and budget

GOT funds, HBF and earmarked funding will jointly contribute to the achievements of the objectives and targets of the HSSP PPP strategy.

The indicative budget allocation for HSPS IV sub-component 3 is 25 million DKK, cf. Table 3.

Table 3. Indicative budget for Sub-Component 3 in million DKK:

	FY starting:					
Outputs	**2009**	**2010**	**2011**	**2012**	**2013**	**Total**
3.1 Improved policies and regulation	1.00	1.00	1.00	1.00	1.00	**5.00**
3.2 Institutional development and capacity building	3.00	3.00	3.00	3.00	3.00	**15.00**
3.3 Improved PPP at zonal, regional and district level	1.00	1.00	1.00	1.00	1.00	**5.00**
Grand Total	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	**25.00**

Note: Virement between budget lines is permitted.

In addition funding is set aside for one long term PPP Advisor throughout the programme period to assist the PPP Unit in institutional development and capacity building including such support to CSSC and APHFTA as necessary, cf. job description in Appendix 5. MOHSW will ensure that counterparts are appointed and available to work with the PPPA. MOHSW will further provide adequate office space for the PPPA.

6.5. Management and Organisation

Oversight and Decision-making Structures

The Head of each of the supported organisations will be responsible for the implementation of the component, e.g. the PS for MOHSW, the Director for CSSC and the President for APHFTA.

A Steering Committee (SC) for the earmarked support to the health sector Mainland will be formed, see also Chapter 5.6, although its activities will be kept to a minimum. The SC will consist of representatives of implementing partners and RDE. Composition, mandate, tasks and working arrangements are described in Appendix 6.

The support to the implementation of the CSSC strategic plan will be provided jointly with Cordaid and EED and any other partners that will wish to assist. A joint MOU is in the process of being developed and is expected to be in place before June 2009. A joint decision-making and oversight structure will be used. The HSPS IV SC will decide on the overall resource allocation only. The CSSC Joint decision-making body will inform the HSPS IV SC on annual plans and progress in implementation.

Before the start of each year an annual work plan and budget will be drafted by APHFTA, and any other private health sector organisation supported, based on its Strategic Plan, to be presented and approved by the HSPS IV SC. The plan should include objectives, outputs, activities and expected results which are considered suitable and appropriate for support under this component.

The JAHSR will assess implementation of the MTEF including the earmarked components as far as they are included in the MTEF. The JAHSR cannot be expected necessarily to go into much detail with all aspects of activities earmarked by individual donors, not least for support outside the MOHSW. Therefore, in conjunction with the JAHSR Meeting, the RDE and MOHSW/CSSC and APHFTA will be responsible for undertaking a brief (1-2 days) Annual Programme Review (APR) of the earmarked support (sub-component 2 & 3). As regards support to private sector organisations the APR may be replaced with a joint review by contributing development partners.

The APR will recommend adjustments to HSPS IV as necessary in view of the sector development. At the same time the need to reallocate funds between the budget lines will be assessed.

Daily Management

All earmarked activities will be detailed in the annual work plans. The day-to-day management may be delegated to senior staff with direct responsibilities for coordination and implementation of activities within each organisation.

MOHSW/PPP Unit – The Director of DHS will be responsible for the coordination of the implementation of the HSSP III PPP Strategy. Overall direction will be provided by the NPPPSC. The Head of the PPP Unit under the DHS will be responsible for the day-to-day management and implementation of activities. The PPP Unit will in liaison with the other organisations involved, through the NPPPSC, prepare annual work plans for the implementation of PPP, including activities to be supported by HSPS through MOHSW. These plans will include time tables, inputs and anticipated outputs with defined indicators.

The PPP Unit will prepare an annual progress report for overall implementation of PPP, including Danida earmarked activities, which will be presented to the NPPPSC meeting and the TC-SWAp and copied to the HSPS IV SC.

CSSC – The Director of CSSC will be responsible for the coordination of the implementation of the Five Year Strategic Plan. The MOU between CSSC and DPs will outline the procedures for preparing annual work plans and technical and financial progress reports.

APHFTA (and others) – The Director/President of the organisation will be responsible for the coordination of the implementation of the Strategic Plan. The MOU between APHFTA and DPs will outline the procedures for preparing annual work plans and technical and financial progress reports.

6.6. Financial management and procurement

The same Procedure Manual as for sub-component 2 will be valid for the implementation of sub-component 3. Programme Activities will be developed and approved by the SC.

Prior to entering into an agreement with a private health sector 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 agreements on financial management and reporting.

Planning and budgeting

Before the start of each year, each organisation is responsible for developing an annual work plan and budget based on their Strategic Plan. The Strategic Plan and annual work plan and budget will be discussed and approved by the relevant Steering Committee before submission to RDE. The work plan for the first year will be prepared in the Spring 2009.

Disbursements

Support to activities undertaken by the MOHSW will be disbursed in the same way as funding under sub-component 2. For the private sector organisation a separate account will be used for Danida

support unless otherwise agreed in relation to a joint funding arrangement. Based on the approved annual work plans, RDE will disburse funds to recipient organisations. Unless otherwise agreed, disbursements will be made in equal portions on quarterly basis. Disbursements will depend on timely and financial reporting on previous periods.

Procurement
The procurement will follow the procedures stipulated in the Procedures Manual.

For international consultants contracted through Danida Copenhagen, Danida's procedures and regulations will apply. Payment will be made directly by Danida in Copenhagen to the consultant according to a contract between these two parties. Goods and services paid for directly by Danida are considered to be grant-in-kind assistance.

Accounting and auditing
Accounting and auditing of support to MOHSW activities will follow the same procedures as for sub-component 2. Private health institutions/organisations will have full responsibility for managing funds received, complying with the financial requirements, including timely accounting and reporting to RDE, in accordance with the signed MOU between the institution/organisation and the RDE (and possibly other partners).

At the end of the financial year there will be an external audit by an audit company of international standard of the books of account and financial statements of CSSC's and APHFTA's and any other recipient non-government organisation, including the Danida funding. The audited financial reports will be made available to the recipient organisation and RDE no later than 6 months after the end of the financial year.

6.7. Monitoring, reporting, reviews and evaluations

The activities will partly be monitored by the MOHSW as part of the monitoring of the MTEF implementation. Furthermore, for the support outside GOT each of the supported organisations will prepare quarterly financial statements and half-yearly progress reports on physical progress. The results will feed into the JAHSR, the HSPS IV APR or any agreed Joint Annual Review of non-state organisations. In the second year of HSPS IV a Joint MOHSW-Danida and Private Partners Review will be undertaken to critically review progress, obstacles and needs for adjustment of sub-component 3.

Danida will, if need arises, carry out any supervisory visits, reviews or evaluations if finds appropriate. This decision will be taken in consultation with the recipient organisation in question as well as the other partners in order to minimise the administrative burden on the organisation. Such independent reviews and evaluations will be an exception and are not expected to occur frequently.

7. Budget

Under Component 1 Danida will support the health sector in Tanzania Mainland for the five-year period July 2009 to June 2014 through a grant of up to 528 million DKK (including contingencies)). Table 4 presents the breakdown of the budget. Financial support to the sub-components has been allocated over the five years, but the breakdown across years is based on assumptions on pace of implementation and is indicative only. Each year detailed work plans and budgets will be developed.

Table 4. Budget for Component 1: Support to the health sector in Mainland. Millions DKK.

