



German Foundation for
World Population (DSW)

HEALTH SPENDING IN TANZANIA

THE IMPACT OF CURRENT AID STRUCTURES AND AID EFFECTIVENESS



ACKNOWLEDGEMENTS

This report was produced by DSW for Action for Global Health and written by Sibylle Koenig and Rebecka Rosenquist.

Action for Global Health would like to thank the representatives from the Ministry of Health and the Ministry of Finance in Tanzania, as well as Members of the Tanzanian Parliament, the representatives of the donor agencies and Civil Society organisations interviewed during the fact-finding visit for taking time to share their views with us, in order to make this policy briefing more relevant. In particular, we would like to thank the Tanzania Country Office of the German Foundation for World Population (DSW) and ActionAid Tanzania for their support with organising and carrying out the interviews.

Action for Global Health is supported by a grant from the Bill & Melinda Gates Foundation.

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Front Cover Photograph: *Kate Holt/Shoot The Earth/ActionAid*
Inside Cover Photograph: *DSW*



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INTRODUCTION AND METHODOLOGY

In recent years, the EU has been committed to reforming its external aid instruments according to aid effectiveness principles established by the Paris Declaration on Aid Effectiveness (2005), as well as the Accra Agenda for Action (2008). In particular, attention has been paid to increasing the “ownership” of developing countries’ development assistance¹.

Despite such positive efforts, key social sectors such as health have suffered significant decreases and gaps in EU funding in recent times. Official Development Assistance (ODA) spending in health worldwide decreased by USD 124 million (ca. EUR 90 million) between 2006 and 2007, mainly due to a decrease in European health ODA. Compared to total ODA disbursements, European donors contribute relatively less to health than other international donors. In 2007, the EU-15 and other European donors represented only 50% of health disbursements, while accounting for some 67% of global ODA².

In the light of such trends, there is a perceived need to reassess aid effectiveness principles against sector-specific funding for health. Action for Global Health (AfGH), a network of European health and development organisations³, consequently decided to commission DSW Brussels to undertake six combined fact-finding and advocacy visits to developing countries in 2010 in order to assess the impact of current aid structures and aid effectiveness principles on health-spending in those countries.

The overall objective of these fact-finding visits is to bring evidence and experience from developing countries to support European advocacy for global health, by producing country-specific policy briefings and disseminating them to key decision-makers and organisations in Europe and in developing countries.

This country briefing aims to compile the main findings gathered during AfGH’s visit to Tanzania in April 2010 and provide recommendations to policy-makers and civil society. During the fact-finding visit to Tanzania, AfGH was represented by DSW’s EU Liaison Office and Interact Worldwide. During the visit, AfGH partners met with key stakeholders in the country, in particular, the Tanzanian Ministry of Health and Social Welfare (MoHSW) and the Ministry of Finance and Economic Affairs (MoFEA). The fact-finding team also interviewed key donors, Members of Parliament and civil society in the country, in particular:

DONORS MET

Delegation of the European Union to Tanzania
World Bank
IrishAid
Embassy of the Netherlands
GTZ
DANIDA
IMF

MEMBERS OF PARLIAMENT MET

Hon. Fuya Kimbita, MP
Hon. Ledian Mafuru, MP

CSOs MET

Tanzania Public Health Association
Tanzania Council for Social Development (TACOSODE)
National Council of People Living with HIV (NACOPHA)
ActionAid International
AMREF
Christian Social Services Committee
UMATI

All interviews held focused in particular on the following three thematic axes related to health aid effectiveness, which were selected for being the most relevant for AfGH’s work:

- Ownership and the participation of civil society and the national parliament in the health sector

¹ For more information on Aid Effectiveness Principles, see: www.oecd.org/dataoecd/11/41/34428351.pdf

² DSW, EPF, EuroNGO. “Euromapping 2009: Mapping European Development Aid & Population Assistance”. 2009, Brussels, Belgium.

³ Established in 2006 by 15 organisations under the leadership of ActionAid, Action for Global Health (AfGH) is today active in France, Germany, Italy, Spain, the UK and Brussels and includes membership of almost 30 NGOs. AfGH advocates for Europe to play a more proactive role in enabling developing countries to meet the Health Millennium Development Goals by 2015. For more information on AfGH, please visit: www.actionforglobalhealth.eu

- The impact of donor coordination on health-spending in developing countries
- The role of aid in progress towards the Millenium Development Goals (MDGs) and in universal access to primary healthcare

The results of these interviews have been complemented with previous and subsequent desk work in order to provide a comprehensive perspective on the effectiveness of health aid in Tanzania, based on the principles of the Paris Declaration and Accra Action Plan on aid effectiveness.

TANZANIA COUNTRY CHOICE

The selection of Tanzania as a target country was based on the following criteria: Tanzania is classified by the UN as one of the least developed countries. However, according to the OECD's 2008 Survey⁴, the country has recently made fundamental progress with regard to its aid effectiveness agenda and the health sector is seen by many in Tanzania as a tracer sector in that respect. The following policy briefing therefore assesses, from a CSO point of view, whether Tanzania can indeed be seen as a best-practice example for health aid effectiveness.

4 www.oecd.org/dataoecd/25/34/42056812.pdf

SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

OWNERSHIP AND PARTICIPATION OF CIVIL SOCIETY AND THE PARLIAMENT

- Transparency and follow-up of consultation processes:** In order to make civil society policy consultation processes more effective, additional efforts need to be made to ensure that CSOs are able to access and understand the documents and processes they are to evaluate and have the capacity to effectively take part in this exercise. In a country such as Tanzania, with a strong urban / rural digital divide, donors and policy-makers need to go beyond the mere publication of information on institutional websites in order to reach rural communities. Moreover, informing the participants about the follow-up to their recommendations should be a mandatory step within the consultation process.
- Improve Government and donor outreach to CSOs:** Additional efforts should also be made to broaden and diversify the spectrum of CSOs involved in consultation processes, namely by ensuring that community-based organisations (CBOs) are given a voice. To that end, specific funding should be provided by donors to enable smaller and community-based organisations to participate in such processes.
- Increased support for CSO advocacy capacity- and partnership-building:** In order to ensure truly participatory processes, allowing for more democratic 'country ownership' in the health sector, donor funding should specifically target strengthening health CSO and CBO capacities for advocacy, as well as supporting the establishment of partnerships and links between Parliamentary Health Committees, INGOs, national CSOs and CBOs, faith-based organisations (FBOs), service providers and other more advocacy-oriented CSOs, academic institutions and local authorities.

DONOR COORDINATION AND ITS IMPACT ON HEALTH SPENDING

- A continuous need for mixed and balanced funding policies:** As long as a dependency on external assistance in countries such as Tanzania exists, European aid should continue to be channelled through mixed funding policies, by ensuring that there is a balance between the three main aid modalities – general budget support, sector budget support and bilateral project funding. In consideration of Civil Society's important role both as a watchdog of Government policies, and with regard to service delivery and reaching the most vulnerable in Tanzania, European donors are urged to **increase their direct support channelled to CSO activities in the health sector.**
- Key development partners in Tanzania point out that **sustained policy dialogue between all stakeholders including the Government, civil society and Development Partners (DPs)** will be essential if the country's currently negative trend of reducing the proportion of Government budget devoted to health is to be reversed. Consequently, DPs should be using policy dialogue to promote the inclusion of the **Abuja Declaration target⁵ among the performance indicators used to monitor General Budget Support (GBS)**, i.e. make the continuation of GBS conditional on an increase in the share of domestic funding to health in order to reach the 15% target. Moreover, African advocates recommend adding per capita spending on health to the evaluation criteria, as a simple percentage of national spending does not give the full picture of how close the country is to spending the amount necessary for a universal package of basic services.
- Development partners interviewed during the fact-finding visit confirmed that funding allocated to the so-called variable tranche of General Budget Support on the basis of performance indicators has not been a strong enough incentive for making substantial progress towards the established health indicators. DPs should consequently assess the possibility of **increasing the share of the variable tranche within the General Budget Support modality, as well as the weight of health indicators in the evaluation of budget support.**

⁵ Signatory governments of the 2001 'Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases' agreed "to allocate at least 15% of our annual budget to the improvement of the health sector". www.un.org/ga/aids/pdf/abuja_declaration.pdf

- As the effectiveness of **General Budget Support** in Tanzania will be reviewed through a national **joint evaluation** to be initiated in **September 2010**, DPs should, in that context, evaluate the impact of General Budget Support on social sectors such as health.
- The **European Division of Labour system should not be used as a pretext by major donors**, such as the European Union, to withdraw from their responsibility for global health and health funding.
- In a country such as Tanzania, where elaborate donor coordination mechanisms exist, efforts should focus on **increasing the efficiency of existing structures**, specifically with regard to their impact on health spending, rather than creating new systems.

RESULTS-BASED MANAGEMENT AND THE ROLE OF AID FOR COUNTRY PROGRESS TOWARDS THE HEALTH MDGS AND UNIVERSAL ACCESS TO PRIMARY HEALTHCARE

- European donors could play a key role in promoting the **link-up between disease-specific programmes and other health initiatives**, such as, for instance, reproductive health and family planning programmes.
- Donors should assist governments in developing countries in seeking long-term, sustainable financing mechanisms in order to make the removal of user fees possible. Donors should follow the **WHO code of practice on the international recruitment of health personnel**⁶ and ensure that both their development and non-development-related programmes and projects do not have a negative impact on the workforce in the health sector in developing countries.



