Université catholique de Louvain - Université libre de Bruxelles - Université de Liège

Research Group on Cooperation Instruments in Support of Sector Policies

GRAP-SWAP

Mission to Tanzania (21 June – 4 July 2005) Tanzania's Health SWAp: Achievements, Challenges and Lessons Learnt

MISSION REPORT

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Catherine PAUL, Research Associate, University of Liège
(Contact : catherine.paul@skynet.be)

Summary

Tanzania's Health SWAp was launched in 1998, and thus boasts a seven-year experience. The purpose of this paper, based on a two-week mission to Dar-es-Salaam in June-July 2005 as well as a documentary review, is to analyse the processes and achievements of the SWAp, as well as the challenges it faces, so as to draw lessons from experience that, together with the results of missions to other "observation countries", will be useful to: (a) other countries that are now proceeding with the adoption or early implementation of their own Health SWAp (or SWAps in other sectors); (b) the Belgian bilateral cooperation, in support of their operations; (c) any other party interested in the results of our work.

After a first part dedicated to the presentation of background information (macroeconomic and institutional context, development cooperation in Tanzania, introduction to the Health sector), the second part of the report analyses the Health SWAp from different angles. The main findings of this second, analytical part are summarised below.

"Breadth and depth" of the Health SWAp

This section of the report analyses the SWAp on the basis of six "components" that are deemed essential for the existence of a SWAp and sector programme. It concludes that the SWAp has considerable "breadth" (since it features all the elements that are recognised as characteristic of the existence of a SWAp), as well as significant "depth" (since the degree of achievement reached in the implementation of each component, although variable, is generally high). More specifically:

- sector policy and strategy are well accepted by all significant donors to the sector, and there is a high degree of ownership by the Tanzanian government;
- the sector's MTEF covers expenditures financed by domestic resources as well as a sizable share of external resources – and the document is considered realistic;
- there is a national sector performance monitoring and evaluation system; even if, overall, M&E remains rather weak, most donors have adopted the national system, and generally support its gradual development rather than conducting their own M&E operations;
- all significant donors to the sector "officially" support the SWAp and its coordination process; there is a formal donor-MoH/PORALG coordination system, under clear government leadership – working on top of a donor-only coordination mechanism that does not seem to be contested; in the past few years, government leadership and the coordination process have been put under considerable strain by the arrival of a number of international "vertical" initiatives;
- opinions are somewhat divided on the degree of procedure harmonisation; as far as disbursement procedures are concerned, most of the efforts undertaken in the context of the SWAp can be attributed to the joint financing mechanism (basket fund), which rests to a very large extent on government procedures – but a significant share of external contributions are still disbursed "off budget"; harmonisation is more advanced in non-financial matters, as development partners increasingly rely on common processes (for overall sector performance monitoring, policy dialogue, expenditure monitoring, …);
- consultation mechanisms with other sector stakeholders are not yet very developed and structured, but civil society, public sector providers, private sector providers and health

service users are all part of nascent consultation mechanisms, some at the national level, some at the local level.

The SWAp's scope is evolving from an initially narrow perspective to a wider and wider embrace.

"Acquis" and impacts of the SWAp

It is not easy to ascribe any of the health sector's achievements specifically to the adoption of a SWAp; other processes are at work in the country (civil service reform, poverty reduction strategy, …) which have a direct impact on the sector's operations and also play a role in any observed evolution. In most cases, there is no way of isolating and "quantifying" the SWAp's specific contribution. We thus simply relied, for this part of the analysis, on the subjective perception of interviewed people as to what role the SWAp might have played.

Keeping this in mind, and with the caveat that our "mini-survey" is only based on 15 replies to a questionnaire (complemented by a larger number of structured interviews), here are the results of our investigation of the achievements of the Health SWAp:

1. Three areas are characterised by very substantial improvement: at least 70% of respondents to our mini-survey believe the SWAp has significantly contributed to:
   - *improving efficiency in the use of financial resources*: the progress made in resource management and efficiency can at least in part be attributed to the synergies between the SWAp, the PER process and the adoption of MTEF planning; at the district level, efforts to improve cost-effectiveness are also under way;
   - *increasing government ownership of health policies and strategies* (although the existence of wider social ownership of the health sector reform programme is questionable);
   - *carrying out in-depth reforms of the healthcare system*: the SWAp has made a significant contribution to the overall success of health sector reforms undertaken since its inception; the decentralisation of primary healthcare, in particular, has been implemented over a short period, and all in all relatively smoothly if one considers the huge obstacles and constraints it faced.

2. Seven areas are characterised by noticeable improvement: 50-70% of respondents believe the SWAp has significantly contributed to:
   - *improving the consistency of health policies with other policies*: health policies have been designed and implemented in a way consistent with decentralisation and the local government reform programme; efforts are also made to make them consistent with overall efforts to tackle the HIV/AIDS issue, and with the poverty reduction strategy; even if much remains to be done on this latter count, awareness of equity issues has notably prompted the MoH to revise the formula for allocating block grants and basket fund grants to districts (this may have been facilitated by the gradual opening of sector dialogue to FBOs and NGOs);
   - *rebalancing the health sector budget in terms of investment and recurrent expenditures*: here, the perception of achievements may overstate their true extent, since capital expenditure remains (in the view of most observers) insufficient; however, the SWAp may at least have provided a forum in which the existing

imbalance could be discussed and addressed – and this has resulted in a recent decision to co-finance infrastructure rehabilitation out of the district basket fund;

- *improving the predictability of external funding for the sector*: significant progress has been achieved, and most donors to the sector now strive to plan three years ahead, in line with the MTEF; however, predictability issues have not disappeared, as budgetary aid (on the increase) is more volatile than project aid, and new "vertical" global initiatives are upsetting the improving trend of the last years;
- *reinforcing government capacities in terms of health sector planning*, and *in terms of health sector financial management*: significant improvements have been achieved both in central and in local government; although local capacity building efforts started a bit late at the local level (in view of the decentralisation agenda), results are now becoming apparent, although not uniformly across districts;
- *stimulating a convergence of donors' policies and strategies* for the development of the health sector – a convergence that, however, now seems to break up over several issues (notably the question of user fees, the wisdom of pursuing the goal of wide-scale ARV therapy for HIV/AIDS patients, and the choice of aid financing modalities);
- *increasing the amount of resources dedicated to the health sector*: here, the perception of achievements may understate their true extent, since objectively, there has been steady progress in the allocation of funds to the health sector since the inception of the SWAp, and the massive increase in external contributions, in particular, is attributed by most to the success of the SWAp; still, concerns arise from the fact that needs are growing even faster than available resources, and the fact that the share of health in public expenditure has tended to stagnate, or even regress, since the peak reached in FY 2001/02..

3. Four areas show only modest or no improvement: less than 50% of respondents believe the SWAp has significantly contributed to:
   - *improving the quality of healthcare*: it is generally deemed to have improved in some regards since the inception of the SWAp, but to remain, overall, much below acceptable standards; this may be explained by the fact that the shift in focus from process and system improvement to quality of care only happened in 2003, five years after the adoption of a SWAp;
   - *reducing aid management costs from the government's perspective*, and *from the donors' perspective*: the SWAp might have somewhat reduced overall transaction costs (thanks to coordination mechanisms, joint review processes, the division of labour and specialisation made possible by the SWAp), but definitely not in a spectacular way; the nature of transaction costs may have changed more than the overall burden, and any small improvements are "fragile" (notably because so much aid is still provided using donor-specific procedures);
   - *improving human resource management in the sector*: this is the area in which the least progress has been achieved, and the SWAp has so far not helped address this issue properly – although this may be changing.

Current issues and challenges

1. Institutional aspects

Three aspects retained our attention:

- The relationship between the MoH and the MoF still needs strengthening: the MoF remains insufficiently involved in the Health SWAp, and the MoH's connections with the MoF still seem to be too weak to guarantee appropriate budget allocations for the health sector without "behind-the-scene" donor intervention.
- The introduction of a joint funding mechanism did somewhat strain relationships between donors; however, the special influence that basket fund donors do indeed seem to enjoy appears to be more related to their commitment to technical work than to the choice of the financing modality. If anything, small donors who are ready to invest time in technical work now have more of a say than they used to before the SWAp process was established.
- As far as cooperation is concerned, HIV/AIDS-related matters are handled in a rather complex way. They are managed, to a large extent, separately from other health-related matters, and do not have a prominent place in the Health SWAp. Coordination between the DPG Health and the DPG HIV/AIDS looks a bit patchy.