Sub-component	2009/10	2010/11	2011/12	2012/13	2013/14	Total
1.1 Support to the health basket funds						
1.1.1 Support to the HBF	60.0	64.0	75.0	82.0	85.5	366.5
1.1.2 Support to the HSDG	10.0	10.0	10.0	10.0	10.0	50.0
Sub total	**70.0**	**74.0**	**85.0**	**92.0**	**95.5**	**416.5**
1.2 Support to capacity strengthening						
1.2.1 Hospital reforms	4.0	4.0	4.0	4.0	4.0	20.0
1.2.2 Drug chain strengthened	4.0	4.0	4.0	4.0	4.0	20.0
1.2.3 Strategic initiatives	1.0	2.0	3.0	2.0	2.0	10.0
Sub total	**9.0**	**10.0**	**11.0**	**10.0**	**10.0**	**50.0**
1.3 Support to PPP						
1.3.1 Improved policies and regulation	1.0	1.0	1.0	1.0	1.0	**5.0**
1.3.2 Institutional development and capacity building	3.0	3.0	3.0	3.0	3.0	**15.0**
1.3.3 Improved PPP at zonal, regional and district level	1.0	1.0	1.0	1.0	1.0	**5.0**
Sub-total	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**	**25.0**
Technical assistance (short and long term)	**5.5**	**6.0**	**6.0**	**6.0**	**5.0**	**28.5**
Administration	**1.0**	**1.0**	**0.5**	**1.0**	**0.5**	**4.0**
Contingencies	**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**4.0**
Grand total	**90.5**	**97.0**	**108.5**	**115.0**	**117**	**528.0**

Note: 5 long term TA included.

The majority of the funding (80 %), is allocated for basket fund support to implementation of HSSP III, 9% for support to capacity strengthening and 5% for support to the private sector, cf. Table 5 below. In total 82% of funding will be channelled through joint funding arrangements.

Table 5. Percentage distribution of Support to the health sector in Mainland

	Mill DKK	Pct
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%
Grand total	524.0	100%

Note: Excluding contingencies.

Reallocation between budget lines within the sub-components is possible subject to approval by RDE. The budget line for administration can, if need be, be used for necessary start up cost for office equipment for the technical advisers, extra cost the MOHSW may incur in connection with the administration of the earmarked funding, assessment of financial management capacity of NGO's, audits, etc.

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[12]. Depending on the magnitude of the proposed funding, the proposal will have to go to Danida Copenhagen (Bilateral Chief) for final approval.

8. Sustainability and replicability issues

Sustainability and replicability

Achieving financial sustainability is not realistic in the short and medium term in view of the significant resources required to allow for scaling up of priority interventions in the health sector in order to reach the MDG targets. Danida is contributing to reducing the sector's existing financing gap in the short term. By channelling the majority of funding through joint funding arrangements Danida contributes to the strengthening of capacity of the government systems and to making the sector less susceptible to fluctuations in availability of funding, thereby increasing the sustainability in service delivery.

Danida's support does contribute to institutional and technical sustainability of the health system through earmarked support and long-term technical assistance aimed at capacity development in drug management and hospital management. The earmarked support aims at ensuring sustainability by building on the experiences gained in HSPS III, using local institutions as much as possible, e.g. to support hospital reforms, and ensuring that the GOT provides most of the resources to hospitals and drugs. As regards the support to strategic initiatives, such initiatives would be assessed in terms of sustainability and replicability.

The majority of support under Component 1 is provided as unspecified support to strategic plans of government institutions or private sector organisations. Replicability is therefore not an issue.

Institutional and target group involvement

Formally, target groups are involved through the process of designing the MKUKUTA, the parliament's decisions on budgets (e.g. MTEF) and the councils' decisions on the annual CCHPs. In reality the democratic and political process in Tanzania is on a long path of development towards achieving substantial involvement of the population, not least as regards target groups such as the poor and women. In this context it is important to note that there is progress good governance in Tanzania.

Involvement of institutions and target groups are high as activities funded are part and parcel of the government and private sector organisations' own prioritised plans. The demand driven approach used for the support to strategic initiatives should ensure institutional and target group involvement at least at the national level.

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

Gender

The overall objective of the programme 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. HSPS IV will support the implementation of the HSSP, including the gender aspects, mainly through the HBF. Gender issues are being addressed jointly by likeminded DPs through the

[12] 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.

policy dialogue in relation to the development of sector strategic plans, policies and their implementation. The planned gender analysis for FY 2008/09 may present opportunities for addressing gender issues. According to the agreed division of labour between DPs the Netherlands is presently the lead on gender issues in health.

Environment

No major environmental impact of HSPS IV is expected. HSPS IV will support the implementation of the HSSP, including environmental health activities. Administration of hazardous waste is being guided by relevant policies and activities that can be funded by the HBF. The rehabilitation of primary health care facilities to be supported through the LGCDG Health Window 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.

Human rights, democratisation and good governance

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. 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. In addition, sub-component 3 includes the option to support specific PPP arrangements with organisations that specifically targets vulnerable groups.

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 sector.

HIV/AIDS

Health sector interventions are addressed indirectly through the support to the HBF. The multi-sectoral aspects are supported directly through Component 3, cf. Annex 3 to the Overall Sector Programme Support Document.

Children and adolescents & Sexual and reproductive health and rights

There is a strong focus on MDGs in the MKUKUTA and in the HSSP especially on MDGs 4 (reduce child mortality), 5 (improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases). These themes are addressed indirectly through support to the HBF.

Cross-cutting issues will be actively pursued in the policy dialogue, however, in accordance with the JAST taking into account the agreed division of labour between development partners. Furthermore, strategic initiatives related to cross-cutting issues are eligible for support under sub-component 2.

10.Implementation arrangements

Where such exist, the implementation procedures will follow the implementation arrangements agreed upon between recipient organisations and DPs and stipulated in an MOU to which RDE is signatory and that outlines in detail the roles, responsibilities and obligation of all stakeholders and describes the implementation arrangements, including disbursement, procurement, audits and reporting,

10.1. Management and Organisation

The following provides a brief overview. Reference is made to Chapters 4.5, 5.6 and 6.5 for more details.

Basket funding arrangements

No separate steering committee will be needed. The programme will rely on the TC-SWAp and the BFC as well as on the TC-LGCDG and the LGCDG System Steering Committee for oversight and decision-making. See also Chapter 4.5.

Earmarked support

Oversight and decision-making structures – The Head of the recipient organisation will be responsible for the implementation of the relevant HSPS IV activities, e.g. the PS for MOHSW, Director for CSSC and the President of APHFTA.

As there is a need for an oversight and decision-making forum for the earmarked support, a Steering Committee (SC) for the earmarked support to the health sector Mainland will be formed, although its activities will be kept to a minimum. The SC will consist of representatives of implementing partners and RDE. Composition, mandate, tasks and working arrangements are described in Appendix 6.

The support to implementation of strategic plans of private sector organisations will as far as possible be provided in collaboration with other DPs and specific oversight and decision-making structures may be outlined in MOUs. Such an MOU is in the process of being developed between CSSC and DPs and is expected to be in place before June 2009.

Daily management – The coordination of resources for the MOHSW is the responsibility of DPP. This includes coordination of the Danish support with other resources. The day-to-day management may be delegated to senior staff of the responsible department/organisation with direct responsibilities for coordination and implementation of activities. The responsibility for daily management of the implementation under each intervention area should be delegated to the units that would normally be responsible for implementation of such activities.

There will not be an HSPS management structure per se.

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.