Contraceptive Implant procedure at SRHR Clinic in Tanzania.

Photograph: *Interact Worldwide*

6 www.who.int/bulletin/volumes/86/10/08-058578/en/print.html

OWNERSHIP AND PARTICIPATION OF CIVIL SOCIETY AND THE PARLIAMENT



Patient at Tanzanian health centre.

Photograph: DSW

DEVELOPMENT STRATEGIES AND HEALTH POLICIES IN TANZANIA

Tanzania is a signatory of the Paris Declaration on Aid Effectiveness. The country's overall development framework and long-term social and economic development goals are laid out in the National Vision 2025 and Zanzibar Vision 2020. The National Poverty Eradication Strategy (NPES) provides the framework for guiding development, and poverty eradication efforts. While the medium-term objectives for mainland Tanzania are guided by the National Strategy for Growth and Reduction of Poverty (NSGRP), or MKUKUTA to give it its Kiswahili acronym, and the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP), or MKUZA, is the guiding framework for Zanzibar. MKUKUTA focuses on three broad clusters: growth and reduction of income poverty (Cluster I); improvement of quality of life and social well-being (including health – Cluster II); governance and accountability (Cluster III). Similarly, MKUZA focuses on three clusters: growth and reduction of income poverty; improvement of social services and well-being; and good governance and national unity.

With both the MKUKUTA and MKUZA coming to an end in June 2010, the government of Tanzania (GoT) initiated a participatory process of elaborating a new poverty reduction strategy

(MKUKUTA II) for Tanzania which came into force on 1 July 2010. Development Partners (DPs) indicate that the process has been very much Government-driven, the latter having also defined the points of entry for CSOs, such as the review of the previous strategy and the sectoral review studies discussed with stakeholders active in the sector. However, some CSOs interviewed during the fact-finding visit claimed that the DPs' influence on what should be a national process was still too high. On a positive note, DPs interviewed during the visit indicated that health financing features strongly in the draft of the new policy document, with 2015 indicators by and large in line with Tanzanian MDG targets. Moreover, it includes an indicator for reducing fertility rates and poverty, which is a key statement to include in a document of such importance.

However, some DPs interviewed also highlighted a change in priorities suggested in the background documents to MKUKUTA II which would have a negative impact for social sectors such as health in Tanzania: According to these documents, the amounts being allocated to Cluster II (which includes health) will be reduced, while Cluster I will be increased as part of MKUKUTA II. For example, in 2009/10, Cluster I received 40% of total MKUKUTA funding, while Cluster II received 44% and Cluster III 16%. The allocations for 2008/09 were 36/48/17% respectively, indicating that

FY 2010 was already reflective of this trend. Under the 50/40/10 proposal for 2010/11, Cluster 1 will see significant increases, while the other clusters are constrained. If this trend is to continue at this pace, this could result in a reduction of TZS (Tanzanian Shilling) 2.4 trillion (= ca. EUR 1,1 billion) for Cluster 2 and TZS 3.3 trillion (= ca. EUR 1.5 billion) for Cluster 3. Despite the fact that these figures were still very preliminary at the time of the visit, some DPs saw the 50/40/10 proposal as accepted.

With regard to health sector frameworks, the National Health Policy (last revision: 2007) defines the long-term policy vision and mission of the health sector in Tanzania. The third Health Sector Strategic Plan (HSSP III) was officially launched in June 2009, and incorporates the findings of the Joint External Evaluation of the Health Sector which took place in 2007 and involved extensive consultations with Development Partners.

According to DPs, the elaboration of the HSSP III was an equally participatory process – however, non-governmental in-country participation seems to have been limited to the private, for-profit sector⁷ and certain FBOs, such as Christian Social Services Committee (CSSC).

In 2007 the MoHSW developed the Primary Health Care Service Development Programme 2007-2017 (PHCSDP – MMAM in Kiswahili). The objective of the MMAM programme is to accelerate the provision of primary healthcare services for all by 2012, while the remaining five years of the programme will focus on consolidation of achievements. It envisages, among other targets, boosting the health-sector workforce by increasing the outputs of the existing training institutions by 100%, to upgrade four schools for enrolled nurses, to upgrade the skills of existing staff through the provision of IT skills and acquiring new medical technology. The rehabilitation of existing health facilities and the construction of new ones, so as to have a dispensary in each village and a health centre in each ward, is planned as well as improving the outreach services. The referral system will be strengthened by improving the information, communication and transport system.

The Programme is said to address the revised Health Policy targets and the health-related Millennium Development Goals in the areas of maternal health, child health and priority diseases.

However, the programme costs are estimated to be around TZS 11.8 trillion (c. EUR 6.1 billion), which is well beyond the presently available budget. Innovative modalities of financing are therefore required.

With regard to Reproductive Health and Family Planning, Tanzania's once successful family planning programme has slowed markedly during recent years, with rates of contraceptive prevalence well below levels needed to reach current demand and country targets. In March 2010, the MoHSW consequently launched the National Family Planning Costed Implementation Programme 2010 – 2015 in order to revitalise family planning use⁸. However, some of the stakeholders interviewed during the fact-finding visit estimated that the resources needed to implement the programme have been considerably underestimated by the Government.

HEALTH SECTOR PERFORMANCE AND CHALLENGES

With regard to health sector performance and challenges in general, Tanzania has achieved substantial gains in Child Survival rates, with a significant decline in the Under-Five Mortality rate. Despite these important achievements, the Government admits⁹ that it is unlikely that all health 2010 MKUKUTA targets as well as the targets for 2015 for the health MDGs will be met. Just to name some of the major challenges the health sector is facing during the coming years: High neonatal death rates are accounting for 30% of all under-five deaths in Tanzania. With regard to Maternal Mortality rates, there is still no evidence to suggest a decline in that ratio in recent years. The staffing situation of skilled human resources remains glaringly deficient. According to the Health Sector Performance Profile report 2009, the health sector will require a threefold increase in its workforce with an annual tenfold increase in hiring rates over the next 10 years if it were to successfully implement the MMAM.

FINANCIAL RESOURCES FOR HEALTH

Tanzania utilises a mixed type of financing for its health systems. It is largely using tax financing which accounts for about 70% of public financing. Taxation is complemented by the National Health Insurance Fund (NHIF), and Community Health Fund (CHF), as well as user fees, defined as a form of cost sharing. The MoHSW believes that

7 Health Sector Strategic Plan III, June 2009-June 2015.

8 For more information, see: www.fhi.org/NR/rdonlyres/e6nfhonaxah7wr44ys6weo72exugago57s6bs3zk7wknqaerb4ssud5jowlaydbzntlokgw/wx3f/NatlPlanFPImplementTZfni2010.pdf

9 MoFEA – budget background and medium-term framework 2009/10 – 2011/12.

user fees are an important source of income for the health sector. This is certainly problematic when the aim is to reach universal access to primary healthcare and user fees have been shown to prohibit access to healthcare for the poorest and most marginalised.

Over the past five financial years, together with the budgeted amount for the current financial year 2009/10, the share of the health sector in total Government budget and expenditures has remained well below the 15% target of the Abuja Declaration. During the period 2004/5 to 2008/9 the share of the health sector budget (including Consolidated Fund Services – CFS [debt service, etc.]) in total Government budget stagnated at c. 10-11% and dropped to 10% in 2008/09¹⁰. It is interesting to note that different figures for the share of the health sector in the 2009-10 budget were provided by the different stakeholders interviewed during the visit. While the MoHSW states that the share of the health sector stands at c. 11% of the total budget, other stakeholders, including the MoFEA in its Mid Term Expenditure Framework 2009/10 – 2011/12, claim that it had dropped to 8.5% – this might be related to the fact that one is including CFS in this data, while the other is not. However, it also reflects the difficulties in collecting accurate information and data when there is no unified way of presenting the data amongst Government institutions.

In terms of per capita spending, actual Government spending for health is increasing and is expected to reach USD 14 (ca. EUR 10) per capita in 2010/11. However, reaching the WHO's estimated per capita spending of USD 40 (ca. EUR 30) in order to adequately address health challenges, remains an uphill task. It is worth noting that the budget allocations are significantly lower than the HSSP III predicted annual growth rates of 24% for on-budget allocations. In general, the MoHSW estimated that there will still be a funding gap of 24% during the implementation period of the Health Sector Strategic Plan III¹¹.

The share of foreign resources in the health sector budget has increased during the last years, from 31% in 2004/5 to 37% of the total expenditures in 2008/9. More worryingly, the share of domestic recurrent expenditure in total health expenditure declined from about 80% of actual expenditure in

2004/05 to 55% of the estimates in 2008/09. At the same time, the share of development expenditure has increased from about 19% of the actual expenditure in 2004/05 to about 36% of the actual expenditure in 2007/08 and about 45% in 2008/09¹².

These trends in recurrent and development budget indicate a significant boom in financing for development projects in the health sector, largely by the Development Partners, but consequently also reflect Tanzania's increased dependency on aid in the health sector. It also leads to the question as to whether the Abuja Declaration target of allocating 15% of the national budget to the health sector should not be further specified, in that it should be seen as a minimum allocation from domestic budgets which should not include foreign aid contributions to the health sector.