2. Aid financing modalities

A significant share (over 50%) of donor support is still disbursed on the basis of donor-specific mechanisms and procedures, and in absolute terms, the amounts spent on projects and other off-budget instruments get larger every year. This is in contradiction with the commitments to "alignment" (on partner government procedures) made in the Paris Declaration (OECD, March 2005). There is a persistent tendency among donors to earmark funds, not just to the sector but, more seriously, within the sector.

A debate over the respective merits of general budget support (GBS) and sector budget support (SBS) has been raging since DFID decided, two years ago, to withdraw the significant contribution it had made so far to the health sector basked fund and increase its GBS contribution instead. This resulted initially in a marked loss of influence of the UK in the health sector dialogue. With external funding contributing over 50% of total public health resources, it is quite likely that the large amounts of aid dedicated to the sector, through fungibility mechanisms, discourage government from investing too much of its own resources in the sector – the main argument advanced by DFID to justify its move. On the other hand, opponents to a rapid phasing out of SBS argue that Tanzania is not yet ready for a "GBS-only" approach.

3. The human resource crisis

Very low salaries for medical staff, and a lack of incentives, are the most prominent factor advanced for explaining the very serious and long-standing HR crisis that affects the health sector. Things are unlikely to improve until HR reform gets a few influential champions, both in government and among donors. The HR problem has until recently not really been on the agenda of development cooperation agencies – nor has it featured high enough on the SWAp's agenda. This may be changing now, but only when concrete

actions are taken to address this fundamental issue will it is be possible to declare that it is really being tackled.

4. Integration of vertical programmes into the SWAp

The situation in Tanzania may be summarised as follows:

- TACAIDS, the MoF and the MoH are thrilled at the financial opportunities offered by new global initiatives;
- the MoH is, at the same time, acutely aware of the risks and challenges they pose, and making significant efforts to avoid undermining the achievements of health sector reform over the past decade;
- development partners could be positioned along a continuum going from severe pessimism to over-optimism as to the capacity of the Tanzanian health sector to withstand the "external shock" of global vertical initiatives.

Whether costs or benefits ultimately weigh most in the balance will depend very much on the extent to which vertical programmes get integrated into existing health structures, programmes and processes. This, in turn, depends on how strongly TACAIDS, the MoH, the MoF and government in general:

- insist on such integration;
- are willing to stand up to the promoters of vertical programmes in order to impose their views and policies during negotiations on the use of funds;
- are prepared to resist the temptation of accepting funds that would not "fit" with national strategies and priorities, and might therefore have destructive effects on the achievements of past and current sector reforms.

5. HIV/AIDS care and treatment

HIV/AIDS care and treatment, and more specifically the provision of ARV therapy to a significant proportion of infected people, probably poses the biggest challenge to the health sector since the major decentralisation exercise. It is also one of the most divisive issues in sector dialogue, and one on which there is no convergence of donor policies or opinions.

The MoH is doing its best to favour integration. However, the HR issue will be the worst source of headache – and the one that may bring down the whole sector if it is not managed properly. The balance of positive and negative effects is likely to depend on three crucial factors:

- the possibility of using the additional "vertical" resources for a general improvement in the quality of care;
- the beginning of a resolution of the HR crisis;
- the mobilisation of all possible resources in Tanzanian society in support of the development of home-based care initiatives.

6. User fees

Alongside the shift to general budget support and ARV therapy, the user fee question is currently one of the most controversial in the health sector's policy dialogue. The question of how to manage an exemption system so that it actually works as intended remains an unresolved question (not just in Tanzania) – but one that will need to be addressed if user fees are to be maintained and contribute to sector financing while PRSP-related equity objectives are pursued. The SWAp should be able to provide (better than it has so far) a structured framework for organising research on this topic, debating and disseminating its conclusions.

7. Role of NGOs and grassroots organisations in the Health SWAp

A few interfaces already exist between the NGOs and the SWAp:

- a few seats are reserved for them in the Joint Annual Review;
- NGOs (primarily representing private, non-profit providers of health services, such as faith-based organisations) hold a few seats on the SWAp Committee;
- there are two NGO seats on the Technical Sub-Committee.

Building on the Health workgroup within the NGO Forum, and on existing interfaces with the SWAp, is probably the way to go to develop civil society participation in sector dialogue. Donor support for capacity-building activities within NGOs (including grassroots and rural ones), rather than just projects, would also help promote a constructive participation in this dialogue. In "exchange", those NGOs that might so far have paid little attention to official health policies and strategies could be expected to make efforts to better "align" their activities with existing, widely approved goals and objectives – and to look for synergies with other sector stakeholders.

Belgium's support to the health sector in Tanzania

Belgium's interventions in the health sector come primarily in the form of projects, as the country is only a minor donor to the health sector. Yet we see a priori no reason for considering the project instrument as the only suitable aid instrument for a small donor: there is room, in the Health SWAp, for small donors to express their opinion and get their voice heard in the various coordination forums, whatever the chosen financial modality.

Belgium's current policy is not to grant, in any country, more than 50% of its aid in the form of budget support. In our view, decisions on how big a share of resources to allocate to each aid instrument would best be left to local representations.

Finally, Belgium is in the awkward position of not participating in the DPG Health – but of financing health-related interventions both as part of its participation in the DPG HIV/AIDS and outside this framework. One suggestion to avoid a lack of coordination with the health sector would be for Belgium to join the initiative of Norway, Sweden and Canada – three countries that are in the same position of supporting HIV/AIDS-related medical activities (more specifically, care and treatment) without participating in the Health SWAp. These three countries attend the annual Joint Health Sector Review, and they send a common observer – from either of the three countries, according to availability – to the DPG Health.

Perspectives for the Tanzanian Health SWAp

The health SWAp has come a long way and, in many regards, achieved remarkable and significant results. In spite of a positive overall assessment however, a feeling of unease is perceptible, that may hide a latent crisis. Some protagonists seem a bit daunted by the considerable challenges that lie ahead.

To successfully face them, a new balance needs to be struck between preserving the achievements of the past and avoiding the trap of excessive resistance to change. A SWAp is a way of doing things, a process, so by definition it must be dynamic. If this new balance is found (and constantly adjusted to new developments), the SWAp will continue to provide *the* framework in which all the current challenges can be tackled just as well as past ones were.

The right "mix" of aid instruments

The "mix" of aid instruments varies, sometimes significantly, across donors. The latitude of their local representations to influence the weight of various instruments in view of local circumstances seems to vary across agencies, but to be rather limited on average; we believe it should be increased.

The simultaneous use of various aid instruments is sometimes viewed as a way of "spreading risk". More positively, it can also be considered as a way of flexibly adapting aid modalities to the specificities of each country and sector in which development partners operate. Provided it:

- fits local needs and conditions;
- results from an in-depth analysis of these needs and conditions, and a thoughtful decision process (rather than the application of inflexible rules dictated by headquarters);
- is respectful of the preferences and development policies of the partner government;
- complements rather than duplicates or undermines the action of other donors;
- meets the requirements of the international harmonisation and alignment agenda;

then the use of a "mix" of aid instruments (including a combination of general and sector budget support) is perfectly acceptable, and we see no reason to rush towards the adoption of general budget support as the *exclusive* aid financing modality.

SWAps and decentralisation

Tanzania's Health SWAp demonstrates there is no inherent contradiction between adopting a SWAp (which provides a general framework for health sector development) and promoting decentralisation. A smoothly running SWAp can actually be a crucial factor for the success of decentralisation reforms. In the Tanzanian case, the support provided by donors in the context of the SWAp (in particular through the district basket fund) greatly facilitated the initial steps of the process.

Yet, district councils remain very much in a "straightjacket", both in terms of planning and in terms of resources. The bulk of the health sector budget is still controlled by central government; even if official statistics poorly reflect the real share of expenditure going to local government, the share of resources it gets remains very low. This may have been justified so far. However, in coming years, a failure to gradually increase the share of

resources directly attributed to regions and local government (both in the government budget and in the basket fund) will increasingly look like a failure of the SWAp to support true decentralisation

The harmonisation and alignment agenda

We did not feel, in the context of this specific SWAp, that this agenda had a high priority among development partners. The drawing up of the JAS provides an opportunity to define a new, more ambitious alignment and harmonisation agenda. The Health SWAp would greatly benefit from such an exercise, notably in terms of reducing transaction costs – a benefit that has eluded the SWAp so far.