All earmarked activities will be detailed in annual work-plans, which would be included in the implementing organisation's overall work plan for the specific intervention area, e.g. the MTEF as regards MOHSW. Within each intervention area progress on Danida assisted activities will be reported as part of the department's regular progress reporting. An annual progress report including the Danida supported activities will be presented to the HSPS IV Component 1 Steering Committee as well as to other interested parties.

Technical assistance

The need and scope for TA will be jointly assessed as part of sector reviews and will be coordinated with other donors. Counterparts 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, work planning for and supervision of both long and short term TA as well as performance assessments at end of contract (short term TA) or annually (long term TA). Identified needs for changes in TOR, working environment or performance issues will be discussed with RDE.

All long term advisors will work within MOHSW and with designated counterparts. They will report to their head of department working within those institutions. The advisors will in general have only limited Danida programme management tasks unless delegated so by their head of department, the exception being that the HPPMA and the PFMA will provide some limited assistance to the SC and supervision regarding preparation of budgets, accounts and audits for the earmarked support. The

advisors will relate to RDE for personnel administrative issues and for regular mutual briefings. Consequently, counterpart institutions will also bear the responsibility and be accountable for implementation of TA assisted interventions.

Recruitment of TA will take place through Danida Copenhagen/RDE. In case a TA pool with financial contribution from individual DPs and engagement of TA by the MOHSW is established (outside or within the HBF) some of the HSPS IV funding for TA and possibly of the unallocated funds under the overall programme may be transferred to such a pool and management of TA will follow procedures agreed for such a pool.

10.2. Financial management and procurement

Joint funding arrangements

The mechanisms for flow of funds, financial management and procurement will follow the agreements of the MOU(s) for the HBF covering the period July 2008 to June 2015 and the 2008-13 MOU for the HSDG & LGDG to be signed soon or of later amendments to which RDE is signatory. Cf. Chapter 4.6 for a summary of main issues.

Earmarked support

A Procedure Manual for the Implementation of HSPS IV Programme Activities will be developed and approved by the SC. The Procedures Manual will describe details of the financial management and procurement of goods and services and be in accordance with Danida Guidelines.

Planning and budgeting

Before the start of each year, each organisation is responsible for developing an annual work plan and budget based on their 5-Year Strategic Plans. The MOHSW (and its agencies) is responsible for proposing annual work plans and budget for the earmarked funds based on the HSSP as part of the annual MTEF planning exercise. Private sector organisations have their own strategic plans.

RDE will notify the Heads of recipient organisations well in advance of the total earmarked amount for the next year. Planning and budgeting for the earmarked funds should, as regards MOHSW, follow the normal government procedures and time lines for development of work plans and budgets. The same time lines will be followed by other organisations supported. The plans and budget will be discussed and approved by the SC before submission to RDE.

Disbursement and flow of funds

For earmarked support to activities undertaken by the MOHSW a designated account in BOT will be used. Based on approved annual work plan, RDE will disburse funds bi-annually based on a request from MOHSW. Funds will be transferred from RDE through the MOFEA to MOHSW and deposited in the designated BOT account. Disbursements will depend on financial reporting on previous periods. Onwards disbursement will follow normal GOT procedures.

For the private sector organisations a separate account will be used for Danida support unless otherwise agreed as part of joint funding arrangements. Based on approved annual work plans, RDE will disburse funds to recipient organisations. Unless otherwise agreed, disbursements will be made in equal portions on quarterly basis. Disbursements will depend on satisfactory financial reporting on previous periods.

Procurement

In case of national procurement of consultancy services or other procurement, the GoT procurement procedures will be applied unless the MOHSW request the RDE to apply Danida procedures.

For international consultants contracted through Danida Copenhagen, Danida's procedures and regulations will apply. Payment will be made directly by Danida in Copenhagen to the consultant

according to a contract between these to parties. Goods and services paid for directly by Danida are considered to be grant-in-kind assistance. Procurement of TA through a TA pool, should such be established, will follow other rules agreed between partners.

Accounting and auditing

The recipient organisation will be responsible for the management of funds, for compliance with Danida financial requirements and for timely accounting and financial reporting. For GOT recipients, GOT accounting and auditing procedures will be followed.

For NGOs the Danida Guidelines for grants through Government and Para-Statal Organisations and NGOs will apply. The Chart of Accounts will as far as possible be compatible with the Chart of accounts for the recipient organisation to facilitate integration into their own financial reporting. Accounts will be kept in accordance with internationally accepted accounting standards. At the end of the financial year there will be an external audit by a certified audit company of international standard appointed by the recipient organisation and approved by RDE.

Recipient organisations will prepare quarterly financial statements and submit these in a timely manner to Danida. The audited financial reports including a management letter will be made available to the appointing organisation and RDE no later than 6 months after the end of the financial year.

10.3. Monitoring, reporting, reviews and evaluations

Monitoring mechanisms

Joint mechanisms for monitoring, reporting, review and evaluation have been developed for the Health SWAp and the GBS facility e.g., as regards public financial management. 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.

For HSSP III a set of indicators and targets covering both outcomes and sector performance as well as a set of priorities and milestones has been developed, cf. HSSP III. The RDE will advocate for the establishment of baseline values before the first JAHSR of HSSP III. Finally, a set of indicators and milestones will be developed for the private health sector organisations supported at the beginning of the support.

Recipient organisations, e.g. MOHSW, CSSC, APHFTA will be responsible for monitoring progress. The development in indicators and milestones will be a subject for discussion in annual review meetings.

Danida will monitor progress on all HSSP indicators, but a few indicators will have particular focus. The proposed indicators are reflected in Table 6 below, but these may change as progress and focus change over the five years.

Progress reporting and financial reporting

Recipient organisations, e.g. MOHSW, CSSC and APHFTA, will prepare quarterly financial statements and half-yearly progress reports on physical progress.

RDE will on a quarterly basis forward financial information to MOHSW, CSSC and others as relevant on expenditures incurred directly by RDE or Danida-Copenhagen, e.g for short term technical assistance, studies etc.

Joint Sector Reviews

Joint Annual Health Sector Reviews take place in September. 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.

An independent technical review will be conducted prior to the full annual review. MOHSW and PMO-RALG will provide a report covering all indicators for this technical review. As one of the DPs, Danida will play its role accordingly and will, as far as possible, incorporate issues of special interest into this technical review. The findings of the technical review will feed into the JAHSR Meeting. The full review will draw conclusions about 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 this joint annual review.

Table 6. Proposed selected results and indicators of particular interest of Danida

SUB-COMPONENT 1.1:		
Specific objectives	**Strategic results**	**Indicators (from the HSSP III)**
Support to the HSSP through HBF	GOT commitment to health maintained	Percentage of government budget for health
	Improved accountability	Percentage of LGAs with clean auditing reports
SUB-COMPONENT 1.2:		
Specific objectives	**Strategic results**	**Indicators (from HSSP III)**
Strengthening Referral Hospital Services	Improved management	Proportion of hospitals with annual plan, annual report and capital investment plan
	Hospital governance strengthened	Proportion of hospitals with functional Boards
Strengthening of pharmaceutical services	Ensure accessibility of pharmaceuticals at all levels	Timeliness of disbursement of funds for medicines and medical supplies
		Availability of tracer medicines in health facilities
SUB-COMPONENT 1.3:		
Specific objectives	**Strategic results**	**Indicators (from HSSP III & NGO Strategic plans)**
Strengthening of PPP	Effective operationalisation of PPP	Functional PPP forums at all levels
	Increased involvement of private providers in service delivery	Percentage of private health facilities with service agreements with government
Institutional development of NGOs		To be selected at the start of the support to individual organisations
CROSS-CUTTING:		
Specific objectives	**Strategic results**	**Indicators**
Gender equality	Increased efforts to address gender issues	Number of gender activities budgeted in the MOHSW MTEF

Annual Programme Reviews

Every year back-to-back with the JAHSR Meeting, Danida and relevant partners (mainly MOHSW, CSSC and APHFTA) will conduct a small bilateral review (1-2 days) focussing on the earmarked funding.