Moreover, Development Partners should assess the possibility of including the Abuja Declaration target among the performance indicators used to monitor General Budget Support. The European Court of Auditors had already come to a similar conclusion in 2008 by stating that "the Commission has not systematically sought to encourage countries to increase national health budgets through the use of performance indicators targeting such increases in its General Budget Support financing agreements"¹³.

CIVIL SOCIETY, THE PARLIAMENT AND OWNERSHIP

In 2001, there were about 3,000 local and international CSOs based in Tanzania. According to the Ministry of Health, the GoT has undertaken a mapping of CSOs, at least for those working on HIV and malaria and service providers. The GoT recognises the importance of Civil Society with regard to its role for service delivery (with a share of about 40% in healthcare) and for reaching the most vulnerable in society.

However, the Ministry of Health representative interviewed during the visit made a clear distinction between two types of Civil Society Organisations (CSOs) in the Health Sector: **Service Delivery Providers** on the one hand and so-called "**CSOs**¹⁴" (seen as mainly responsible for advocacy work) on the other. While direct service

¹⁰ Health Sector Performance Profile Report – Nov. 2009.

¹¹ Health Sector Strategic Plan III, p. 8.

¹² Health Sector Performance Profile Report – Nov. 2009.

¹³ European Court of Auditors Report 2008 "DEVELOPMENT ASSISTANCE TO HEALTH SERVICES IN SUB-SAHARAN AFRICA"

¹⁴ This was the terminology used by the Ministry of Health representative interviewed during the visit. From our point of view, the terminology "CSO" is obviously broader in that it extends to all types of civil society organisations, including those providing service delivery.

agreements have been put into place with a high number of faith-based organisations and networks for service delivery, there is a general mistrust on the side of Government officials towards the so-called “CSOs”. The latter are said to be ill-prepared for governmental consultation processes and to lack transparency with regard to their funding sources¹⁵. Some Members of Parliament share this suspicion, claiming that most of the advocacy CSOs in the health sector are somehow linked to the pharmaceutical industry. DPs confirm that although the platforms for Civil Society involvement exist, there is still some resistance from within the GoT against increased CSO involvement in policy-making processes – a resistance which DPs have worked to broker to some extent. However, the GoT is increasingly choosing not to support CSOs/FBOs but rather to channel money through the local level government, which is weakening civil society.

Moreover, the number of CSOs invited to actively participate in policy-making processes still tends to be limited to certain well-known FBOs, international, and/or umbrella organisations, whose ability to represent the sector is sometimes questionable. Just to name a few of the most prominent organisations which are often quoted by the Government and DPs when asked to name CSOs participating in consultation processes: TACOSODE, TACID, TANGO, Policy Forum, Christian Social Services Commission (CSSC), YAV, UMATI, the Gender Network. Most of the other organisations interviewed during the visit, however, claimed that they had had little or no opportunity to get involved in policy-making processes.

With regard to civil society’s involvement in this year’s elaboration process of the **new MKUKUTA**, for example, a CSO stakeholder meeting was convened in September 2009, in which 60 CSOs participated – most of them umbrella organisations or international NGOs working in Tanzania. Among others, these included: Policy Forum, TANGO, Oxfam, and ActionAid. However, DPs comment that few resources were made available to ensure that CSOs could afford to participate. Further to the consultations, the draft strategy of the new MKUKUTA was released in mid April 2010 and comments were expected by mid May 2010, which left stakeholders with very little time for an in-depth analysis.

The same is true for Civil Society’s participation in **health policy-making** and monitoring processes: There is a mechanism for CSO participation in the technical committees of the Health Sector Wide Approach (Health SwAP) and in the Joint Annual Sector review, as well as in policy processes such as the elaboration of the Health Sector Strategic Plan and the MMAM.

However, the MoHSW again tends to invite well-known FBOs, international, and/or umbrella organisations and does not make the effort to reach out to smaller CSOs – particularly CBOs. At a recent meeting in November 2009, for example, two umbrella organisations – the Christian Social Services Committee (CSSC) and the Association of Private Health Facilities in Tanzania (Aphfta) – participated in the meeting, as well as one well-known CSO, the Youth Action Volunteers (YAV). In addition to that, DPs point out that CSOs may have a seat at the table but it is questionable whether they also had a voice and whether there was any follow-up to their recommendations. Some of the interviewed CSOs claimed that they were “not fully listened to” and that they are often invited to the consultation processes at very short notice, impeding their ability to participate.

DPs on the other hand point out that, considering their crucial role with regard to service delivery, Tanzanian CSOs are “punching below their weight” when it comes to advocacy, where they are often seen as being weak. For this reason, CSOs are also not invited to participate at national level for the sector but only at a technical level. This situation is confirmed when it comes to calls for proposals for service delivery, which usually attract much higher numbers of proposals than the ones aimed at supporting CSO advocacy. For instance, DSW Tanzania has been the only NGO which received EU funding for advocacy work in the framework of recent EU calls for proposals.

DPs seem supportive of the need for funding **advocacy capacity-building for health CSOs** as they see a need for the latter to contribute, through their technical expertise, to existing DP coordination mechanisms, such as the Health SWAp, CSOs are currently missing out on important opportunities for empowerment by refraining from submitting joint advocacy capacity-building proposals to international donors. Partnerships should be created between faith-based organisations and other more advocacy-oriented CSOs, including academic institutions, in

¹⁵ This statement refers to the opinions expressed by the stakeholders interviewed and does not necessarily reflect AfGH views.

order to increase the chances for receiving funding for such activities. On the government side, capacity-building is, for example, provided to CSOs through the Prime Minister's Office's Tanzania Commission for Aids (TACAIDS - training for HIV/AIDS Counsellors) – however, training opportunities should be increased and broadened so as to address a greater diversity of health issues.

Moreover, with regard to CSO access to **EU funding**, most CSOs interviewed had not been able to access it, claiming that the procedures were too complex. It is worth noting that the EU is trying to support partnerships between CSOs and local authorities in order to ensure the sustainability of funded projects. However, CSOs indicate that the relationship between civil society and local authorities is still marked by mutual mistrust and suspicion. Consequently, a recent EU call for proposals aimed at strengthening partnerships with local authorities only attracted three proposals in Tanzania, all of them in the area of health and all presented by a local authority rather than CSO. These proposals were clearly lacking CSO health expertise input, which shows that there is a need for CSOs and local authorities to seek opportunities to work together.

With regard to the past and upcoming EU consultation processes, 20 umbrella organisations, as well as those NGOs supported by the EU had been invited seven weeks in advance to give input to the **mid-term review of 10th European Development Fund (EDF)**, but only two organisations responded. There are many factors explaining the lack of participation in these processes – the most important ones being time and human resource constraints due to multiple activities and conflicting deadlines, a lack of background information on the documents

received, as well the common feeling amongst CSOs that there is no follow up to their recommendations.

In order to make consultation processes more effective, additional efforts need to be made to ensure that CSOs understand the documents and processes they are to evaluate and comprehend the importance of this exercise. Moreover, they need to be informed about the outcomes and impact of the consultation process. Additional efforts should also be made to diversify the spectrum of CSOs involved in these consultations, namely by ensuring that community-based organisations (CBOs) are able to participate.

However, this also implies increased capacities on the donor side, as some DPs are equally experiencing shortages in personnel for their country offices. This is, for instance, one of the reasons why the EU Delegation decided against implementing local calls for proposals, i.e. calls which are managed by the Delegation and are open exclusively to non-state actors working in Tanzania, despite knowing that the latter would have had a far greater outreach to National CSOs and CBOs than the global calls for proposals. In a global call the Tanzanian CSOs need to compete with CSOs worldwide.

Consequently, there is also a need for CSOs – specifically INGOs and National CSOs – to offer their support to DPs through information-sharing and capacity-transfer from INGOs and bigger CSOs to CBOs and small CSOs. In the health sector, CSOs can also play an additional role in providing DPs with advice and information on the area related to their expertise.

CSOs interviewed in Tanzania also consider the Global Fund and its Tanzanian national



Meeting with CSO representatives in Dar es Salaam

Photograph: DSW

coordinating mechanism (TNCM) to be a best practice example in terms of CSO involvement. Lessons could therefore be drawn from this mechanism for donor decision-making at other levels. With regard to funding mechanisms for CSOs, those interviewed considered USAID through PEPFAR, SIDA and NORAD to be the most accessible, a view which should be reflected upon by European donors.

Another key tool for civil society empowerment in countries such as Tanzania is **strengthening its links with Parliament**. According to some Tanzanian MPs, CSOs have the opportunity to get involved in the budgetary procedure, namely during the public hearing which usually takes place in May and where a draft budget is presented by the Parliament Committees to the public. NGOs can attend these and weigh in with comment on the budget before it is passed by Parliament. However, many CSOs do not use this opportunity due to time and human resource constraints.

Within the Tanzanian Parliament, there are three committees monitoring the Government's social sector expenditures: the Public Accounts Committee (PAC), the Local Authority Accounts Committee (LAAC) and Public Organisations Accounts Committee (POAC), all of which are currently chaired by members of the opposition. These committees, as well as the Social Service Committee, regularly undertake field visits, for example to district-level health facilities, in order to monitor whether the annual expenditure committed by the Government has actually been disbursed. Discrepancies between commitments and expenditures may eventually lead to disciplinary measures; however, the results of these findings can only have a real impact on the health sector if they are effectively used as advocacy tools not only by Members of Parliament, but also by other actors, such as civil society.