Lessons for emerging Health SWAps

1. SWAps have their ups and downs. They are also regularly confronted with new challenges. If motivated and committed partners to the SWAp can be found in all concerned groups, it is possible to resolve differences and face up to new challenges. Protagonists in a SWAp should thus not be discouraged too quickly if the process occasionally goes through rough periods.

2. Adequate institutions, processes and procedures are of course important. But the participation, in all stakeholder groups, of a number of open, co-operative, committed individuals, seems to be equally important. In view of the scarcity of human resources available both on the government's side and, to a large extent, also on the donors' side, the reliance of the Tanzanian Health SWAp and other SWAps on committed personalities is likely to remain a dominant feature in coming years. Partners engaging in new SWAps anywhere should be aware of the importance of strong personal relationships and, while avoiding the trap of relying exclusively on them to make things work, should nurture a collaborative spirit. This may notably require an adaptation of the profile of people assigned to the management and follow-up of SWAps in the local offices of development agencies as well as the involved government agencies.

3. Tackling the human resource issue should be number one on the agenda of any starting SWAp, with the understanding that resolving it is the most difficult issues of all – but that it is also crucial to success, since the quality of care may depend on it more than on any other factor.

4. Real improvements in service delivery cannot be expected until the quality of care gets high priority in the SWAp process. The sooner quality improvement is made a core objective of the SWAp, the better. The promoters of new Health SWAps, and in particular the donors that support them, should be realistic about the time it takes to improve service delivery – but never get so mired in administrative, institutional and procedural details that they lose sight of the ultimate goal of positively influencing health outcomes through better quality of care.

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List of acronyms

AfDB	African Development Bank
AMMP	Adult Morbidity and Mortality Project
ARV	Anti-Retroviral
BFC	Basket Financing Committee
BTC	Belgian Technical Cooperation
C&T	Care and Treatment
CAS	Country Assistance Strategy
CHSB	Council Health Service Board
CHMT	Council Health Management Team
CIDA	Canadian International Development Agency
DANIDA	Danish International Development Agency
DCI	Development Cooperation Ireland
DHS	Demographic and Health Survey
DFID	Department for International Development [UK]
DGDC	Directorate General Development Cooperation [Belgium]
DPG	Development Partner Group
EC	European Commission
ESRF	Economic and Social Research Foundation
FBO	Faith-Based Organisation
FOB	Free on Board
GAVI	Global Alliance for Vaccine and Immunisation
GBS	General Budget Support
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GoT	Government of Tanzania
GRAP-SWAP	Groupe de Recherche en Appui aux Politiques – Sector-Wide Approaches
GTZ	(Deutsche) Gesellschaft für Technische Zusammenarbeit
HBS	Household Budget Survey
HIPC	Highly Indebted Poor Country
HMIS	Health Management Information System
HR	Human Resources
HSBF	Health Sector Basket Fund

HSSP	Health Sector Strategic Plan
IDA	International Development Association (World Bank Group)
IMCI	Integrated Management of Childhood Disease
IMF	International Monetary Fund
IMG	Independent Monitoring Group
IPFM	Integrated Public Finance Management
JAS	Joint Assistance Strategy
JICA	Japanese International Cooperation Agency
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MoEC	Ministry of Education and Culture
MoF	Ministry of Finance
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NGO	Non Governmental Organisation
NHIF	National Health Insurance Fund
NIMR	National Institute of Medical Research
NSGRP	National Strategy for Growth and the Reduction of Poverty
OECD	Organisation for Economic Cooperation and Development
PEFAR	Public Expenditure and Financial Accountability Review
PEM	Public Expenditure Management
PEPFAR	[US] President's Emergency Plan For Aids and Relief
PER	Public Expenditure Review
PFM	Public Finance Management
PoA	Plan of Action
PORALG	President's Office – Regional Administration and Local Government
PO-PSM	President's Office Public Sector Management
PPP	Public-Private Partnership
PPP	Purchasing Power Parity
PRBS	Poverty Reduction Budget Support
PRGF	Poverty Reduction and Growth Facility [IMF]
PRS	Poverty Reduction Strategy

PRSC	Poverty Reduction Support Credit [WB]
PRSP	Poverty Reduction Strategy Paper
RHMT	Regional Health Management Team
SBS	Sector Budget Support
SDC	Swiss Development Cooperation
STI/STD	Sexually Transmitted Infection/Sexually Transmitted Disease
SWAp	Sector-Wide Approach
TA	Technical Assistance
TACAIDS	Tanzania Commission on AIDS
TAS	Tanzania Assistance Strategy
TB	Tuberculosis
TEHIP	Tanzania Essential Health Interventions Project
TZS	Tanzanian Schilling
UCL	Université Catholique de Louvain
ULB	Université Libre de Bruxelles
ULg	Université de Liège
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation
ZTC	Zonal Training Centre

Disclaimer

The views presented in this report are those of the author and do not represent the official views of the University of Liège nor any other institution.

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We would like to thank very warmly all the people in Tanzania who accepted, often at short notice, to meet us in the context of this research – as well as Julie McLaughlin of the World Bank, who accepted to fill in the questionnaire although we could not meet her. In view of the length of the list, we will not mention here the names of all interviewed people (see Annex 1) – but we are grateful for the time they dedicated to interviews as well as the support documents they provided. We hope that in spite of the fact that their knowledge of the local situation is infinitely superior to the knowledge we could put together over this short mission, some of the findings in this report will be useful to their work and the ongoing sector dialogue.

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1. Introduction

1.1 The GRAP-SWAP research project

In a context in which donors try to improve the performance of development cooperation and the contribution their activities makes to poverty reduction, comprehensive approaches to the development of a sector (*sector-wide approaches* or *SWAps*) became popular a bit less than a decade ago. Sector-wide approaches are supposed to avoid the weaknesses of traditional intervention modalities thanks to better ownership of development policies by government, a reinforced partnership between donors and beneficiary countries, joint responsibility taking, better governance and the adoption of a comprehensive vision of the fight against poverty.

How are things in reality? Does the sector-wide approach meet the expectations it raises? Does it have a future, now that some donors are already moving one step forward and advocating the use of general budget support as the main cooperation instrument? In order to investigate these questions, Belgium's University Committee for Development (Commission Universitaire pour le Développement) is financing a four-year research project carried out by the Research Group on Cooperation Instruments in Support of Sector Policies (hereafter referred to as "GRAP-SWAP"). This group is made up of three teams from, respectively, the Catholic University of Louvain (UCL – School of Public Health), the Free University of Brussels (ULB – School of Public Health) and the University of Liège (ULg - Faculty of Economics, Management and Social Sciences).

Together, we are exploring this topic in a concrete manner, in partnership with the Belgian Directorate-General for Development Cooperation (DGDC) and other players in the field. Our research focuses on the application of the sector-wide approach to the health sector, and is organised along **two axes**:

- the sector-wide approach as a **cooperation instrument**: its components, processes, institutional implications, and financing modalities;
- the **impact** of the adoption of a sector-wide approach, in terms of sector reforms, easing of the constraints that prevent the generation of significant effects for target populations, poverty reduction, etc.

The GRAP-SWAP's central research question can be declined as followed: *Does the adoption of a sector-wide approach, and of its implementation modalities, make a difference compared to "traditional" cooperation approaches, when it comes to:*

a) *overcoming the limitations of project approaches and increasing the **efficiency** and **sustainability** of external aid interventions*, from a financial and economic perspective and also from an institutional perspective?

b) *facilitating health sector reforms, improving their **relevance*** (quality of policies), *their **effectiveness*** (quality of implementation) *and their **impact***, taking into account and easing the constraints that often prevent the generation of significant effects for target populations – thereby *contributing to poverty reduction strategies*, notably in terms of access of the poor to health services?

1.2. Purpose of the mission to Tanzania

The research is carried out in two different groups of countries:

- *target countries*, where GRAP-SWAP members have good contacts and the Belgian cooperation is or plans to be active in the health sector: Bénin, Mali, Rwanda, Senegal (possibly also Niger and the Democratic Republic of Congo, if adequate financing is found); these countries are in the initial stages (or considering the adoption) of a Health SWAp;
- *observation countries*, where GRAP-SWAP members do not have privileged contacts but where a Health SWAp has been implemented for several years, and from which useful lessons can be learnt: Mozambique, **Tanzania**, Uganda.