However, in after two years this will be replaced by an external review of the progress of sub-component 2 and 3. Otherwise such reviews will be kept to a minimum.

Evaluations

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

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 their performance evaluation.

Technical advisers will be evaluated each year by the counterpart institutions, based on their TORs and mutually agreed work plans and targets related to the annual work plans of the institution that they are providing technical support to, including capacity building targets. Technical advisers cannot be held responsible for implementation of activities on which they do not have specific influence. MOHSW is responsible for the implementation and for the allocation of sufficient funding and data.

11. Assessment of key assumptions and risks

Sub-Components	Assumptions	Risks	Risk Mitigation
1.0 General support to the implementation of the HSSP III through the Health Basket Fund and the Local Government Capital Development Grant	DPs will continue to be committed to the SWAp approach and more DPs will be willing to participate in the joint funding arrangements.	GOT management of the basket is too poor Vertical funding programmes may not be willing to align and pool funding using common procedures.	TA is provided to support MOHSW in providing adequate financial and technical reporting. DPs can support the MOHSW in its dialogue with vertical DPs in the discussions on preferred financing modalities.
	GOT will continue its commitment to the health sector by at least maintaining the present level of financing in absolute and relative terms	There are some indications of stagnating financial commitments.	The development will be monitored closely by RDE and addressed in the policy dialogue. TA will provide assistance to the annual PER Updates and to improved management to justify increased allocations. DPs can support the MOHSW in its dialogue with MOFEA to ensure sufficient funding
	GOT will continue to allocate sufficient resources to the health sector; will demonstrate willingness to prioritise essential health care with fous on those most at risk; and will pursue the realisation of efficiency gains.	The MMAM proposes considerable capital investments. There is a risk that expansion of infrastructure may not translate into expansion of health services, if insufficient funding is allocated to address the human resource shortage, to pharmaceuticals and other running costs.	The development will be monitored closely by RDE and addressed in the policy dialogue. The PFMA will provide assistance to the annual PER Updates.
	GOT will be able to improve the human resource situation supported by other DPs in accordance with division of labour among DPs		
	MOHSW and LGAs have sufficient administrative capacity	Many LGAs struggle with limited capacity in the administration, leading	TA will assist MOHSW in identifying shortcomings and propose solutions to

Sub-Components	Assumptions	Risks	Risk Mitigation
		to delays and sub-standard quality of work, late disbursements, late or incomplete reports and bad audits.	be discussed DPs. RDE will raise shortcomings and discuss solutions in the policy dialogue and when discussing action plans in the Audit Sub-Committee, Basket Fnancing Committee and the TC-SWAp and its working groups.
2.0 Support to health systems development and capacity strengthening	The commitment of DHS to take leadership in hospital reforms is increased and reflected in the attention and human and financial resources dedicated.	While the human resource situation in the Hospital Reform Secretariat has improved and the HRTF has started functioning, the risk remains that insufficient attention will be given to the implementation of hospital reforms.	A Hospital Reform Adviser will be placed in the Hospital Reform Secretariat. The issue of a counterpart to the Hospital Reforms Adviser will be raised by RDE if it turns out to be a problem. A special review will be undertaken after two years to assess whether and how to progress with the support to hospital reforms
	The revised Health Services Act will be enacted in 2009 and will provide the institutional framework for establishing Regional Hospital Boards.	There is a risk that the enactment will be delayed. MOHSW intend to appoint advisory Boards in the interim. There is a risk that this may not happen and the Advisory Boards may not be delegated sufficient authority from the RAS.	The issue will be pursued in the policy dialogue with MOHSW and PMORALG
	MOHSW is willing to pursue the already started organisational development exercise of the PSU		TA will be posted in the PSU to facilitate the process.
	The Chief Accountant has sufficient administrative capacity to take over accounting responsibilities for HSPS IV	The Chief Accountant currently has vacancies and it may not be possible to attract the necessary accounting staff.	Three or more of the trained HSPS accountants will be transferred to the Chief Accountant's Office. RDE will monitor the situation and may need to provide funding for contracting of the necessary staff.

Sub-Components	Assumptions	Risks	Risk Mitigation
3.0 Support to strengthening the non-government health sector and PPP	MOHSW/PMORALG will continue to be committed to collaboration with the private sector and DPs and will give higher priority to PPP as reflected in the attention and resources dedicated to PPP.	The MOHSW has not been convincing in its role as a steward and regulator of PPP. There is a general inadequate recognition of the role and potential of PPP in the health sector. There is a risk that this attitude will not change; and that the necessary resources will not be allocated.	A PPP Adviser will be placed in the DHS to support the MOHSW in developing and mainstreaming PPP. The issue of PPP will also be pursued in the policy dialogue. The issue of a counterpart to the PPP Adviser will be raised by RDE if it turns out to be a problem.
	Senior church authorities maintain a firm commitment to CSSC.	CSSC is an umbrella organisation. The church authorities may have other objectives that they want to pursue. Rivalry between members may hamper the decision-making capacity.	RDE will monitor the issue and raise problems, if they arise
	The non-governmental organisations will have sufficient administrative capacity	All stakeholders struggle with limited administrative capacity	STA may be availed if necessary
Overalll programme			
	RDE will have sufficient capacity to participate actively in the policy dialogue and programme administration.	RDE may not have enough staff or lack capacity to participate adequately in all the required Technical Working Groups or to oversee financial management.	STA may be hired to assist if necessary

12. 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
2009	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Annual Program Review
2010	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Optional Annual Program Review
2011	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Annual Program Review Special Review of earmarked support
2012	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Optional Annual Program Review
2013	March to June: Approval of annual MTEF and POA Sept:ember: JAHSR + Annual Program Review

Appendices

Appendix 1: Draft Job description for Health Policy, Planning & Management Adviser

Draft Job description
Health Policy, Planning & Management Adviser
Ministry of Health and Social Welfare, Tanzania Mainland

Background
Health Sector Reforms in Tanzania aim at improving access, quality and efficiency of district level services. To this end strengthening of secondary and tertiary service delivery in support of primary health care and strengthening support services at the central level in the Ministry of Health and Social Welfare (MOHSW), its agencies and training institutions is also needed. The MOHSW has developed a new Health Sector Strategic Plan (HSSP III) for Tanzania Mainland covering the period July 2009 to June 2015. The main emphasis continues to be on district health services and on providing an enabling environment for implementing the National Health Policy through the regional level and the central ministries.

In Tanzania the Sector Wide Approach (SWAp) is well-established. The Health Basket Fund (HBF) has been instrumental in pooling resources. New sources of funding, e.g. global initiatives, are however predominantly provided as project funding. It will be important for overall efficiency in planning and management of the sector that Development Partners (DPs) increasingly harmonise support. The improvement of Government of Tanzania (GOT) procedures as well as of harmonisation and alignment is an ongoing process. The further improvement of existing procedures, and the adjustments that may be needed to enable DPs that would normally provide project funding are likely to require capacity development in areas of financial management, technical and financial reporting, monitoring and follow up.