With regard to the Parliament's role in setting the national budget, the Ministry of Finance briefs the Parliament with the budget overview and the parliamentary committees meet throughout May in order to pass a budget in June (10 June, the same day across all of eastern Africa). Even though there is theoretically room for amendments to the general sector ceilings set by the MoFEA, it is very unlikely that these major amendment proposals pass the plenary due to the difficulty of finding a consensus on these issues between the different parties and parliamentary committees. At the time of the fact-finding visit, some committees were trying to push

the Government for an increase in its overall allocation to the health sector from 11% to 12 or 13%, but due to economic constraints burdening the country – particularly since the financial crisis –, it is seen as unlikely that this aim will be achieved.

While MPs' work is consequently limited by their role within the budgetary process and their own party's manifesto, CSOs could use the information provided by MPs as a tool for broader advocacy, including at policy-making level. In this context, MPs could also play a key role in facilitating the contact between CSOs and Government authorities. On the other hand, as pointed out by one MP, CSOs could provide MPs with valuable first-hand information and data based on their technical expertise and work within the communities, which MPs could use as tools for their own advocacy work. One CSO, for instance, suggested sharing its knowledge about medical supplies stockouts in health facilities at community level.

Donor funding specifically targeted at establishing or strengthening the partnership and links between Parliamentary Health Committees, INGOs, National CSOs and CBOs working on health could therefore help achieving true broad country ownership of health decision-making. MPs indicated that many stakeholders came together as part of planning for Tanzania's "one action plan" in response to HIV and AIDS. A USAID programme providing specific funding for building links between MPs and CSOs in the area of HIV/AIDS was also mentioned. The challenge is now to replicate these positive experiences in other health areas.

Finally, it is interesting to note that DPs have established a website on "Civil Society Support"¹⁶ in Tanzania, where one can compare the different funding opportunities for Civil Society made available by each donor, by sector/region/etc.

16 For more information, visit: www.civilsocietysupport.net.

THE IMPACT OF DONOR COORDINATION ON HEALTH SPENDING IN DEVELOPING COUNTRIES

DONOR COORDINATION MECHANISMS AND DIVISION OF LABOUR IN TANZANIA

Tanzania has been carrying out aid management reforms as part of the broader economic reforms undertaken since the mid 1990s. Due to its sophisticated donor and assistance coordination systems, Tanzania has, in recent years, been evaluated as being a best-practice example for aid effectiveness¹⁷. It is therefore worth giving a brief overview of these mechanisms, as well as the different aid modalities used in Tanzania, in order to be able to consequently analyse their respective impact on the country's health sector, and hopefully on health outcomes.

THE JAST AND THE DPG HEALTH

In December 2006, Tanzania launched its **Joint Assistance Strategy (JAST)**, as a successor to the Tanzanian Assistance Strategy (TAS – 2002-2006). JAST (2007-2011) is a medium-term framework aimed at bringing together all Development Partners under a single strategic framework that guides their development assistance in line with the MKUKUTA and the MKUZA. In comparison to the TAS, the JAST has

aimed to be more comprehensive, going beyond the 13 best practices and four priority areas of the TAS and covering all aspects of the development partnership between the Government and Development Partners as well as the role of non-state actors therein. However, non-state actors interviewed during the fact-finding visit stated that, despite knowing about the JAST process, they had never been invited to any meetings pertaining to the framework process. It is also worth noting that although coordination will be maintained, DPs and the Government have decided not to have a new, single JAST document for the period starting in 2012¹⁸. It therefore remains to be seen whether Tanzania will progress or make a step backward with regard to its aid effectiveness agenda.

On the donor side, the **Development Partners Group (DPG)** was established in 2004 and works, under the leadership of the GoT, to promote aid effectiveness and the mechanisms of managing aid, including coordination and cooperation among the various stakeholders supporting the national efforts. Membership currently comprises 21 organisations in Tanzania, including the UN, the EU Delegation and International Financial Institutions. A number of sector / thematic coordination groups



Action for Global Health and DSW Tanzania meet Hon. Lediana Mafuru, MP.
Photograph: DSW

¹⁷ For example: 2007 External Evaluation of Health Sector in Tanzania; OECD Survey 2008 on Aid Effectiveness.

¹⁸ Statement made by one DP interviewed during the visit – no further information can be provided at this stage.

have been formed to work on both macro and sectoral issues.

The **Development Partners Group for Health (DPG Health)** is a collection of 10+ bilateral and multi-lateral agencies supporting the health sector in Tanzania. The total cumulative contribution of those Development Partners to the Health Sector in 2007/08 was USD 280 million (c. EUR 193 million), not including HIV/AIDS funding or funding from the Global Health Initiatives. Funds are provided through general budget support, the health basket, projects, and technical assistance. After a reorganisation of the DPG Health group in accordance with the JAST, the lead is conducted in the form of a troika (3 person lead arrangement with one incoming chair, one chair and one outgoing chair). At the time of the fact-finding visit, the Troika was chaired by the Netherlands, the World Bank and Switzerland. Meetings between the DPs and the GoT are taking place as defined in

the SWAp arrangement (see page 17). As of June 2009 there were 10 active partners and 2 contributing partners in the DPG Health¹⁹.

Despite the fact that some DPs see the negotiation processes within these coordination mechanisms as rather slow and cumbersome, the DPG Health distinguishes itself through its sophisticated troika-system, which ensures that at least three development partners from the group are continuously taking a strong lead for health. Also in terms of transparency, the group is exemplary, as it has its own website²⁰ which gives a comprehensive overview of all key policy documents and processes in the health sector. However, in a country such as Tanzania, with a strong rural/urban digital divide, additional efforts need to be made to ensure that this important information reaches key groups in rural areas, such as, for example, community-based organisations.

10 TOP DONORS TO THE HEALTH SECTOR IN TANZANIA - COMMITMENTS, AVERAGE, IN USD MILLION

Donor Name	USD Million	as a share of total aid to health for the selected recipient, %	as a share of total aid for the selected recipient, %
All Donors	552.1	100.0	18.3
United States	202.8	36.7	42.8
Global Fund	121.7	22.0	100.0
IDA	55.3	10.0	10.4
Netherlands	36.4	6.6	23.8
Germany	21.3	3.9	27.9
AfDF	21.2	3.8	8.9
Norway	19.2	3.5	11.8
Ireland	14.2	2.6	27.7
Canada	12.1	2.2	25.3
Switzerland	7.8	1.4	27.0

Source: OECD Health Focus Charts 2006-2008

However, the impact of this system on the country's health sector is not merely positive: For example, due to division of labour considerations, the EU Delegation decided to step out of the health sector. Consequently, the sector not only lost what could have potentially been its strongest donor, but was also weakened in terms of advocacy partners for

health: Despite claiming that new aid modalities, such as MDG contracting²¹, should help country progress towards the health MDGs, the EU Delegation in Tanzania is lacking the necessary human resources, health expertise and prioritisation to effectively push for such progress in its policy dialogue with the Government.

19 For more information, visit the DPG Health website: www.tzdpdg.or.tz/dpghealth

20 www.tzdpdg.or.tz/dpghealth/

21 See overleaf for further explanations on this aid modality

AID MODALITIES AND THEIR IMPACT ON THE HEALTH SECTOR

While project-based support still constitutes the most important aid modality (46% of total overseas aid recorded in 2008/9) – mainly due to non-European project funding – General Budget

Support has clearly gained in popularity among donors during the last years, accounting for 36% of overseas aid in 2008/9, compared to only 18% for Basket funds²². However, according to some DPs, there are recent indications that this popularity is somewhat waning.

FUNDING MECHANISMS IN THE HEALTH SECTOR

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

GENERAL BUDGET SUPPORT (GBS)

Most major donors active in Tanzania provide some GBS through the Poverty Reduction Budget Support (PRBS) facility. The facility is a single account into which donors disburse the GBS they provide to the Government and can be drawn upon by the Government when necessary. Eleven bilateral and three multilateral DPs (including the EU Delegation) provide aid through the GBS modality. In FY 2008/09, DFID and the World Bank were the biggest GBS donors, together accounting for c. 50% of total GBS. According to some DPs interviewed during the fact-finding visit, the annual GBS meeting is the highest-level meeting of the year between GoT and DPs. It allows for issues of governance and other concerns to be raised. The **GBS Annual Review** assesses the Government and Development Partners' performance against the jointly agreed Partnership Framework Memorandum (PFM) signed in 2006, in particular the Government's commitment to promote high economic growth and reduce poverty through implementation of MKUKUTA, and the Development Partners' commitment to provide financial assistance to that end. The assessment also includes the jointly agreed **Performance Assessment Framework (PAF)** Matrix, which

draws indicators from the MKUKUTA and other national processes, including certain health indicators, such as, for example, births attended by skilled health personnel.