Tanzania, with its many-years experience of running a Health SWAp, is thus an "observation country" – the first one to be visited in the context of the project. Our main purpose in studying the processes, achievements and challenges of Tanzania's Health SWAp is to draw lessons from experience that, together with the results of missions to other observation countries, will be useful to: (a) other countries that are now proceeding with the adoption or early implementation of their own Health SWAp (or SWAps in other sectors); (b) the Belgian bilateral cooperation, in support of their operations in "target" and other countries; (c) any other party (governments, bilateral or multilateral cooperation agencies, NGOs, …) interested in the results of our work.

1.3. Methodology

The findings presented in this report result from an analysis of the Tanzanian Health SWAp based on:

- interviews carried out during a two-week mission to Dar es Salaam in late June – early August 2005 (see list in Annex 1);
- a document and literature review (see references at the end of the report).

The objective of the documentary review was to complement the information we could gather during interviews, get some figures, establish some facts, with a focus on highlighting ongoing, dynamic processes within the SWAp. We thus chose not to spend time on a detailed analysis of the Health SWAp's founding documents (Statement of Intent, MoU, etc.), but rather to focus on more recent official documents, studies and publications.

As far as interviews are concerned, most of them were based on a questionnaire presented in Annex 2, which investigates:

- the "breadth and depth" of the Health SWAp in Tanzania, according to six criteria that were identified by the European Commission (EC 2003a:14-15) and other authors (see for instance Foster 2000 and Walford 2003) as essential components of a SWAp/sector programme;
- the perception by our interlocutors of the SWAp's achievements.

Although the sample is relatively small (15 respondents) [1], and survey results can thus not be considered "statistically significant", they are presented in sections 5 and 6 comments. The questionnaire should be regarded primarily as a support instrument for "structured interviews": open discussions around it brought about a lot of useful information – especially as the standard answers provided in the questionnaire did not always match the complex reality of a SWAp. Please also note that the questionnaire was not used with people who were not particularly familiar with the Health SWAp; with these interlocutors, discussions focused on specific topics relevant to their competences and experience.

Apart from the questionnaire, other questions raised during interviews were derived from two "data collection grids" (a general one on Health SWAps and a specific one on public finance issues) presented in Annexes 3A and 3B. Given the time constraints faced by all our interlocutors, discussions focused on the topics most relevant to their area of expertise, and we did not attempt to cover all questions with all interviewed people. Nevertheless, given the variety in the background and professional experience of interviewed people, most topics ended up being covered by multiple interviews. Some of the topics were investigated in more depth than others because they rapidly emerged as particularly interesting or critical to the Tanzanian Health SWAp.

Finally, it must be mentioned here that due to the rather unfortunate timing of our visit (which coincided with the presentation of the new health budget to Parliament), many government officials were in Dodoma, the administrative capital, or simply unavailable for interviews due to their heavy workload. As a result, we conducted only one interview with an official of the Ministry of Health – so that the point of view of government is much less represented than that of other stakeholders in our report. This weakness is at least partly compensated by the fact that quite a number of other interviewed people, native Tanzanians, are familiar with government and presented, on top of their own opinion, their understanding of government's position on some issues.

1.4. Geographical coverage

This report focuses on the situation of the Health SWAp in Tanzania's mainland. Given the short time available for the mission, there was no time to study the management of the health sector by the authorities of Zanzibar.

1.5. Scope of the report

It is not possible, on the basis of a single two-week mission to Dar es Salaam and a limited documentary review, to get a full grasp of the situation of the Health SWAp. Thus *we do not claim to present an exhaustive view of the SWAp's results, achievements, failures and challenges.* In spite of our best efforts, the knowledgeable reader may find some details inaccurate or some presentations incomplete. Nevertheless, we have strived to provide a rather comprehensive and documented picture, referring to official documents and other "authoritative" sources to consolidate the information gathered during interviews. We also endeavoured to reflect the various, sometimes divergent, points of view of our many interlocutors in a balanced way.

[1] Two people sent us their replies to the questionnaire after the end of the mission: one who has been interviewed, and a person we could not meet during our stay in Dar es Salaam.

1.6. Structure of the report

After the short introduction which constitutes this *Chapter 1*, Part I of the report proposes some background information deemed useful for understanding the more analytical section that follows.

Chapter 2 gives an overview of the macroeconomic and institutional context prevailing in Tanzania, including a section on development cooperation. *Chapter 3* provides an introduction to the health sector and, in this context, a short history of the SWAp and some information on its working modalities. *Chapter 4* is dedicated to health sector financing, and how donors contribute to it.

Readers who are familiar with these background elements are invited to move directly to Part II, the analytical part of the report.

We start, in *Chapter 5*, by assessing the "breadth and depth" of the Health SWAp through a review of six essential components. *Chapter 6* constitutes an attempt to assess the "acquis" and impacts of the Tanzanian Health SWAp – with the caveat that any observed improvements may be attributable to other factors than the SWAp process itself. The analysis in Chapters 5 and 6 rests to a large extent on the results of the "mini-survey" carried out among interviewed people, as well as the discussions held around the questionnaire.

Chapter 7 looks into how some institutional questions and relationships influence the SWAp, then addresses a number of issues and challenges currently facing the SWAp.

Chapter 8 provides two short "extensions". The first one briefly discusses the situation of Belgium – which is not part of the DPG Health but nevertheless supports a limited number of health-related projects. The second one takes a quick look at the Tanzanian Education SWAp which, although it started at approximately the same time and involves roughly the same development partners as the Health SWAp, has evolved in a very different way.

Finally, *Chapter 9* is dedicated to conclusions; it covers a range of topics including some lessons for emerging Health SWAps in other countries.

PART I: BACKGROUND INFORMATION

2. The macroeconomic and institutional context

2.1. The macroeconomic context

2.1.1. EVOLUTION OF THE MACROECONOMIC SITUATION

Tanzania is one of the poorest countries in the world, with serious poverty primarily a rural phenomenon. The country experienced severe economic problems in the early 1980s, which can be traced back to the 1970s, characterised by a mixture of unsound economic policies, failed "social engineering", deterioration in the terms of trade (concomitant rise in oil prices and decrease in the prices of Tanzania's traditional agricultural exports), and the cost of a military venture into Uganda to remove Idi Amin Dada (The Economist 21/10/1999).

Economic reforms were adopted as from the mid-1980s, after the international debt crisis compounded the collapse of the economy. Severe budget restrictions were imposed in the context of a long and painful process of structural adjustment, which notably led to a serious deterioration of the extensive health and education infrastructure developed by the socialist regime (de Savigny et al. 2004). Structural adjustment, reinforced since the mid-1990s by ambitious reforms of the public sector, has now allowed the macroeconomic situation to improve considerably, and *performance has been strong over the past few years. Still, Tanzania's economy remains vulnerable to external shocks, and very dependent on foreign aid*. Here are some key economic statistics (IMF 2005a, IMF 2005b):

Indicator	Average 1987-1996	2002/03	2003/04	2004/05 (proj.)	2005/06 (forecast)
Nominal GDP (bn TZS)		9,445	10,692	11,821	
Nominal GDP (mn USD)		10,077	10,464	10,915	11,923
Real GDP growth (at factor cost, annual)	3.6%	6.2%	5.6%	6.3%	6.5%
Real GDP/capita growth (at market prices, annual)		5.1%	5.0%	4.0%	4.0%
Consumer price inflation (annual)	27.6%	4.6%	4.4%	4.2%	
Current account balance (% of GDP)	-5.3%	-2.4%	-5.9%	-5.9%	-6.6%
Exports (FOB, mn USD)		1,010	1,174	1,289	1,459
Imports (FOB, mn USD)		1,660	2,155	2,492	2,686

Tanzania still benefits from IMF support, in the form of a Poverty Reduction and Growth Facility. The country is currently "on track" with regard to its commitments to the IMF. Among the notable achievements of recent years are:

- an improvement in government's capacity to raise taxes - a key factor in generating resources for poverty reduction expenditures and reducing the degree of aid dependency;
- and an increase in the share of budget dedicated to poverty-reducing expenditures.

Challenges for the years to come are by and large those already identified a few years ago:

- economic growth is improving, but remains unequally distributed;

- as a result, poverty persists – in spite of significant efforts, over the past decade, to re-orient public spending towards actions contributing to poverty reduction; [2]
- aid dependency, although slightly lower than it was a few years ago, remains considerable (OCDE 2003:13).