Danida has supported Tanzania's health sector for several decades The majority of support under Health Sector Programme Support, Phase IV (2009-14) supports the government's HSSP III with un-earmarked support through the HBF, supplemented by earmarked funding in areas where Danida has comparative advantage and where such support is deemed more appropriate in terms of being more flexible and allow more innovation than the routine government systems. The well developed division of tasks between the development partners forms part of the rationale for choice of earmarked support areas: Drugs Management and Use, Hospital Reforms, Public Financial Management and Public Private Partnership.

Scope of work:
The Health Policy and Planning Adviser will be placed in and report to the Department of Policy and Planning (DPP) and be counterpart to the Director of Policy and Planning, but will work in close liaison with the office of the Chief Medical Officer (CMO). Office space will be made available as close as possible to the DPP. The Adviser will have multiple skills in areas of policy and planning, development of strategies, experience with decentralization skills, ability to link and work with different technical departments in the health and social welfare sector. The Adviser should be action oriented with focus on health sector outcomes and should have ability to influence change through health reforms.

The Adviser will be required to be multi task, with specific notable capacities in:

- Policy development, Planning in the context of Least Developing Countries especially in Sub-Saharan Africa or countries of similar nature, that will have impact at community level.
- Ability to develop and articulate workable strategies that have impact and are applicable to Low Income Countries
- Actioning Policies and Strategies to operational plans that have impact on the community.
- Experience in decentralization through devolution and shepherding decentralization health systems and services within Local Government System, with the lowest unit being the House Hold.
- Must have solid experience in managing health systems at senior management level, with the ability to link and coordinate with the lower levels.
- Ability to work with mixed skilled teams, linking technical departments for purposes of advising and advocating change for the better and having impact at community level.
- Ability in eliciting outcomes and impact at Community level from various interventions. This includes use of routine data and regular surveys or operational research.

The Adviser will aim to improve partnerships through supporting the strengthening of effective coordination, management and communication in the sector as well as assisting with implementation of non-routine activities which may be funded under the HSPS IV from funds for strategic initiatives, through the office of the CMO. The Adviser will assume a limited role as liaison between the MOHSW senior management and other HSPS IV funded long-term technical assistants in issues which may arise which are not provided for under their general job descriptions or agreed through their annual job plans.

The technical assistance will include, but not necessarily be limited to, the following areas:

- Provide inputs in the development of annual work plans based on the HSSP III priorities and the available resource envelope, ensuring that budget formulation relates to approved policies and will have impact at community level.
- Provide inputs in the monitoring and follow-up on agreed activities prioritised by GOT/Development Partners, that are relevant and will have impact at community level.
- Provide inputs in strengthening the implementation of the Monitoring and Evaluation framework processes, including reporting systems, to provide evidence-based findings to inform decision-making at all levels to ensure actions taken are adequate and more effective at each level.
- Provide inputs in the development of performance reporting which is relevant for decision-making (MOHSW senior management, Parliament, SWAp partners, basket fund partners, the community etc.)
- Provide inputs in the review and development of programmes and plans to strengthen systems for accountability within the health sector, mechanisms for intra- and multi-sectoral collaboration as well as donor coordination, e.g. administrative and management systems, effective communication strategy at all levels.
- Provide inputs in the review and revision of guidelines and plans for the implementation of the Health Sector Reforms, including support in revising comprehensive guidelines for management and organisational structures, decentralisation of health services, and integrated management of resources (e.g. staff, transport, drugs, etc). at all levels.

- Provide technical inputs in key areas to be identified by the Ministry of Health and Social Welfare, pertaining to Health Sector Reforms, both within the Department of Policy and Planning, Health Sector Reforms Secretariat as well as the Units and Sections within the Ministry of Health and Social Welfare, Prime Ministers Office, and Regional Administration and Local Government. This will include support to regions and districts
- Provide inputs in the preparation of and participate in the Joint Annual Health Sector Review for Tanzania Mainland and identifying needs for operational research or consultancy services in relation to the support to strategic initiatives, drafting terms of reference and facilitating consultancy work.
- Participate in planning of and as resource person in the Basket Finance Committee (BFC) and Technical Committee-SWAp meetings.
- Develop/maintain an in-depth knowledge and understanding of the health sector in Tanzania.

HSPS – specific:

- Through the office of the CMO on HSPS IV issues, including preparation of SC Meetings, liaise with other Directorate and make follow-up on progress in implementation of programme components, identification of problems, bottlenecks and possible solutions.
- Liaise with other HSPS IV supported long-term Advisers on issues which arise and may not be covered through their job descriptions, job plans and reporting arrangements, and vice-versa.
- Participate as resource person in the HSPS IV Steering Committee Meetings for Tanzania Mainland.
- Preparation of and participate in HSPS IV (bi-)annual review meeting of earmarked support to Tanzania Mainland.
- Participate on a regular basis in briefings with the Royal Danish Embassy (RDE)

Qualifications

The Adviser should have a basic degree as well as preferably post-graduate degree in relevant discipline, e.g. Medicine, Public Health, Epidemiology, Health economics and management. In addition, the adviser should have at least 10 years professional experience of which at least 3 years should be from working in developing countries or international organisations. Experience in mounting SWAp-programmes and knowledge of Danida's development policy and guidelines will be considered assets. Fluency in spoken and written English is essential, knowledge of Swahili an advantage.

Appendix 2: Draft Job description for Public Financial Management Adviser

Draft Job Description
Public Financial Management Adviser
Health Sector Programme Support, Tanzania

Background
Health Sector Reforms in Tanzania aim at improving access, quality and efficiency of district level services. To this end strengthening of secondary and tertiary service delivery in support of primary health care and strengthening support services at the central level in the Ministry of Health and Social Welfare (MOHSW), its agencies and training institutions is also needed. The MOHSW has developed a new Health Sector Strategic Plan (HSSP III) for Tanzania Mainland covering the period 2009 to 2015. The main emphasis continues to be on district health services and on providing an enabling environment for implementing the National Health Policy through the regional level and the central ministries.

In Tanzania the Sector Wide Approach (SWAp) is well-established. The Health Basket Fund (HBF) has been instrumental in pooling resources. New sources of funding, e.g. global initiatives, are however predominantly provided as project funding. It will be important for overall efficiency in planning and management of the sector that Development Partners (DPs) increasingly harmonise support. The improvement of Government of Tanzania (GOT) procedures as well as of harmonisation and alignment is an ongoing process. The further improvement of existing procedures, and the adjustments that may be needed to enable DPs that would normally provide project funding are likely to require capacity development in areas of public financial management, technical and financial reporting, monitoring and follow up.

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. One of the main sources of delays in program execution is the overly bureaucratic procedures of the allotment of health resources, procurement processes and administrative procedures that have to be followed in order to trigger payments. Moreover the institutional culture within MOHSW has resulted in the introduction over time of numerous controls and hierarchical checks on the budgeting, allotment and spending of resources. The current processes in the health sector are bureaucratic, unnecessarily duplicative and each process involves numerous steps that could be removed.

Danida has supported Tanzania's health sector for several decades. The majority of support under Health Sector Programme Support, Phase IV (2009-14) supports the government's HSSP III with un-earmarked support through the Health Basket Fund, supplemented by earmarked funding to Drugs Management and Usee, Hospital Reforms, Public Financial Management and Public Private Partnership.