Tanzania is one of 10 countries to be chosen, due to its good track record, for "**MDG contracting**" as a specific form of EU long-term (6-year) General Budget Support. The contract in Tanzania was signed in November 2009 and the first tranche of the disbursement was made in December 2009. The contract has a fixed tranche which cannot be modified, whereas the amount of the so-called variable tranche depends on the performance of the Government with regard to a set of established indicators, aimed at contributing to progress towards the MDGs. However, most indicators are not based on MDG targets, but have been taken from national frameworks – including the health indicators. Moreover, the EU Delegation has recently stepped out of the health sector in Tanzania, a decision which is said to be based on division of labour considerations among European donors in Tanzania, as well as the EU Delegation's own expertise with road and transport infrastructure programmes. This evidently raises the question as to how the Delegation can track performance in a sector such as health where it lacks the necessary

22 Policy Forum, 2009. Aid Effectiveness and General Budget Support in Tanzania: www.policyforum-tz.org/files/GeneralBudgetSupport.01.pdf

skills and expertise. In Tanzania, specific MoUs had to be established with other EU health donors, particularly Germany, in order to overcome this dilemma.

Another challenge linked to General Budget Support is that past experience has shown that the counterparts within the GoT are reluctant to revise indicators in order to progressively set higher targets – the tendency is to justify maintaining the same indicators in order to account for high population growth. This raises the question whether the variable tranche indicators can still be seen as effective incentives for progress. Moreover, according to some DPs, the Government has failed to comply with 50% of these indicators in the past.

It is worth noting that the effectiveness of this modality in Tanzania will be reviewed through a **joint evaluation to be initiated in September 2010**. In this context, DPs should evaluate the impact of General Budget support on social sectors such as health.

THE SWAP AND HEALTH BASKET FUND

In June 1998, the MoHSW and DPs agreed to pursue a sector-wide approach (SWAp) to health sector reform. The SWAp aims at increasing coordination among donors and Government, supporting one health sector programme. Based on the SWAp approach, a joint funding mechanism (the Health Basket Fund) was created in 1999. The basket consists of two elements:

- The **central basket**, funding the Ministry of Health headquarters and other central organisations with central support functions.
- The **district basket**, funding running costs for District and Municipal Council health services based on an action plan. The district basket aims at providing a stable and predictable resource base for local councils, complementing the District Health Block Grant from the GoT.

The SWAp Committee is the agreed overall body for dialogue among all stakeholders in health: MoHSW, Prime Minister's Office Regional Administration and Local Government (PMO-RALG), MoFEA, NGOs, private sector and DPs. There are two meetings a year – one is the Joint Annual Health Sector Review (JAHSR) and the other is a six-month interim progress meeting. Topics discussed are the health sector performance; health sector plans and budget (MTEF - Mid-term Expenditure Framework); and

other jointly agreed topics. The Technical Committee of the SWAp comprises of representatives of the stakeholders in the SWAp. Membership among some stakeholders (NGOs and Development Partners) rotates along with the representation of the numerous entities. The Technical Committee serves as a joint monitoring body of the goals and activities of the health sector as outlined in the Health Sector Strategic Plans II and III, Medium Term Expenditure Framework, Regional Health Plans and Comprehensive Council Health Plans.

The Joint External Evaluation of the Health Sector in Tanzania concluded that the SWAp has contributed to improvements in health outcomes and to improvements in the quality of health services at community level. As highlighted by one DP, many of the Health Basket Partners also provide GBS, suggesting that they recognise the limitations of the GBS modality in ensuring that funds get allocated as needed in frontline service delivery.

PROJECT AND PROGRAMME SUPPORT

As mentioned above, project and programme support still constitutes an important part of the aid architecture in Tanzania. Some projects / programmes run through an exchequer system, which is seen as progressive by the Government, but most projects cannot be adequately captured and traced by this. It is interesting to note that Global Fund disbursements are now captured on-budget in Tanzania and they represented as much as 49% of total MoHSW expenditure in the 2010/2011 budget. This obviously raises the concern that due to these high amounts of disease-specific funding available, domestic and recurrent health funding will be reduced in the long-run, to the detriment of health-system strengthening.

ALIGNMENT AND COUNTRY OWNERSHIP IN THE HEALTH SECTOR: IS GENERAL BUDGET SUPPORT THE WAY FORWARD?

There is notable disagreement among stakeholders in Tanzania about which of the above-mentioned aid modalities are most aligned with the country's policies and needs, including different views within the Government itself: The MoFEA is strongly in favour of GBS, which can primarily be related to this institution's power with regard to setting national budget ceilings. The Ministry also argues that GBS is the most predictable aid modality, as funds are frontloaded in the first quarter of the fiscal year, whereas basket funds need to be approved by donors before being disbursed, a

requirement which sometimes delays the process. With regard to the transparency of aid flows, the Ministry claims it is working on the establishment of an aid management platform – a web-based database, to which donors will be invited to contribute by directly entering planned disbursements to be validated by the Government.

The MoHSW, on the other hand, argues in favour of continued Health Sector budget support, as the Ministry considers that GBS alone bears the risk that the needs of social sectors, such as health, are neglected in the long run due to growth and macroeconomic priority setting, irrespective of expressed political will to make health a priority²³. Such differences challenge the assumption of GBS being the only aid modality ensuring country ownership, especially when considering that the Cotonou Agreement urges donors to support the participation of technical and sector ministries in decision-making processes in developing countries.

With regard to the Development Partners Group (DPG), General Budget Support is still seen as the preferred aid modality by most European donors, but critical voices are becoming more and more prevalent, leading some DPs to assume that Tanzania might, at some point, see a shift in its aid structure. Some of these voices admit that dialogue within the DPG is rather limited, slow, tedious and labour-intensive. They also see a risk in the fact that during the past 10 years, such coordination mechanisms had been dominated by generalists (rather than health specialists), who often give great focus on the need for ownership and harmonisation and tend to neglect other Aid Effectiveness principles.

However, it needs to be acknowledged that some DPs also see a risk in increasing earmarked funding for health in Tanzania, especially when allocated according to donors' highest priorities, such as the three communicable diseases (Malaria, Tuberculosis and HIV/AIDS), with a particular focus on HIV/AIDS. Even though members of the Development Partner Group for Health (DPGH) have – in principle – agreed to align their health aid with the priorities of the third Health Sector Strategic Plan, the reality shows that each donor is still picking out their special areas of focus. Due to the high amounts of funding available, in particular for the two most prevalent communicable diseases in Tanzania (Malaria and HIV/AIDS), the Government tends to see the health sector in

general as being 'taken care of' by the donor community, consequently reallocating General Budget Support, as well as domestic funding, to other priorities.

As a consequence, recurrent funding needed for other health priorities, such as health system strengthening or human resources in health has decreased in recent years. This tendency might be exacerbated by the fact that Global Fund allocations are now being captured on-budget and are therefore expected to substantially increase the share of external resources in the national health sector budget.

With the share of foreign financial resources in the sector budget already nearly reaching 40%, this poses a fundamental challenge to the country's ownership of the health sector, and the sustainability of current funding levels. DPs involved in the Health SWAp proposed a temporary process action to GBS that would at least stop the decline of the national health budget, a suggestion which encountered significant resistance from DPs not engaged in the health sector. However, the European Court of Auditors, in its 2007 Evaluation of EU Health funding in Sub-Saharan Africa, had already urged DPs to promote increases in national health budgets through the use of performance indicators, targeting such increases in its General Budget Support financing agreements.

Nevertheless, the terminology in of itself needs to be re-defined: it is essential to insist on the fact that not only nominal figures are increased, but that the share of national health funding in the general budget increases by using international agreements, such as the Abuja Declaration target, as a reference. Currently, the GoT does not differentiate between domestic and external funding when calculating the share of the health budget in the national budget, which means that international aid is used to comply with the commitments made in the framework of the Abuja Declaration. This is neither a very sustainable strategy for meeting recurrent health funding needs in the long term, nor does it correspond to the original intention of Abuja Declaration signatories. Moreover, African advocates, such as the African Public Health Alliance, working on the Abuja target have recently redefined their advocacy to include a greater focus on per capita spending on health as they are aware that a simple percentage of national spend does not give the full picture of how close the country is to spending the amount necessary

²³ Also see remarks in the first part of this paper about changes in Government priority-setting over the last few years: Development Strategies and Health Policies in Tanzania – p. 4.

for a universal package of basic services. As the principle of “ownership” should also be seen as being exercised not only by the Government, but also by non-state actors, it is equally important to take into account the point of view of Tanzanian CSOs, most of which advocate for increased direct or project support, arguing that this is often the only way to reach the most vulnerable in their society. Moreover, direct support is needed for CSOs to carry out their “watchdog” role within the Tanzanian society: With regard to the donor coordination mechanisms, such as the JAST and the Health SWAp, only two of the seven well-respected CSOs interviewed confirmed having participated in the discussions in recent years. Those who have not been involved claim that the key obstacles for participation are a lack of human and financial resources, as well as advocacy expertise among CSOs.

Consequently, in the case of Tanzania, the hypothesis that GBS is the best aid modality for increasing country ownership appears to be unfounded when considering the diversity of views expressed by actors who should be involved in policy-making processes. Moreover, true ownership implies that the country should also be relatively independent with regard to its financial resources envelope. However, as long as there is a high dependency on foreign aid, as is the case in Tanzania, ownership is not a reality. The GoT – even in the case of GBS – is still exposed to aid-related risks, such as the unpredictability or delays in aid flows. As long as such a dependency exists, aid should continue to be provided through mixed funding policies.

IHP+ AND EUROPEAN DONOR COORDINATION: TOO MANY PARALLEL STRUCTURES?