Only by sustaining the past years' macroeconomic performance (notably prudent fiscal and monetary policies) and by moving ahead with the implementation of the structural reform programme can the country hope to gradually ease these problems. The government remains focused on accelerating growth and reducing poverty, in line with the new National Strategy for Growth and Reduction of Poverty (see section 2.4.2.). Meanwhile, the donor community's "continued strong support" will remain "critical to Tanzania's adjustment efforts for many years". Actually, registering satisfactory progress against the Millennium Development Goals is likely to require even more foreign assistance than is currently received by Tanzania – but "effective use of higher donor inflows will probably require further improvements in absorptive capacity" (IMF 2005b:9,18).

2.1.2. GOVERNMENT BUDGET OPERATIONS AND FINANCING

The following table gives an overview of government revenue and expenditure as a percentage of GDP, and shows how government budget has been financed in recent years:

Description	of which:	2000/01	2001/02	2002/03	2003/04	2004/05 (proj.)
Total revenue		***12.0%***	***12.1%***	**12.1%**	**12.9%** ***(13.0%)***	**14.0%**
of which:	Tax revenue	*10.7%*	*10.9%*	11.0%	11.8% *(11.9%)*	12.8%
	Non-tax revenue	*1.3%*	*1.2%*	1.1%	1.1%	1.1%
Total expenditure		***17.0%***	***17.6%***	**19.8%**	**22.2%** ***(22.5%)***	**25.8%**
of which:	Recurrent expenditure	*12.8%*	*13.6%*	14.8%	16.6% *(16.8%)*	19.1%
	Development expenditure	*3.7%*	*3.4%*	5.0%	5.6% *(5.7%)*	6.7%
Overall balance (deficit) before grants		***-5.3%***	***-5.6%***	**-7.8%**	**-9.1%** ***(-9.5%)***	**-12.1%**
Grants		***3.7%***	***4.5%***	**6.2%**	**6.2%**	**7.7%**
of which:	Programme aid (incl. basket funds)	*1.5%*	*2.1%*	2.9%	3.3%	4.5%
	Project aid	*1.6%*	*1.6%*	2.5%	2.2%	2.5%
	HIPC grant relief	*0.6%*	*0.7%*	0.7%	0.7%	0.7%
Overall balance (deficit) after grants		***-1.6%***	***-1.1%***	**-1.6%**	**-2.9%** ***(-3.3%)***	**-4.3%**
Financing		***1.6%***	***1.1%***	**1.6%**	**2.9%** ***(3.6%)***	**4.3%**
of which:	Foreign (net)	*1.2%*	*1.4%*	2.0%	3.3% *(3.9%)*	3.1%
	Domestic (net)	*0.0%*	*-0.3%*	-0.4%	-0.4% *(-0.3%)*	1.3%

(Sources: IMF2005b:25; *in italics: PEFAR 2005 figures, between brackets if different from IMF figures, which were calculated before the PEFAR exercise*)

[2] This effort is notably related to Tanzania's participation in the Enhanced HIPC initiative, since 2000.

So:

- government expenditure remains significantly higher than government revenue and, in spite of slow improvements in domestic resource mobilisation (i.e. government revenue as a share of GDP), the fiscal deficit is widening year after year;
- external aid remains extremely important for the financing of government operations: in FY2004/05, grants equivalent to an estimated 7.7% of GDP or nearly 30% of government expenditure significantly contributed to closing the financing needs – and net [3] foreign inflows (grants + foreign net financing) amounted to 10.8% of GDP or nearly 42% of government expenditure;
- budget support ("programme aid") is steadily increasing, while project aid has not yet experienced any significant decrease.

What the table does not show is that the composition of foreign net financing is rather unpredictable (PEFAR 2005:9). As a result, although the situation is currently positive for Tanzania, *risk is high as aid flows are rather volatile, and do not always match the budgeted amounts*.

2.1.3. HUMAN DEVELOPMENT AND POVERTY SITUATION

In the latest UNDP Human Development Report, *Tanzania ranks 164 out of 177 countries* in terms of Human Development Index (HDI), with a *HDI score of 0.418*. This poor score is primarily attributable to:

- a low life expectancy index (life expectancy at birth was 46 years in 2003, lower than in the early 1970's, and lower than the 50.1 years estimated in 1990) (UNDP 2005, IMF 2005b);
- and a low GDP index (GDP/capita in 2003 was 621 PPP USD) (UNDP 2005).

Unsurprisingly, the poor HDI results coincide with a high incidence of poverty:

Indicator	Value
Poverty incidence according to the international "1$/day" poverty line	19.9%
Poverty incidence according to the international "2$/day' poverty line	59.7%
Poverty incidence according to the national poverty line	35.7%

(Source: UNDP 2005 – on the basis of estimates made in 2002)

2.2. Public expenditure planning and management

2.2.1. PER, MTEF AND BUDGETARY PROCESS

Over the past decade, Tanzania has made significant efforts to improve the transparency and accountability of public expenditure management (PEM) – both because reforming PEM is important for the pursuit of growth and development objectives, and because this is a condition for receiving assistance in the form of budget support. *One of the top priorities for the government of Tanzania*, with the support of development partners and notably the World Bank, *has been and remains to improve the strategic allocation of resources and the*

[3] i.e. after deducting interest charges and capital reimbursement on loans contracted in the past.

operational efficiency of public expenditures. This requires a close collaboration between the President's Office Public Sector Management (PO-PSM) department (strategic planning entity) and the MoF (budgeting authority).

In order to achieve this objective, Tanzania adopted in FY 1997/98 a process of annual Public Expenditure Review (PER) – an ex post review exercise aimed at analysing the structure and efficiency of public spending, the quality of budget execution, and the matching of expenditures with national and sectoral needs. The PER was then integrated with the planning of budget allocations through the elaboration of a rolling three-year Medium Term Expenditure Framework (MTEF) [4] covering both recurrent and capital expenditures, as well as sources of financing. The two processes are now conducted on a yearly basis, with PER findings expected to feed into budget guidelines, the MTEF and annual budgets. The *budgetary process* is organised as follows:

- from October to December-January, the Budget Guidelines Committee prepares budget guidelines including indicative budget allocations; initial work carried out in the context of sectoral PERs may influence the process if submitted in time; the budget guidelines are issued in January;
- in February and March, line ministries work on their sectoral MTEFs and prepare their budget bids;
- in April-May, the government finalises the budget and the MTEF – taking into account, in principle, the findings of final sectoral PERs;
- in June, the budget for the new fiscal year (starting on 1 July) is presented to Parliament – which first votes on overall allocations, then votes on more detailed sectoral budgets.[5]

The PER and MTEF processes are fully owned by government and conducted under its firm leadership. Even though their integration is not always as smooth as it should be, they generate a variety of benefits:

- for government and the MoF, they provide an opportunity to improve the planning of budget allocations, and to *prioritise public expenditure* (notably in view of reaching the objectives of the poverty reduction strategy) in a more rigorous, resource-based framework;
- for donors as well as government, they offer a *forum for dialogue on budget priorities*; by increasing budget transparency, they facilitate the integration of external aid with the State budget, and make it easier to justify the provision of large amounts of budget support;
- for other stakeholders, notably civil society organisations, they also provide an important *platform for dialogue*, and an opportunity to have a closer look at how the budget is stitched up. Indeed, the PER process is open and participatory: it involves a wide range of development partners – not just official donors, but also NGOs and civil society organisations, who have the opportunity to analyse the national budget or components thereof in a critical way.

[4] Technically, it is a Medium Term Budget Framework (MTBF) in the sense that: (i) it encompasses all government expenditures, and is fed by sectoral MTEFs for which the term MTEF is often reserved; (ii) it covers not just expenditures, but also a wide range of sources of financing.

[5] Sources : interviews + draft DFID internal document entitled "Resource allocation in Tanzania", no date, no author.

Government is aware of the importance of reinforcing the link between the budget and its overall development policy. The link between the PER and the PRSP/NSGRP is gradually strengthening, with a major effort delivered on the occasion of the preparation of budget guidelines for the 2005/06-2007/08 period: a new Strategic Budget Allocation System has recently been established in which preference is no longer given to priority sectors but to priority outcomes (MoH 2005:16).

Finally, it should be noted that:

- the quality of both the PER and the MTEF varies significantly across sectors; it is generally deemed to be high in the health sector (ESRF 2005, PEFAR 2005:23);
- as from FY 2004/05, the PER has been upgraded to PEFAR (Public Expenditure and Financial Accountability Review), so as to streamline exercises that used to be conducted separately into a single exercise.