Scope of work:
The Public Financial Management Adviser will provide technical assistance on public financial management to improve the capacity and efficiency in financial management, analysis and systems development in the MOHSW, in particular with a focus on three interlinked areas: objective based planning and budgeting, accounting and administrative procedures in general, and financial reporting with special focus on senior management (and DPs) needs. The Adviser will collaborate with the

Budget Section/DPP; the Chief Accountant and the DPP respectively in these areas. Initially, the Adviser will be placed in the Chief Accountants Office and will be counterpart to the chief accountant. The placement of the Adviser may change as the key tasks shift over time. Some advice may be needed under Components 3, but this will be limited to providing technical advice on their financial management systems and not involvement in the financial management of funds.

The technical assistance will include, but not necessarily be limited to, the following areas:

Public Financial Management development in relation to the sector reforms

- Assist MOHSW/Ministry of Finance and Economic Affairs in simplification of the intra-ministerial financial management processes, including assistance to further development of the procedures and accounting manuals with the aim of simplifying procedures etc. and to guide the various administrative and financial processes within the MOHSW
- Assist in the development of a management information system with focus on financial management strategies, policies and procedures in support of health and local government reform, including facilitation of objectives-based financial reporting.
- Assist in the preparation of annual budgets and expenditure reports as well as in the preparation of input to the meetings of the Basket Financing Committee (BFC).
- Contribute to and facilitate the development of institutional and human resource capacity in health administration relating to financial management in the LGAs, MOHSW and its agencies.
- Contribute to policy analysis using financial data, e.g. analyses related to health financing, financial aspects of health sector reform, assessments of cost effectiveness and value for money. This will include assisting in Public Expenditure Reviews.
- Assist in various aspects of public financial management in the intervention areas covered by the sub-components, e.g. in the development of Financial and Administrative Management System (FAMS) in regional hospitals.
- On a needs basis provide technical advice to other components (HIV/AIDS and MOHSW Zanzibar) on their financial management systems, advice should mainly be restricted to commenting on terms of reference for technical assistance to support the strengthening of their financial management systems.

Specific tasks in relation to the HSPS IV financial management

- Assist the Chief Accountant in the MOHSW in liaising with the Royal Danish Embassy (RDE) Accountant in planning, budgeting, accounting, administration and financial reporting and audit of the utilisation of HSPS IV funds
- Participate on a regular basis in briefings with the RDE

Qualifications

The Adviser should be qualified in accounting and/or financial management (at university or business school level) or in general management with a good working knowledge of public accounting and administration. In addition, the adviser should have 5 years of relevant professional experience, of which at least 3 years from working in developing countries, including solid knowledge of computerised administration and accounting systems, experience with planning, implementation and monitoring in government institutions and sector programmes. Experience with SWAps and joint funding arrangements will be considered an advantage.

Appendix 3: Draft Job description for Hospital Reforms Adviser

Draft Job Description

Hospital Reforms Adviser
Ministry of Health and Social Welfare, Tanzania Mainland

Background
Within the context of the National Health Policy and Health Sector Strategic Plan and the reform of local government, the Ministry of Health and Social Welfare (MOHSW) and the Prime Minister's Office for Regional and Local Government (PMORALG) is giving increasing emphasis to hospital reforms and capacity building in hospital governance and management. Whilst previous hospital reforms have concentrated on the national and tertiary level hospitals, the emphasis is now on the District and Regional Hospitals. The government is concerned that hospitals will play an effective and appropriate role within a health system based on the primary health care approach. As part of its overall approach to poverty reduction, it is determined that poor people have access to hospital services. It is responding to public concerns about the quality of public hospital services.

Within this context a sub-component on hospital management was included in the 3rd Phase of Danida Health Sector Programme Support in Tanzania. The sub component provided support to the national programme of support to hospital reforms and management capacity building with some emphasis on activity in the "Lake Zone" Regions, and building-upon the investments that have been made in the Kagera Regional Hospital.

The majority of support under Health Sector Programme Support, Phase IV (2009-14) supports the government's HSSP III with un-earmarked support through the HBF, supplemented by earmarked funding in areas where Danida has comparative advantage and where such support is deemed more appropriate in terms of being more flexible and allow more innovation than the routine government systems. The well developed division of tasks between the development partners forms part of the rationale for choice of earmarked support areas: Drug supply & use, Hospital reforms, Strategic initiatives and Public Private Partnership. The support to hospital reforms aim at using a balanced approach focusing on improving hospital management capacity in terms of skills and systems, governance arrangements and quality of care mainly at the level of regional hospitals.

Scope of Work
The Hospital Reforms Adviser (HRA) will be placed in the Hospital Reform Secretariat in the Directorate for Hospital Services in MOHSW and refer to the Director of Hospital Services. The Head of the Hospital Reform Secretariat will be the direct counterpart. The HRA will also work closely with PMORALG as well as the Health Sector Reform Secretariat, the Department of Policy and Planning, and other relevant Departments of the MoHSW and other partners (e.g. Christian Social Service Commission). The HRA will also work with other stakeholders through the MOHSW Department of Hospital Services.

The Adviser will primarily contribute to capacity building in the areas of institutional and organisational development, including governance mechanisms, performance contracting as well as aspects of health systems analysis. Given the current lack of capacity, the adviser will also be a member of the Hospital Reform team, provide the necessary mentorship to full time hospital reforms officers, identify short and long term training needs and contribute to the work in the Hospital Reform Secretariat.

Tasks and responsibilities will include but not necessarily be limited to the following:

- Assistance to the development of modalities for effective operation of the National Hospital Reform Task Force, including facilitation of the involvement of the right skill mix and representation by different stakeholders.
- Assistance in regular progress reporting on the implementation of hospital reforms (GOT funded or earmarked activities funded by Danida and other DPs), including supporting effective reporting through the Hospital Reform Task Force to the Technical Committee of the SWAp
- Assistance in designing and setting up a system for regular monitoring of hospital performance and of the implementation of hospital business plans.
- Assistance to the MOHSW and PMORALG on the translation of legislation and regulation into effective implementation of hospital reforms and enhancement of hospital autonomy.
- Assistance in the development of a systematic approach to strengthening of the Hospital Management Boards
- Assistance in the development and implementation of service agreements in the public sector.
- Assistance (through the MOHSW Director of hospital services and human resources) to organisations and institutions with a current or potential role in hospital management capacity building to develop plans for enhancing their contribution.
- Assistance with timely preparation and updating of key Hospital Reforms Documents: Hospital reforms strategy, annual plans, guidelines etc.
- Advice and support to the development of mechanisms for the identification and dissemination of good practices in the improvement of hospital performance – in quality, effectiveness and efficiency. This could include peer-review mechanisms.
- Support in the establishment of effective means of co-ordination between the national level, the Regional Secretariats and "Zonal" organisations.
- Assistance in the development of capacity of Hospital Management Teams with regard to delegated management within the hospital to improve efficiency as well as human resource management
- Assistance in systematic initial assessment and follow-up on new initiatives for strengthening the referral system.
- Participation on a regular basis in briefings with the RDE

Qualifications and Experience

The Adviser will have a University Degree in a relevant discipline (e.g. medicine, economics or management), and a post-graduate qualification in public administration, health care management or public health, policy and planning, depending on the basic qualification. The adviser will have substantial experience in hospital management, with a minimum post-graduate professional experience of 5 years and 3 years from developing countries. Excellent English language (including writing) skills are essential.