With regard to the **International Health Partnership (IHP+)**, the ministries interviewed and many DPs are sceptical about the added value of such mechanisms in a country such as Tanzania, where elaborate donor coordination mechanisms are already in place and have proven to be relatively efficient. They see a risk of over-complicating structures and increasing transaction costs by imposing additional vertical initiatives on Tanzania which fall outside of existing donor alignment mechanisms. They hope that the IHP+ Joint Assessment of National Strategies framework would not demand that Tanzanian structures would have to be changed. Only the World Bank has a vested interest to get a country compact signed, mainly due to the fact that IHP countries get a preferential treatment when accessing certain

World Bank funds. However, in practice, it has not pushed the issue. As for the civil society organisations interviewed, the majority had never heard about the IHP+ initiative.

With regard to **European donors’ internal coordination**, the question was ultimately raised as to whether the EU should speak “with one voice” in Tanzania. However, as in the case of the IHP+, EU Member States questioned the added value of EU coordination within the general coordination process, due to the high efficiency of existing mechanisms and a division of labour matrix that goes beyond the EU.

In short, efforts should focus on increasing the efficiency of existing donor coordination mechanisms in Tanzania, rather than creating new ones.

It is worth mentioning an interesting example for **internal coordination of European bilateral funding** to the health sector, however: Germany, one of the biggest donors to the health sector in Tanzania, has established a joint health programme to which all of its five development cooperation agencies (GTZ, DED, CIM, KfW, InWEnt) are contributing according to their respective expertise: The Tanzanian German Programme to Support Health (TGPSH) began its activities in 2003 and aims at supporting the health sector reform in Tanzania in achieving its goal “to improve the health and well-being of all Tanzanians with a focus on those at most risk and to encourage the health system to be more responsive to the needs of the people”. The planned results of the programme will mainly concentrate on capacity building for district health services, sustainable rehabilitation and maintenance of existing health facilities, support for co-operation between public, private for-profit and non-profit providers of healthcare, development, dissemination and financing of decentralised models to fight HIV/AIDS, as well as assistance to develop cost-sharing systems.

RESULTS-BASED MANAGEMENT:

THE ROLE OF AID FOR COUNTRY PROGRESS TOWARDS HEALTH MDGs AND UNIVERSAL ACCESS TO PRIMARY HEALTHCARE SERVICES

Aside from their debatable impact on health-spending, donor coordination and alignment efforts also need to be evaluated against country progress towards achieving the Health MDGs and universal access to primary healthcare during recent years.

As mentioned above, the Joint External Evaluation of the Health Sector in Tanzania concluded that the Health SWAp has contributed to improvements in health outcomes and to improvements in the quality of health services at community level, which can possibly be linked to progress towards the MDGs and PRSP/MKUKUTA goals. The devolution of responsibilities for health facilities and health planning to Local Government Authorities has unquestionably contributed to improving health sector delivery in Tanzania. The associated financial support (through Health Basket fund and Block Grants) was essential to achieving this result.

However, some DPs claim that, in a country as stable as Tanzania and with such a commitment / focus from donors, aid could have produced even more change. While significant progress has been made in reducing child mortality since the year 2000, maternal mortality remains one of the key challenges within the health sector, with a ratio of c. 578 deaths per 100,000 live births according to Tanzania's latest available data dating from 2004/05²⁴. At least donor funding for this issue seems to have increased during recent years as a result of CSO advocacy: CSOs state that the number of calls for proposals on maternal health and family planning have increased compared with previous years, and these issues can now be included in their programmes. However, CSOs point out that they face a major challenge in accessing updated official data on these issues – a problem which is illustrated by the outdated character of the data on maternal health (see above).



Kisarawe District Hospital Ambulance co-financed by the European Union.
Photograph: DSW

24 Health Sector Performance Profile Report – Nov. 2009.

Moreover, the Tanzanian health sector is still marked by flagrant inequities with regard to universal access to primary healthcare services. A joint external evaluation of the health sector in Tanzania for the period between 1999 and 2006 was undertaken in 2007, the results of which fed into Tanzania's third Health Sector Strategic Plan covering 2008-2015. One of the conclusions of the final report was that equal access to health services in Tanzania remains a problem, and that the benefits of improved health services – and HIV/AIDS programmes in particular – are thus not shared equitably. The sector has not responded effectively to address these constraints.

As pointed out by a Tanzanian MP interviewed during the fact-finding visit, access to primary healthcare services, specifically for marginalised populations in rural areas, is still limited by a number of factors, including, among others, poor road infrastructure and long travel distances to the hospitals, significant shortages in skilled health personnel, as well as gender inequality issues. According to the MP, addressing the challenges faced within the health sector requires an integrated, cross-sector and cross-thematic approach. For example, maternal mortality cannot be reduced if gender issues, such as women's low status in society and the lack of prioritisation of their specific needs within a patriarchal family structure.

Firm commitments to addressing some of the major health issues have been made by the President of Tanzania himself in recent years, including a statement on the need for substantial progress on reducing maternal mortality²⁵, as well as fighting

Malaria²⁶, a disease still killing about 125,000 people each year in Tanzania. However, it will take some time for donors and the Government to tackle these major challenges.

A visit to a dispensary in Kisarawe District half an hour away from Dar es Salaam, mirrored some of the key challenges the health sector is facing in Tanzania, such as high absenteeism, shortages in personnel and ineffective referral systems. According to a Kisarawe District official, health facilities sometimes struggle with scarce resources that the Government is allocating to the districts according to catchment areas, rather than taking into account annual user rates per health facility. Consequently, some dispensaries have experienced shortages in supplies due to the need to attend a high number of patients coming from other districts and using their facility.

Tanzania uses a 'cost-sharing' model of health financing which means that people pay fees when they access public health services. A district official stated that a one-time user fee of USD 1 (= ca. EUR 70 cents) is charged when each person first uses their health services. Access for pregnant women, the elderly and the disabled should be free – a policy which, according to some CSOs and donors, is not a reality yet in many health facilities. Part of the problem is that any health centre that follows the official policy is supposed to absorb the costs of providing these services for free because there is no reimbursement from the Government. This raises a lot of questions about incentives for health centres to toe the line when the fees probably provide the majority of their budget.



Kisarawe District Hospital and "On Call List": shortages of staff are striking.

Photograph: Interact Worldwide

²⁵ Available at: <http://allafrica.com/stories/200708031104.html> - viewed: 10 July 2010

²⁶ Speech 25 April 2010 – World Malaria Day

Any successful removal of user fees would require much greater financial and technical support in order for centres to be able to support the policy and deal with the increased demand for services. Public-Private Partnership initiatives are currently being piloted by the Government, whereby a service agreement is established between the Government and private clinics on subsidised and free provision of healthcare to certain population groups. While some important DPs are still in favour of the cost-sharing system, others are looking into the possibility of co-financing the cost of the removal of user fees, which, however, raises the question of the sustainability of the system.

However, the existence of user fees is only one of the many challenges facing the health sector. The Government's primary healthcare strategy includes plans for establishing a dispensary in each village in order to reduce the distance that anyone has to travel to get to a health facility. But the plan – while commendable – is let down by a lack of foresight about the quality of the services themselves. There were complaints that some newly-built dispensaries are sitting empty because there are not enough well trained personnel to staff them.

According to the GoT, increased multi-level training opportunities are offered to district health personnel, in order to overcome the shortage of skilled health workers in rural areas. However, DPs criticise the fact that this training has not yet been linked to effective incentives for retaining health personnel in rural areas, and therefore sometimes results in increasing the shortage in human resources. Brain drain from the public to the private sector and to donor-funded projects is another problem that still needs to be addressed.

Moreover, some DPs point out that task shifting has not yet been implemented in the way that it has been done in Malawi or Uganda, for example, as medical associations in Tanzania are against it. The Human Resources in health focal points – currently being SIDA and USAID – within the technical working groups of the Health SWAp, are said to be working on this issue.

The Ministry of Health is currently piloting a "Pay for Performance" initiative, but DPs are divided on the effects of such a mechanism – some fear that certain health areas which cannot be covered by the programme will consequently be neglected, which would lead to a stronger imbalance in the system. The programme is supported by some DPs, but has been fiercely criticised by most, as well as external evaluators. It is said to have been recently stalled due to a lack of funding made available – only its data collection component seems to be ongoing.

The majority of – especially non-European – donor funding to the health sector in Tanzania is still allocated to the two most prevalent communicable diseases affecting the country, i.e. Malaria and HIV/AIDS. However, as pointed out by one MP, funding for these diseases, despite its magnitude, will never be sufficient, particularly when it comes to HIV/AIDS, where continuous funding is needed to provide life-long treatment. According to this MP, current donor funding only covers about 20% of existing needs for HIV/AIDS programmes in Tanzania. However, in order to reduce donor dependency on funding for ARV some Parliamentary Committees are advocating for the creation of an integrated Tanzanian fund for HIV/AIDS and Reproductive Health, supported by innovative financing mechanisms.

BREAKDOWN OF HEALTH AID BY SUBSECTOR - COMMITMENTS

	2006-2008 USD Million average
Population policy & admin. management	3.5
Basic health infrastructure	10.6
Medical services, training & research	5.1
Family planning	5.9
Reproductive health care	27.7
Infectious disease control	77.6
Basic health care	72.6
Health policy & admin. management	69.8
STD control including HIV/AIDS	279.2
Grand Total	552.1

Source: OECD Health Focus Charts 2006-2008

In general, according to the country's last Health Sector Performance Report, the health sector in Tanzania is still facing a funding gap of 24%.