2.2.2. BUDGET EXECUTION

A persistent weakness in the system is that "Tanzania remains on a tight cash budget system [6], in which monthly budget release depends on revenue collection. Spending departments cannot therefore rely on approved budgets actually being available" (Brown 2000:25). Monthly releases are still deemed to "adversely affect service delivery", even in priority sectors (PEFAR 2005:30). Also, "budget execution problems" stemming notably from weak capacities, problems encountered in computerisation and delays in counterpart funding "continue to cause lags and discrepancies in commitment and disbursement" (WB 2003:61-62).

Significant budget deviations are still observed. Nevertheless, "priority sectors" (of which the health sector) are "generally protected from expenditure cuts in the course of budget execution" (PEFAR 2005:15). It also appears that actual spending in the health sector, at all levels of government, is now extremely close to budget (PER 2005).

2.2.3. PUBLIC EXPENDITURE MANAGEMENT (PEM)

Reforms are taking place in the context of a Public Finance Management (PFM) Reform Programme, in close collaboration with the IMF and the World Bank. Significant progress has been made: several assessments note "improvements in public financial management and fiduciary systems in recent years" (IMF 2005b:60).

In the context of PFM improvement, a modular, integrated financial management system (IFMS) aiming for compatibility with the GFS [7] Manual has been developed. The system, nicknamed *Platinum/EPICOR*, was initially deployed in central government institutions only. [8] In order to improve the transparency and accountability of PEM in the context of

[6] This system was adopted to promote fiscal discipline. In recent years, the constraints imposed by the system have been partly eased by "front-loading of budget support", i.e. the disbursement by donors of the bulk of budget support early in the fiscal year (PEFAR 2005).

[7] Government Finance Statistics. The GFS Manual (the latest edition of which came out in 2001) is a publication of the IMF's Statistics Department. It covers concepts, definitions, classifications, accounting rules, etc. – for the purpose of improving transparency and accountability, harmonising government practices internationally, and thereby facilitating international comparisons of government statistics.

[8] The health sector was a pioneer in the use of the system (as in other innovative practices), with the Ministry of Health (MoH) among the first to have an IFMS in place.

decentralisation, a rollout of this system to districts is now under way, but the process is rather slow.

With the help of the IFMS (where available), budget control is exercised in a rather strict manner, according to internationally accepted fiduciary practices.[9] All in all, financial accountability is now generally considered satisfactory in central government, but weaker in local government (WB 2003:41). Things are gradually getting better; further institutional strengthening and improvements in district PFM capacities are expected as from 2005 with the support of the World Bank's Local Government Support Project (IMF 2005b:57-60).

Finally, a word on corruption. Tanzania scores 90 out of 146 in Transparency International's latest (2004) International Corruption Perception Index (CPI), with an unenviable CPI score of 2.8 (TI 2005).[10] Although the corruption issue was raised by only one of our interlocutors as relevant in relation to the Health SWAp, the problem is not without consequences; it notably leads to the adoption of more cumbersome procedures than would otherwise be necessary in the management of the basket fund (with adverse consequences in terms of transaction cost reduction); and it may partly explain the reluctance of some donors to disengage from projects and earmarked sector budget support in favour of general budget support. More generally, corruption affects the accessibility of public services (including health services) for the poor.

2.3. The institutional context

2.3.1. ADMINISTRATIVE CULTURE

Policy development and implementation in Tanzania have a reputation for being slow processes, since "decision making is often based on consensus". This slowness has drawbacks, but also advantages as "so far this approach has prevented policy reversals" (Brown 2000:3-4). Another source referred to this culture of consensus, pointing out that government usually tries to accommodate various "streams" of thinking, which may result in a lack of clear direction for policies.

Tanzania also has a rather long tradition of centralisation: government and public administration were extremely centralised under the long presidency of Mr Nyerere – in particular as from 1972, when the government abolished local government authorities, and imposed a system in which authority was "deconcentrated" to regions and districts (GTZ 2001:46) under very strong central control. Serious attempts have been made over the past decade to change this culture of centralisation. However, centralising forces are still powerful within government (ESRF 2005:18).

2.3.2. THE DECENTRALISATION PROCESS AND LOCAL GOVERNMENT REFORM

Decentralisation coupled with local government reform was conceptually embraced in the mid-1990s[11] as an effort to improve the effectiveness of government interventions and the

[9] The assessment is based on the PFM Performance Measurement Framework of the Public Expenditure and Financial Accountability (PEFA) programme, jointly financed by the World Bank and a number of other bilateral and multilateral donors (PEFAR 2005:25).

[10] The CPI score reflects the perception of the degree of corruption by business people, academics and risk analysts ; it ranges between 10 (highly clean) and 0 (highly corrupt).

[11] Actual implementation of decentralisation started in January 2000.

management of programmes at the local level. Both public service and local government reforms aim "to reorient government so that central and sectoral ministries are responsible for policy making, regulation, monitoring, and assessing performance and interventions, whilst local government, service boards, executive agencies, NGOs and the private sector take responsibility for implementation of services" (Brown 2000:4-5).

Decentralisation can take two forms: *devolution* which implies a real transfer of competences to local government, and *deconcentration* which implies the establishment of central government representatives at various territorial levels (Land & Hauck 2003). The process in Tanzania combines devolution, in that it implies a transfer of planning, management and financial competences to local governments, and deconcentration, since regional government and public officials are appointed by central government.

Local government reform, initially a component of the Civil Service Reform Programme and now a separate process managed by the President's Office Regional Administration and Local Government (PORALG) department, started in 1994. The comprehensive Local Government Reform Programme (LGRP) included, in addition to the implementation of the devolution strategy, an increase in local government resources, a strategy to improve local government service delivery and promote the integration of sector reforms with local government reform, and some capacity building measures.

The LGRP was implemented in three phases, starting in January 2000; it was completed by the end of 2004. It enjoyed "strong political backing" from government (Brown 2000:5), and also received considerable support from donors (Hobbs 2001). Still, *the government is sending mixed signals on its commitment to decentralisation*. For instance, by abolishing a number of local taxes that used to bring non-negligible resources to district councils, it has increased local governments' dependence on financial resources originating from central government (ESRF 2005:19, PEFAR 2005:35-36). [12] Also, planning and spending by local governments remain under the tight control of central government, as illustrated by the case of primary healthcare (see further). With local government reform "incomplete, still in transition or inadvertently undercut by other new policy processes" (ESRF 2005:20), it is felt that the decentralisation process, although formally completed, still has some way to go.

2.4. Development policy and poverty reduction strategy

2.4.1. DEVELOPMENT POLICY AND THE FIRST PRSP

In the mid-1990s, government identified four large obstacles to development (OCDE 2003:14):

- poor governance and weak institutions;
- aid dependency;
- serious capacity constraints, notably poor economic management capacities;
- inefficiency in the implementation of policies.

In response, ambitious reforms were launched, including a *Public Sector Reform Programme*, a *Local Government Reform Programme*, a *Public Finance Management Reform Programme*,

[12] Local governments' "own source revenues" only amounted to 11% of their resources in 2003, and this share was anticipated to go down to 7% in 2004 – against 18% in 2001 (PEFAR 2005:36).

a *National Anti-Corruption Strategy*, a *National Framework on Good Governance*, and a *Legal Sector Reform Programme*. These reforms, all aimed at improving the performance, accountability, transparency and integrity of the public sector, are closely linked with other major reforms, notably those related to the adoption of a clear development and poverty reduction strategy (IMF 2005b:60).

In this regard, in 1995, a consultative process was launched and led to the elaboration and publication in 1998 of a *National Poverty Eradication Strategy* – which became the basis for the *Poverty Reduction Strategy Paper* (PRSP) published in 2000 (OCDE 2003:14). A document entitled *Tanzania Development Vision 2025*, which defines a general framework for the country's social and economic development, was also published in 1999.

During the same period, Tanzania became eligible to benefit from the Highly Indebted Poor Country (HIPC) initiative – which led the country to prepare a PRSP meeting the requirements of the World Bank and IMF. The strategy proposed in the first PRSP was articulated around seven priority sectors, of which the health sector and the fight against HIV/AIDS.