Appendix 4: Draft Job description for Pharmaceutical Services Adviser

Draft Job description
Pharmaceutical Services Adviser
Ministry of Health and Social Welfare, Tanzania Mainland

Background
Health Sector Reforms in Tanzania aim of improving access, quality and efficiency of district level services. To this end strengthening of secondary and tertiary service delivery in support of primary health care and strengthening support services at the central level in the Ministry of Health and Social Welfare (MOHSW), its agencies and training institutions is also needed. The Government of Tanzania (GOT) has developed a new Health Sector Strategic Plan (HSSP III) for Tanzania Mainland covering the period 2009 to 2015. The main emphasis continues to be on district health services and on providing an enabling environment for implementing the National Health Policy through the regional level and the central ministries.

Danida has supported Tanzania's health sector for several decades The majority of support under Health Sector Programme Support, Phase IV (2009-14) supports the government's HSSP III with un-earmarked support through the Health Basket Fund (HBF). The basket funding is supplemented by earmarked funding in areas where Danida has comparative advantage and where such support is deemed more appropriate in terms of being more flexible and allow more innovation than the routine government systems. The well developed division of tasks between the Development Partners (DPs) forms part of the rationale for choice of earmarked support areas: Drugs Management and Use, Hospital Reforms, Public Financial Management and Public Private Partnership.

Overall there has been improvement in the supply of pharmaceuticals and medical supplies in the public health facilities in recent years. Nevertheless, drug supply is still reported to be erratic and with frequent stock-outs occurring at district level and below. Challenges arise at several points along the drug chain, from policy level to end users. To address the lack of availability of drugs at the health facility level it is essential to strengthen the entire supply chain management both 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 and monitoring and evaluation of parts of the supply chain. A targeted approach has been hampered by the lack of monitoring of the flow of information, funds and commodities all the way from the health facilities to District Medical Officer (DMO) to Medical Stores Department (MSD) and MOHSW. Such a monitoring tool is currently in the process of being developed.

The focus of support in the current phase of the Danish support has to a large extent been on MSD and Tanzania Food and Drugs Authority (TFDA) and less on the Pharmaceutical Services Unit (PSU) itself. A well-functioning PSU is key to further improvements in the functioning of the drug chain. However, PSU is inadequately resourced. Although the staff strength has increased in recent years, PSU has many tasks and the workload and contents do not match the capacity of staff and systems available in the unit. Prior to the start of HSPS IV an institutional analysis looked into institutional issues, advised on organisational set-up and the need for capacity building to fulfil roles and responsibilities. A consultancy to assist in the development of a monitoring tool to monitor flow of funds, drugs and information has also been undertaken.

Scope of work:

The Pharmaceutical Services Adviser (PSA) will be placed in the Pharmaceutical Services Unit (PSU) in the Directorate of Hospital Services in the MOHSW and will report to the Director of DHS. The PSA will work closely, as counter-part with the Head of the PSU. The Adviser will primarily build capacity in strategic planning and management, monitoring and evaluation, including a system for engagement with and support to the regional and district levels regarding effective drugs management and use, as well as supporting the Head of the PSU to implement the main recommendations of the organisational and institutional reviews of the PSU.

The technical assistance will include, but not necessarily be limited to, the following areas:

- Capacity building in development of strategic & annual planning, in monitoring of implementation (using indicators where possible), and in taking adequate action
- Assist in the development of formal coordination mechanisms, including administrative and management systems, for the multiple stakeholders (e.g. MSD, TFDA, Pharmacy Council, National Therapeutics Committee) involved in the implementation of the Pharmaceutical Master Plan
- Assist in the development of a strategy/system for exchange of information between district and regional pharmacists and PSU, which ensure regular information flow to PSU and regular feedback to lower levels
- Assist in the implementation of the Monitoring Tool, which is currently being developed
- Assist in setting up a system for the provision of technical support from PSU to regional and district pharmacists (e.g. as regards quantification, integrated logistics system, training, supervision, organising drug use surveys, etc.)
- Assist PSU in developing a strategy for promotion of the role of pharmacists in the Regional Health Management Teams and Council Health Management Teams
- Build capacity in general management procedures in PSU (e.g. holding effective team meetings, delegation of responsibilities and related supervision, providing guidance to staff, performance evaluation/assessments)
- Assist in further analysis of options for the organisational position of PSU within the MOHSW
- Support the Head of the PSU in implementing the main recommendations of the PSU institutional analysis and development of monitoring system
- Participate on a regular basis in briefings with the Royal Danish Embassy

Qualifications of candidate

The Adviser should have a university degree as well as preferably a post-graduate degree in a combination of relevant disciplines, e.g. health sciences, pharmacy, economics, management or social science. In addition, the adviser should have at least 5 years professional experience of which at least 3 years should be from working in developing countries. Experience in working with drug chain management is desirable and in institutional strengthening an advantage.

Appendix 5: Draft Job description for PPP Adviser

Draft Job description

Public Private Partnership Adviser
Ministry of Health and Social Welfare, Tanzania Mainland

Background
Health Sector Reforms in Tanzania aim at improving access, quality and efficiency of district level services. To this end strengthening of secondary and tertiary service delivery in support of primary health care and strengthening support services at the central level in the Ministry of Health and Social Welfare (MOHSW), its agencies and training institutions is also needed. The MOHSW has developed a new Health Sector Strategic Plan (HSSP III) for Tanzania Mainland covering the period 2009 to 2015. The main emphasis continues to be on district health services and on providing an enabling environment for implementing the National Health Policy through the regional level and the central ministries.

Danida has supported Tanzania's health sector for several decades The majority of support under Health Sector Programme Support, Phase IV (2009-14) supports the government's HSSP III with un-earmarked support through the Health Basket Fund (HBF), supplemented by earmarked funding in areas where Danida has comparative advantage and where such support is deemed more appropriate in terms of being more flexible and allow more innovation than the routine government systems. The well developed division of tasks between the Development Partners (DPs) forms part of the rationale for choice of earmarked support areas: Drugs Management and Use, Hospital Reforms, Public Financial Management and Public Private Partnership (PPP).

Scope of work:
The Public Private Partnership Adviser will be placed in the PPP Unit as counterpart to the Head of the Unit and work closely with the Directorate of Hospital Services/MOHSW, Prime Minister's Office, Regional Administration and Local Government (PMO-RALG), other relevant departments of MOHSW, Christian Socail Services Commission (CSSC), Association of Private Health Facilities in Tanzania (APHFTA) and other private sector organisations. The Adviser will contribute to capacity building in policy development, strategic and operational planning and management, monitoring and evaluation. Furthermore, the Adviser will contribute to capacity strengthening with regard to coordination of the multiple stakeholders involved in the implementation of the PPP strategy and with regard to mainstreaming of PPP at all levels (central, regional and district). Finally, the Adviser will assist in the institutionalisation and further development of the service agreements. The Adviser will participate in the National Public Private Partnership Steering Committee meetings.

The technical assistance will include, but not necessarily be limited to, the following areas:

- Assist in the formulation of a national PPP policy, strategic framework and operational plan
- Assist in capacity building in PPP mainstreaming at regional and council health management levels.
- Assist in the development and implementation of a strategy for mainstreaming of PPP in policy development, regulation and legislation as well as in planning and management at all levels
- Assist the further development and institutionalisation of the service agreements with private providers.