Consequently, some DPs – including an increasing number of European donors – argue that GBS alone is not yet the way forward and that it is important to keep the Health SWAp as a way to promote equitable access to health. According to several DPs, another key challenge related to GBS is transparency and accountability: Monitoring of spending is not undertaken in a timely, nor effective manner.

Taking the example of Tanzania's MDG Contract with the European Union, signed in November 2009, which provides the country with a new, six-year framework for General Budget Support amounting to EUR 305 million: This framework includes an MDG-based tranche of 30% including 10 MDG outcome indicators from the PAF in the area of Growth and Reduction of Income Poverty (3 indicators) and Improvement of Quality of Life and Social Well-being – including Health (7 indicators). However, the MDG tranche is only envisaged to take effect from years 4 to 6 (2012-2014). This unavoidably raises the question as to whether it will be possible to effectively assess General Budget Support delivered by the European Union against MDG performance under the current framework.

With regard to Health basket funds, there are apparently no major problems with releasing the funds to the Ministry of Finance, but there are delays in releasing the part allocated by the Ministry of Health to the districts. DPs argue that Communities need to demand to see the local budget for better governance. However, even though this information is publicly available, communities need to be supported to be able to carry out this watchdog role.

At the same, CSOs also need to make self-critical assessment on the impact of aid channelled through project support: Those interviewed during the visit admitted that monitoring the impact and results of a project remains a challenge even for those organisations working closest with their final beneficiaries and vulnerable groups. One key element for donors should be to allow for the budgeting of an ex-post evaluation of the impact and sustainability of the project – the European Commission sometimes finances such an evaluation, but only if the project budget is in excess of EUR 1 Million. Another key element is that CSOs should be able to recover costs made during the preparation phase of the project if selected – for example, those costs related to building partnerships with local governments and communities – as these activities are often crucial for the sustainability of the action.

RECOMMENDATIONS TO STAKEHOLDERS IN THE EU AND IN TANZANIA

OWNERSHIP AND PARTICIPATION OF CIVIL SOCIETY AND THE PARLIAMENT

- Donor priorities and country ownership:** There was a common feeling among those CSOs interviewed during the fact-finding visit that donor priorities still had a disproportionately significant role in governmental policy-making (for example: the MKUKUTA process) and funding decisions in Tanzania. Even though DPs claim that their actions are fully aligned with country priorities, they should not underplay the weight and influence they have through policy dialogue mechanisms. However, rather than following their specific priorities, donors could use this influence to promote true country ownership through the participation of CSOs and the parliament in policy-making processes, as well as to ensure country compliance with international frameworks, such as, for instance, the Health MDGs and the Abuja Declaration.
- Transparency and follow-up of consultation processes:** In order to make consultation processes more effective, additional efforts need to be made to ensure that CSOs are able to access and understand the documents and processes they are to evaluate and have the capacity to effectively take part in this exercise. Moreover, they need to be informed about the outcomes and impact of the consultation process.

CSOs interviewed in Tanzania consider the Global Fund and its Tanzanian national coordinating mechanism (TNCM) to be a best practice example in terms of CSO involvement. Lessons could therefore be drawn from this mechanism for donor decision-making at other levels.

- Improve Government and donor outreach to CSOs:** Additional efforts should be made to broaden and diversify the spectrum of CSOs involved in these consultations, namely by ensuring that CBOs are able to participate. To that end, specific funding should be provided by donors to enable smaller and community-based organisations to participate in such processes. Even with regard to the TNCM, which is seen as a best practice example for CSO involvement (see above), CSOs interviewed during the visit highlighted the need for increased CBO participation in decision-making processes.
- Increased focus from CSOs on advocacy:** This policy briefing demonstrated that CSOs are currently missing important opportunities for empowerment, by refraining from presenting joint advocacy capacity-building proposals to international donors who are willing to support them.
- Strengthen and diversify partnerships:** Partnerships should also be sought between faith-based organisations and other more advocacy-oriented CSOs, academic institutions and local authorities in order to increase the chances for receiving funding for such activities.
- Increased support for links between CSOs and the parliament:** Donor funding specifically targeted at promoting truly participatory processes and establishing or strengthening the partnership and links between Parliamentary Health Committees, INGOs, National CSOs and CBOs working on health could help achieving country ownership. MPs indicated that many stakeholders came together as part of planning for Tanzania's 'one action plan' in response to HIV and AIDS. A USAID programme providing specific funding for building links between MPs and CSOs in the area of HIV/AIDS was also mentioned. The challenge is now to replicate these positive experiences in other health areas.

- **Information-sharing and capacity-transfer:** INGOs and National CSOs should take responsibility for information-sharing and capacity-transfer from INGOs and bigger CSOs to CBOs and small CSOs. In the health sector, CSOs can also play an additional role in providing DPs with advice and information on the area related to their expertise.
- With regard to **access to funding** for CSOs, those interviewed considered USAID through PEPFAR; the SIDA fund for local CSOs; NORAD and the Presidential Fund to be the most accessible sources. It would be recommendable for donors to reflect upon the reasons behind this evaluation and use this analysis as a basis for reviewing their own funding mechanisms. In general, CSOs urge donors to make their selection processes more transparent, to simplify application, procurement and disbursement procedures, as well as to make funding available for long-term, institutional strengthening and capacity-building of CSOs and CBOs.
- **Co-funding requirements** need to be revised by donors as even the bigger and more experienced CSOs are often struggling to comply with them. For community-based organisations, the co-financing rule is often a key factor hampering their participation in calls for proposals.
- Moreover, CSOs met during the visit see a need for the Government to establish a specific **CSO desk** not only for managing the existing NGO register, but also **for managing funds**.

DONOR COORDINATION AND ITS IMPACT ON HEALTH SPENDING

- **A continuous need for mixed and balanced funding policies:** As repeatedly illustrated throughout this paper, the hypothesis that General Budget Support (GBS) is the best aid modality for increasing country ownership appears to be unfounded when considering the diversity of views expressed by actors which should be involved in policy-making processes. As long as there is a high dependency on foreign aid, as it is the case in Tanzania, ownership is not a reality, as the Government – even in the case of GBS – is still exposed to aid-related risks, such as the unpredictability or delays in aid flows. As long as such a dependency exists, aid should continue to be provided through mixed funding policies, by ensuring that there is a good balance between all three aid modalities.
- In consideration of Civil Society's important role with regard to service delivery and reaching the most vulnerable in Tanzania, donors are urged to **increase their direct support channelled to CSO activities in the health sector**, as funding opportunities within the General Budget Support and the health basket funding modality remain very limited for CSOs. Specifically targeted funding should be available for community-based organisations.

At the same, CSOs also need to make self-critical assessment of the **coherence, impact and sustainability of aid channelled through project support**: Those organisations interviewed during the visit admitted that monitoring the impact and results of a project remains a challenge even for those organisations working closest with their final beneficiaries and vulnerable groups. A first key factor pre-conditioning the success of a project is thorough preparation and planning: Partnerships should already be established before applying for funding and each project should be preceded by a "project identification" or "field assessment" mission aimed at identifying key partners and stakeholders on the ground, as well as possibilities for synergies with existing activities. As such activities are costly, but

often crucial for the sustainability of a project, **CSOs should be able to recover costs made during the preparation phase of the project** if selected. Another key element for donors should be to allow for the budgeting of an **ex-post evaluation** of the impact and sustainability of the project – the European Commission sometimes finances such an evaluation, but only if the project budget exceeds EUR 1 Million.

- Key development partners in Tanzania point out that sustained policy dialogue between all stakeholders including the Government, civil society and DPs will be essential if the country's currently negative trend of reducing the proportion of Government budget devoted to health is to be reversed. Development Partners (DPs) should consequently be using policy dialogue to promote the inclusion of the **Abuja Declaration target²⁷ among the performance indicators used to monitor General Budget Support (GBS)**, i.e. make the continuation of GBS conditional on an increase in the share of domestic funding to health in order to reach the 15% target. The European Court of Auditors had already come to a similar conclusion in 2008 by stating that "the Commission has not systematically sought to encourage countries to increase national health budgets through the use of performance indicators targeting such increases in its General Budget Support financing agreements"²⁸.

Moreover, African advocates recommend adding per capita spending on health to the evaluation criteria, as a simple percentage of national spending does not give the full picture of how close the country is to spending the amount necessary for a universal package of basic services.

- Development partners interviewed during the fact-finding visit confirmed that funding allocated to the so-called variable tranche of General Budget Support on the basis of performance indicators has not been a strong enough incentive for making substantial progress towards the established health indicators. DPs should consequently assess the possibility of **increasing the**

share of the variable tranche within the General Budget Support modality as well as the weight of health indicators in the evaluation of budget support.

- The **European Division of Labour system should not be used as an excuse by major donors**, such as the European Union, to withdraw from their responsibility for global health and health funding.
- With regard to the **International Health Partnership (IHP+)**, the ministries interviewed and many DPs are sceptical about the added value of such a mechanism in a country like Tanzania, where elaborate mechanisms are already in place and have proven to be relatively efficient. In short, efforts should focus on **increasing the efficiency of existing donor coordination mechanisms** in Tanzania, rather than creating new ones. However, it remains to be seen whether IHP+ could become of value to Tanzania in case the Government and DPs decided to go ahead with their plan to cease continuing the current single JAST coordination framework by 2012.