2.4.2. THE SECOND PRSP : THE NATIONAL STRATEGY FOR GROWTH AND REDUCTION OF POVERTY

A second, more comprehensive PRSP, renamed National Strategy for Growth and Reduction of Poverty (NSGRP) and known in Kiswahili as *Mkukuta*, was approved in April 2005; it covers the period 2005-2010. The new strategy, aimed at achieving "faster, more equitable, and sustainable growth", "adopts an outcome-based approach (in contrast to the priority sector spending approach under the first PRSP) in three major areas: (i) growth and reduction of income poverty; (ii) improved quality of life and social well-being; and (iii) good governance and accountability". It recognises the private sector's leading role in promoting growth, makes proposals to improve the business environment and governance, and addresses specific constraints to growth-enhancing investment such as poor infrastructure, limited access to credit, cumbersome business licensing requirements, etc. (IMF 2005b:9,56)

As far as sectoral reforms are concerned, the implications are potentially far-reaching but not yet entirely clear. With sectors no longer addressed separately, but grouped into three thematic "clusters", the new strategy promotes the establishment of more links and deeper cooperation between sectors in order to reach outcomes that are frequently dependent on concerted efforts. This will require the adaptation of many sector and sub-sector policies. However, the strategy is not prioritised, and inter-sectoral platforms have hardly been developed – so it may (at least initially) be more difficult for individual sectors to define their contribution to the PRSP than it was in the past.

2.5. Development cooperation in Tanzania

2.5.1. TANZANIA'S ASSISTANCE STRATEGY

In June 2002, the GoT adopted a document entitled *Tanzania Assistance Strategy* (TAS), which sets out a coherent framework for the management of external resources and for government cooperation with development partners. This initiative stems from the government's willingness to regain ownership of its development policies, and take leadership

in the aid coordination process. The TAS promotes good governance, accountability, capacity building, and improved effectiveness in aid delivery, in a spirit of "transparency and trust between donors and the partner government" (OECD 2003b:14).

The TAS expresses a clear preference for "programme aid" (and thus SWAps) rather than project aid, and for aid financing in the form of budget support or joint financing mechanisms in support of SWAps, rather than instruments governed by donor procedures. However, donors who wish to continue providing aid according to "traditional" modalities are still welcome – they are just encouraged to consider a gradual transition to the new modalities. The adoption of joint monitoring and evaluation procedures and processes is also among priorities (OECD 2003b:14). Interestingly, on top of joint evaluations, an independent review mechanism of the implementation of the TAS has been set up and entrusted to a group of experts known as the Independent Monitoring Group (IMG) (ESRF 2005).

In spite of government's willingness to exercise leadership and better own its development policies, one of our interlocutors mentioned that overall government leadership may not be as strong as it should be, in the sense that there is a lack of cohesion in the government's development approach. According to this source, an all-inclusive attitude (both towards internal currents and towards donors) prevails, and the persistence of a "take what you can get" attitude towards donors still prevents government, in many areas, from refusing to finance some activities that are not naturally among its priorities.

Overall however, in spite of "inequalities" in the exercise of ownership and leadership across sectors, the IMG considers that "GoT leadership and ownership has indeed been strengthened" (ESRF 2005:6). Where considerable progress must still be achieved is in developing broad-based national ownership of policies and strategies. The formulation of the NSGRP has been characterised by broad consultations with all stakeholder groups – but the use of participatory processes for policy formulation and evaluation remains exceptional.

2.5.2. THE DEVELOPMENT PARTNER GROUP AND THE JOINT ASSISTANCE STRATEGY

Many development partners (bilateral, multilateral, international NGOs, …) operate in Tanzania. In reply to the TAS and/or in order to adapt to the PRSP, most of them have elaborated a *Country Assistance Strategy* (CAS), which spells out priorities and objectives for their actions as well as principles guiding their collaboration with government. Many are now in the process of updating their CAS to take account of the changes in Tanzania's development strategy introduced by the NSGRP.

Since the late 1990s, donors have also organised their cooperation in the context of a multi-donor forum initially known as the DAC (Development Assistance Committee), then renamed DPG (Development Partner Group). "The rationale for the DPG (…) is to complement GoT's own coordination efforts by promoting internal coherence among the [development partners] (…)" (ESRF 2005:34). The DPG's efforts are focused on a number of areas:

- establishment of stronger links between general development policies and sectoral policies – notably through the development of sectoral or thematic sub-groups within the DPG (of which the DPG Health);
- reinforcement of cross-sectoral coordination on "horizontal" issues such as HIV/AIDS;
- identification of common positions on certain policy issues (e.g. consolidated donor comments on the draft NSGRP);

- substantive work on development- and aid-related issues (ESRF 2005:34-35).

It seems that "the group has been welcome by GoT as credible and legitimate", and as a result of its work, "high-level consultation between GoT and bilaterals have been redefined to be less frequent and to cover more general issues rather than details" (ESRF 2005:35). It is standard practice within the DPG that once something is agreed upon internally, the group only sends a limited number of representatives to discuss with government (ESRF 2005:17).

As a further step towards alignment with the government's strategy (and in particular the NSGRP) and integration of TAS principles, and also in the context of international pressure in favour of alignment and harmonisation, the main donors and government are currently working on the definition a *Joint Assistance Strategy* (JAS) that should, in time, replace individual donor CAS. The JAS, which would notably promote the use of joint funding arrangements as well as a division of labour among development partners, is expected to be finalised in the course of 2006. It is envisaged to make it a binding agreement.

2.5.3. AID MODALITIES

In its latest monitoring report, the IMG forcefully recommends that the JAS be "more assertive" as far as the choice of aid modalities are concerned: "The GoT has expressed preference for [general budget support] as an aid modality. In practice the GoT has not been sufficiently emphatic on this preference. In our opinion, GBS should continue to be the preferred aid modality (…)"(ESRF 2005:7); and "while TAS has taken a more or less voluntary stance in its approach, JAS is going to take a more definitive stance in outlining government principles in a framework that [development partners] are required to align to" (ESRF 2005:14). The report makes a number of detailed proposals concerning the principles that should guide any derogation from the provision of aid through general budget support.

Budget support in general is very "fashionable" among donors at the moment, for a variety of reasons. [13] All in all, more and more development partners spend a larger and larger share of their financial assistance to Tanzania in the form of budget support, either sectoral (SBS) and/or general (GBS). Much of general budget support goes to a Poverty Reduction Budget Support (PRBS) facility jointly managed by the World Bank, the EC, the AfDB and eleven bilateral donors. The PRBS co-finances seven priority sectors; payments are related to the achievement of progress in the implementation of its poverty reduction strategy (PRS). Yet, not all donors are ready to use this instrument, or use it exclusively: sector budget support, projects, and technical assistance remain popular aid instruments. It is can thus not be taken for granted that a majority of development partners will accept to be bound by strict rules on the choice of aid modalities.

[13] It is expected to promote the ownership of development policies, to support the development of PFM institutions and systems, to reduce aid management costs; less officially, it can also increase a donor country's leverage over general or sectoral policies and reforms, increase the overall political influence of a donor on a government, and make a convenient instrument for accelerating aid disbursement rates.

3. Introduction to the Health sector in Tanzania

3.1. Short historical overview

Tanzania has inherited from socialist times a vast network of public health infrastructure (several thousand facilities, including dispensaries, health centres, hospitals and medical training centres). About 90% of the population lives less than 10 km away from a health facility (WB 2003:14, based on HBS 2002). The system started collapsing in the mid-1980s, when the country was hit by economic crisis, and severe budget restrictions were imposed. The health sector particularly suffered as the funds needed for infrastructure maintenance and the operation of medical training centres dried up, while inflation eroded the salaries of medical staff (de Savigny et al. 2004). As a result, much of the infrastructure is now dilapidated, and the provision of health services is further hampered by a persisting and acute shortage of medical staff (at all skill levels).

A health strategy based on the development of primary healthcare was adopted years before the Almaty Conference in 1978 officially made it a global policy. The implementation of this policy was hindered, however, by economic crisis, the verticalisation of health programmes (see next paragraph), and inefficiencies in the highly centralised management structures imposed by the government. Also, as from 1977, the private provision of health services was severely restricted – although voluntary agencies continued to operate alongside the government-run public health infrastructure.