- Assist development and evaluation of new specific PPPs that will increase access to quality health services
- Facilitate an institutional analysis of the capacity of the PPP unit in relation to its mandate and responsibilities
- Assist in establishing a constructive dialogue between the MOHSW/PMO-RALG and the private sector as equal partners to contribute effectively to the provision of quality health care.
- Assist the MOHSW and the private health sector in documenting lessons learnt at micro level with a view to feeding into policy and strategy
- Assist the MOHSW and the private health sector in designing new pilots, which include assessment of their impact
- Assist the development of a system for monitoring and supervision of the private health sector, e.g. through self-regulation, peer-review, joint supervision with regional and council health management teams
- Participate in the National Public Private Partnership Steering Committee meetings
- Participate on a regular basis in briefings with the Royal Danish Embassy

Qualifications

The Adviser should have a university degree as well as preferably post-graduate degree in a combination of relevant disciplines, e.g. medicine, management or social science. In addition, the adviser should have at least 5 years professional experience of which at least 3 years should be from working in developing countries or international organisations. Experience in working with PPP and knowledge of Danida's development policy and guidelines for health will be considered assets. Fluency in spoken and written English is essential, knowledge of Swahili an advantage.

Appendix 6: Terms of reference for HSPS Health Sector Mainland Steering Committee

Background
The Steering Committee (SC) is the formal mechanism for joint decision-making concerning HSPS IV operational issues as regards earmarked support under Component 1: Support to the Health Sector in Mainland, i.e. regarding sub-component 2 and 3.

Mandate and Scope
The SC decides on the overall priorities of the Component in accordance with the programme document, the Government Agreement, and other legal documents. Where deviation form the programme document is considered necessary, the SC takes the decisions. The mandate of the SC includes approval of major planning documents, progress reports, work plans, budgets, audit reports and decisions regarding major implementation issues such as procurement procedures.

Composition
Members of the SC are the Permanent Secretaries (PS) from MoH&SW and PMORALG, RDE as well as relevant MoH&SW and/or PMORALG Directors with responsibilities for the implementation of different intervention areas and the relevant private health sector representatives.

Advisors and other relevant persons may be invited as resource persons to the SC.

Specific tasks of the SC

- Discuss annual progress and financial reports
- Approve annual work plans and budgets within the framework of the programme document as well as other possible joint binding agreements
- Take note of the annual audit report and ensure management follow-up on recommendations
- Monitor overall progress of the component with special emphasis on delays, problems and bottlenecks
- Monitor the continued coherence between the programme and developments in the sector.
- Take decisions where needed concerning deviations from the programme document

Working procedures
The SC will be co-chaired by the PS (MoH&SW) and the PS (PMORALG) and the RDE. The HSPS Coordinator/focal point and the SHMA will act as the secretariate to the SC.

The SC will meet once a year. The secretariat will announce the meetings with at least two weeks' notice. All documentation for the meetings (plan/budget, reports, proposal for adjustment etc.) shall be distributed to the members at least one week in advance together with a draft agenda.

Decisions made will take effect after approval of the minutes. Minutes of the SC meetings will be drafted by the secretariat and circulated to all participants within a week of the meetings. The signatures from the PS/MoH&SW, PS/PMORALG and RDE on the minutes serve as approval.

For issues that appears ad hoc and requires immediate attention during the year the following procedures should be followed: Close consultations between MoH&SW, PMORALG and RDE should be established and documented communication between the parties should be signed or letters exchanged to certify that the decision has been taken in consensus.

Appendix 7: Key references

APHFTA Constitution. November 2006.

APHFTA. Quality Health Care for All. Powerpoint presentation June 2008.

APHTA. Financial Management Manual.

APHTA. Operational Manual

APHTA. Strategic Plan 2005- 2010.

Danida/Ministry of Foreign Affairs. Denmark's development assistance to Tanzania 2007-2011. Copenhagen, January 2007.

Demand driven District capacity building programme in Tanzania's lake zone: An External Review. Draft report for comments. Leon Bijlmakers, ETC February 2008.

Development of an equitable drugs and medical supplies resource allocation formula. December 2007

Drug Tracking Study, Final Report. EHG and MSH Tanzania, August 2007

Government of Tanzania, Ministry of Health and Social Welfare, Prime Minister's Office for Regional Administration and Local Governments and Development Partners. Health Basket Fund -Generic Document . Final Draft August 2008.

Guideline for Reforming Hospitals at Regional and District Levels, Ministry of Health, United Republic of Tanzania, March 2005

Household Budget Survey 2000/01, Dar es Salaam, July 2002, National Bureau of Statistics, Tanzania

Joint External Evaluation of the Health Sector in Tanzania

Memorandum of Understanding Between The Partners (Government of Tanzania & Development Partners participating in the pooled funding ("Basket") of the Health Sector concerning The pooled funding for the Government of Tanzania's Health Sector Programme based on the Second & Third Health Sector Strategic Plan, The Health Sector Medium Term Expenditure Framework of the Ministry of Health and Social Welfare and Prime Minister's Office Regional Administration & Local Government and the Comprehensive Council Health Plans, July 1, 2008 – June 30, 2015.

Ministry of Health and Social Welfare - HSPS III. Review of Hospital Component of HSPS III. Draft Report for Comments. Mike Naylor, Oxford Policy Management Ltd, UK and Alto Simime, Mzumbe University, Tanzania. January 2008.

Ministry of Health and Social Welfare, Health Sector Strategic Plan III, July 2009 – June 2015.

Ministry of Health and Social Welfare, Medium Term Strategic Plan 2007 – 2010. November 2006.

Ministry of Health and Social Welfare. Health Sector Performance Profile Report For Mainland Tanzania July 2006-June 2007. Monitoring and Evaluation Section, Directorate of Policy and Planning, Ministry of Health and Social Welfare. February 2008.

MOHSW & WB. National Health-Care Waste Management Plan - Final Report – March 2003.

MOHSW 2006. Annual Health Statistical Abstract, April 2006.

MOHSW 2007. Country Health Profile.

Mpango wa Maendeleo wa Afya ya Msingi (MMAM) 2007 – 2017,Primary Health Services Development Program (PHSDP) 2007-2017 DRAFT May, 2007

MSD Medical Stores Department – Tanzania, Medium Term Strategic Plan 2006 – 2012 Final Report April 2007

National Strategy for Growth and Reduction of Poverty (NSGRP) MKUKUTA , Vice President's Office June 2005

P. Smithson, Health in Tanzania – What has changed, what hasn't, and why? Commissioned by DFID Tanzania, January 2005-07-22

Policy Note 4 (Budget Execution Challenges). Health Sector for FY 2004/05 to First two Quarters of 2007/08. 11 August 2008.

Public Expenditure and Financial Accountability Review (PEFAR) 2006/07.

2006/07 Preliminary findings of the procurement assessment of Medical Stores Department. September 2007

Public Expenditure and Financial Accountability Review of the Medical Stores Department, 06 September 2007 DRAFT Euro Health Group

Supporting improved Public Financial Management in Tanzania: Challenges to the Effective Financing of the Health Sector. Draft August 2008.

Tanzania Gender Networking Program (TGNP) and Macro International Inc. 2007. Women's Health in Tanzania. Dar es Salaam, Tanzania: TGNP and Macro International Inc.

Tanzania Joint Programme Document. Dar es Salaam, December 2006.

Technical Review 2005, Public Private Partnership for Equitable Provision of Quality Health Services, Independent Technical Review on Behalf of the MOH, PORALG and the Government of Tanzania, March 2005, Final Report, HERA

Terms of reference for the National Public-Private Partnership Steering Committee. MOHSW June 2007.

The National Health Policy Revised Version June, 2007

APHFTA. The Private Health sector HIV/AIDS strategy 2007-10. March 2007.

United Republic Of Tanzania. Joint Assistance Strategy for Tanzania (JAST). November 2006

WHO 2007. Tanzania Service Availability Mapping (SAM) 2005-06.