27 Signatory governments of the 2001 'Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases' agreed "to allocate at least 15% of our annual budget to the improvement of the health sector". www.un.org/ga/aids/pdf/abuja_declaration.pdf

28 European Court of Auditors Report 2008 "DEVELOPMENT ASSISTANCE TO HEALTH SERVICES IN SUB-SAHARAN AFRICA"

RESULTS-BASED MANAGEMENT AND THE ROLE OF AID FOR COUNTRY PROGRESS TOWARDS THE HEALTH MDGS AND UNIVERSAL ACCESS TO PRIMARY HEALTHCARE

This paper illustrates that Tanzania's health sector – despite its elaborate donor coordination mechanisms – is still marked by flagrant inequities. In order for aid to have a real impact on country progress towards the health MDGs and universal access to primary healthcare, donors should consider to take the following actions:

- The majority of – especially non-European – donor funding to the health sector in Tanzania is still allocated to the two most prevalent communicable diseases affecting the country, i.e. Malaria and HIV/AIDS. While continuous support for fighting these diseases is important, this tendency has already led to the emergence of health orphans. European donors could play a key role in promoting the **linkage between such disease-specific programmes and other health initiatives**, such as, for instance, reproductive health and family planning programmes.
- Even though numerous expert studies²⁹ have shown that the **removal of user fees** is a crucial step towards achieving **universal access to primary healthcare**, it is not a reality yet in many countries, including Tanzania. As illustrated in this paper, any successful removal of user fees would require much greater financial and technical support in order for health centres to be able to support the policy and deal with the increased demand for services. Donors should assist governments in developing countries in seeking long-term, sustainable financing mechanisms in order to make the removal of user fees possible.

- According to the GoT, increased multi-level training opportunities are offered to district health personnel, in order to overcome the **shortage of skilled health workers in rural areas**. However, DPs need to assist the Government with linking such training to effective incentives for retaining health personnel in rural areas.

Brain drain from the public to the private sector and to donor-funded projects is another problem that still needs to be addressed. Donors should develop and follow the **WHO code of practice on the international recruitment of health personnel**³⁰ to ensure that both their development and non-development-related programmes and projects do not have a negative impact on the workforce in the health sector in developing countries where health worker shortages are acute.

Any pay for performance initiative must be carefully thought through before implementation in order to avoid adverse effects being created by certain incentives and with a recognition for the type of interventions for which this modality is not appropriate.

29 For example: "WHO discussion paper: the practice of charging user fees at the point of service delivery for hiv/aids treatment and care". WHO, December 2005; "Uganda's experience with abolishing user fees". Authors: G.M. Burnham; G. Pariyo; E. Galiwango; F. Wabwire-Mangen Publisher: Bulletin of the World Health Organization : the International Journal of Public Health, 2004

30 <http://www.who.int/bulletin/volumes/86/10/08-058578/en/print.html>

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LIST OF ACRONYMS

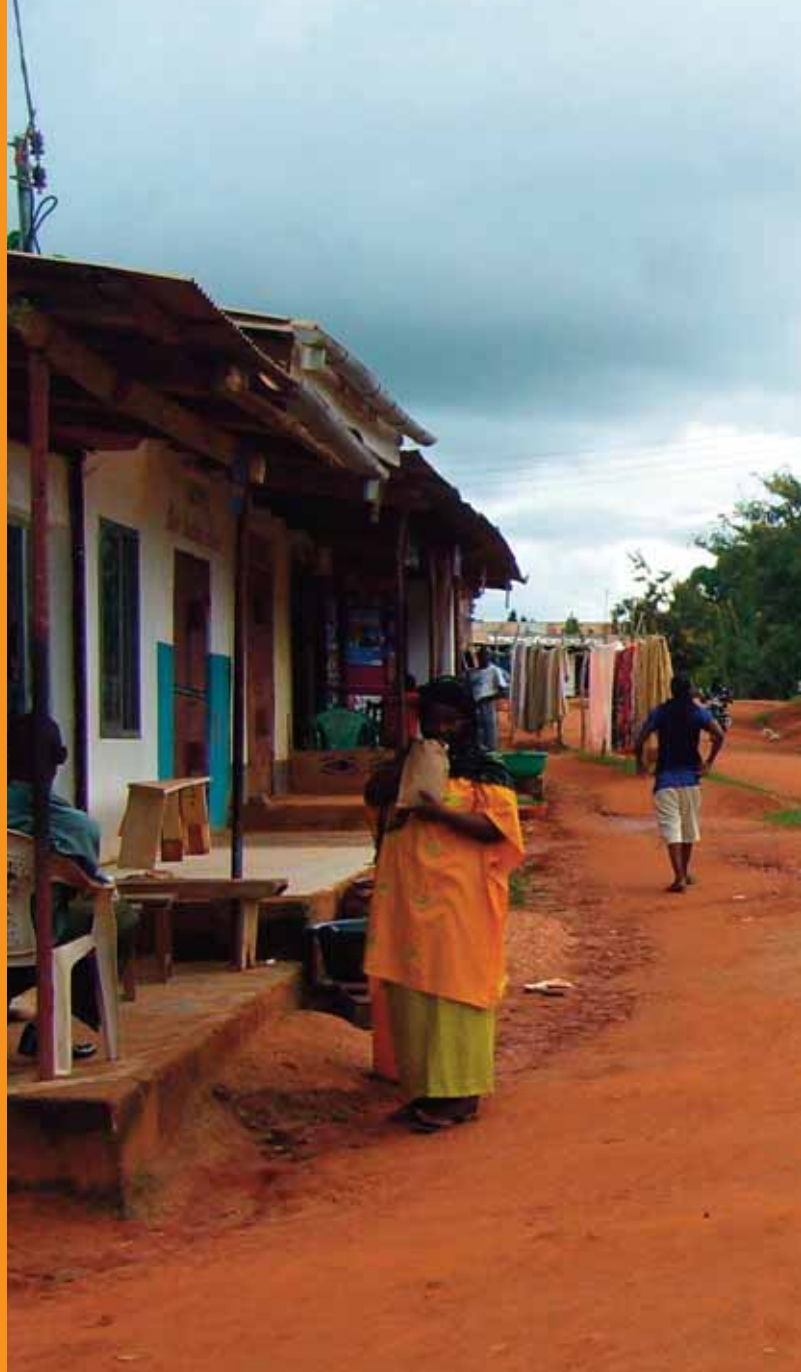
AfGH	Action for Global Health European NGO Network	IHP+	International Health Partnership
CBO	Community-based Organisation	IMF	International Monetary Fund
CSO	Civil Society Organisation	INGO	International Non-Governmental Organisation
DP	Development Partner	MDG	Millennium Development Goals
DSW	Deutsche Stiftung Weltbevoelkerung (German Foundation for World Population)	MKUKUTA	National Strategy for Growth and Reduction of Poverty (NSGRP)
EDF	European Development Fund	MKUZA	Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP)
EU Delegation	Delegation of the European Union to Tanzania	MMAM	Primary Health Care Service Development Programme (PHCSDP)
EU funding	European Union funding excluding EU member states' bilateral aid.	MoFEA	Ministry of Finance and Economic Affairs
EU-15	15 EU Member States prior to the accession of 12 new members (2004 and 2007). EU-15: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom	MoHSW	Ministry of Health and Social Welfare
FBO	Faith based organisations	MTEF	Mid-term Expenditure Framework
FY	Financial Year	NGO	Non-Governmental Organisation
GBS	General Budget Support	NPES	National Poverty Eradication Strategy
GoT or Government	Government of Tanzania	ODA	Official Development Assistance
HSSP	Health Sector Strategic Plan	PMO-RALG	Prime Minister's Office Regional Administration and Local Government
		STD	Sexually Transmitted Diseases
		SWAp	Sector-wide Approach
		TNCM	Tanzanian national coordinating mechanism
		TZS	Tanzanian Shilling

Action for Global Health is a network of European health and development organisations advocating for the European Union and its Member States to play a stronger role to improve health in development countries. AfGH takes an integrated approach to health and advocates for the fulfilment of the right to health for all. One billion people around the world do not have access to any kind of health care and we passionately believe that Europe can do more to help change this. Europe is the world leader in terms of overall foreign aid spending, but it lags behind in the proportion that goes to health.

Our member organisations are a mix of development and health organisations, including experts on HIV, TB or sexual and reproductive health and rights, but together our work is organised around a broad approach to health. AfGH works to recognise the interlinkages of global health issues and targets with a focus on three specific needs: getting more money for health, making health care accessible to those that need it most and strengthening health systems to make them better equipped to cope with challenges and respond to peoples' needs.

In the light of the upcoming Fourth High Level Forum on Aid Effectiveness in South Korea in November 2011, Action for Global Health commissioned DSW Brussels to undertake six combined fact-finding and advocacy visits to developing countries in 2010 in order to assess the impact of current aid structures and aid effectiveness principles on health-spending in those countries. The overall objective of these fact-finding visits is to bring evidence and experience from developing countries to support European advocacy for global health, by producing country-specific policy briefings and disseminating them to key decision makers and organisations in Europe and in developing countries.

Contact: coordination@actionforglobalhealth.eu



Visit our website to learn more about our work and how to engage in our advocacy and campaign actions.

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