As far as development cooperation is concerned, back in the 1960s and 1970s, most donors picked some areas for selective support, and vertical programmes thrived (e.g. vaccines, TB, bilharziosis, drug supply, …). This approach delivered some benefits: the outcomes of vertical programmes were usually clear, easy to measure, and sometimes quite spectacular. These programmes generally used existing infrastructure (notably dispensaries) for delivering their goods at grassroots level – but there was very little integration otherwise: each programme had its own procurement and disbursement mechanisms, training programmes, reporting requirements, and possibly used dedicated staff. There was ultimately very little transfer of skills and technology, funding was fully controlled by donors (and thus subject to their whims, political priorities and donor fatigue), and it soon turned out that these programmes, initially deemed satisfactory for their short-term benefits, were unsustainable. [14]

As from the late 1980s, these problems led government to envisage a series of reforms. The national health policy adopted in 1990 included a renewed emphasis on primary healthcare development, the decentralisation of health services, and the search for new options for financing healthcare (Tanzania introduced user fees for health services in 1992). In the wake of the more liberal policies adopted after the change in government in 1985, private for-profit practice was authorised again in 1991 (GTZ 2001:50).

On their side, donors also reflected on ways to better help the health sector; they notably set up a Health & Population Group in 1986. In 1993, the publication by the World Bank of a World Development Report entitled "Investing in Health" (WB 1993) triggered health sector

[14] Source : interview.

reforms and the drawing up of health sector strategies and action plans in many countries, including Tanzania. It led to the adoption of a *Strategic Health Plan* for 1995-98, as well as an *Action Plan* for 1996-1999, in agreement with donors (Brown 2000). In 1998, the Health & Population Group of donors converted itself in what is now known as the DPG Health [15], and a decision was made to go for a sector-wide approach to health sector development (see section 3.3.).

3.2. Health sector structure and characteristics

3.2.1. A MAJOR REFORM: THE DECENTRALISATION OF PRIMARY HEALTHCARE

The decentralisation of primary healthcare services constitutes the cornerstone of the health sector reforms undertaken in the 1990s. It started in 2000, in the context of the general decentralisation exercise carried out under the public service and local government reform programmes. The health sector was in fact a pioneer in the adoption of decentralisation, devolving planning and management responsibilities to local government authorities (LGAs) ahead of all other sectors and, in the view of one of our interlocutors, going "faster than the decentralisation process itself".

3.2.2. PUBLIC HEALTH INFRASTRUCTURE

The public healthcare system has a "pyramidal referral structure" encompassing:

- village posts, community dispensaries and health centres at the primary healthcare level;
- district, regional and voluntary agency hospitals at the secondary level;
- consultant, national and specialised hospitals at the tertiary level (HERA 2005:20, NHP 2003:1).

3.2.3. RESPECTIVE ROLES OF INSTITUTIONS IN THE DECENTRALISED ENVIRONMENT [16]

3.2.3.1. CENTRAL GOVERNMENT: THE MOH

With decentralisation, the MoH is gradually shifting away from service delivery, and developing a "stewardship role" in the field of *policy development*, *national strategic planning*, the establishment of a *regulatory framework*, *standard setting and quality assurance*, the *monitoring and evaluation of policy implementation* (in collaboration with PORALG), and *human resource development* (with PORALG again). Other significant roles of the MoH in the new structure are to provide for adequate *sector financing, budgeting* and the *equitable allocation of resources* (in collaboration with PORALG); *sector coordination*; *health research*; and *the continuing education of health workers*, through the management of Zonal Training Centres.

In theory, the MoH remains involved in service provision only through the management of public tertiary care facilities. Also, the procurement of drugs remains a quasi-monopoly of central government, exercised by the *Medical Stores Department* (a department of the MoH).

[15] Formerly known as the "DAC Donors Group" on Health.
[16] Various sources were used for this section, including interviews, Hobbs (2001), HSSP (2003), NHP (2003) and WB (2003).

3.2.3.2. CENTRAL GOVERNMENT: PORALG

PORALG plays a "stewardship role" similar to that of the MoH, in relation to regional and local administrations. Its overall mandate is to *coordinate central and local government relations*. With regard to the health sector, its responsibilities are technical, logistical and financial. They include:

- a contribution to sector financing;
- the provision of guidelines for local governments and regional secretariats (to ensure that the MoH's policy and strategy are translated into actions at decentralised levels);
- the supervision of their health-related activities;
- the preparation of consolidated reports of district health plans (annually) and district quarterly/annual reports (based on the intermediate consolidation performed by Regional Secretariats);
- human resource management (in close coordination with the MoH).

3.2.3.3. REGIONAL SECRETARIATS

Regional secretariats are an extension of central government (deconcentration), operating under the supervision of PORALG. Regional Health Management Teams (RHMTs), designated by the MoH but attached to the secretariats:

- manage regional hospitals (under the responsibility of a Regional Medical Officer);
- provide managerial and technical support to districts;
- supervise district plans and activities, notably to guarantee adherence to policy and guidelines (e.g. eligibility of planned expenditure with regard to government block grants and basket fund grants) and to ensure national minimum quality standards (determined by the MoH) are met;
- plan and supervise the rehabilitation of district hospitals and primary healthcare facilities;
- consolidate annual district health plans as well as districts' quarterly and annual reports;
- perform audits of district-level activities;
- support districts in data collection, data management and decision making;
- facilitate the exchange of experiences and best practices among districts.

All interviewed people concurred that *RHMTs are severely understaffed*, if one considers the scope of their responsibilities.

3.2.3.4. LOCAL GOVERNMENT AUTHORITIES (LGAS)

Districts [17] are now "the focal point in health planning and health services delivery" (HERA 2005:20). District councils are involved in health sector management in the following ways:

[17] In this report, we refer indifferently to "districts", "councils" or "local government authorities" (LGAs). To be precise, the latter include both "district councils" and "urban councils" – however we use the word "district" in a generic manner.

- Council Health Management Teams (CHMTs) prepare and submit budgets and annual plans (*District Health Plans*, also known as *Comprehensive Council Health Plans*) and reports, as well as quarterly and annual reports describing progress in the implementation of the plan and detailed expenditures; in so doing, they have to follow a series of guidelines elaborated by the MoH and PORALG, covering district planning and the utilisation of government block grants and grants from the Health Sector Basket Fund (see further); council health plans are increasingly expected to encompass the health services run by the private sector (notably by faith-based organisations), so as to provide a comprehensive picture of the local services and resources [18], ensure coordination, foster complementarity and allocate money in a more equitable manner;
- CHMTs, with the support of Health Facility Committees, manage primary healthcare service delivery, through a network of health centres, dispensaries and village posts;
- District Medical Officers manage the financial as well as the operational performance of all service delivery outlets;
- Council Health Service Boards (CHSBs), including the Medical Officer, a CHMT representative, community and NGO representatives, and private hospital representatives, provide a multi-stakeholder forum promoting local participation and dialogue; CHSBs assist the CHMT with the preparation of comprehensive council health plans:
- Health Facility Committees, which like CHSBs are still in the process of being established, provide a consultative forum aimed at ensuring community participation in the management of individual facilities.

District Councils are expected to raise local revenues to supplement the resources provided by central government and the basket fund – although this task has been made difficult by the suppression (by central government) of a series of local taxes.

3.2.3.5. COORDINATION MECHANISMS

Complicated and somewhat unclear arrangements were initially made to ensure coordination between the MoH, PORALG, regional and local authorities. In 2000, one observer noted that "although the regional and district [health] teams lie administratively under MRALG [the predecessor of PORALG], they are 'technically answerable' to MoH, which has overall responsibility for health matters. […] The result has been unsatisfactory. Lines of authority and accountability at district level are unclear, and staff lack decision-making powers over use and allocation of resources […]" (Brown 2000:21).

These fears have now been partly assuaged, as coordination mechanisms have become significantly smoother. The Permanent Secretaries of the MoH and PORALG co-chair the SWAp and Basket Financing Committee (see section 3.3.2.). The technical staff of both ministries collaborate on a day-to-day basis, with the MoH exercising responsibility for the technical performance of health staff at all service levels, while PORALG and LGAs exercise administrative responsibility (HSSP 2003). Still, one of the people we interviewed was of the opinion that respective roles and responsibilities are still not defined as clearly as they should be. Some confusion may notably arise from the fact that local and regional medical staff is administratively answerable to a local or regional authority, and technically answerable to the MoH.

[18] This is difficult in practice, especially when it comes to assessing the resources that are available to private sector operators.

3.2.4. MANAGEMENT ARRANGEMENTS IN THE DECENTRALISED ENVIRONMENT

Block grants are allocated by government to local authorities against the presentation and approval of a comprehensive district health plan (rather than subventions being paid out of itemised line budgets). They are disbursed to allow the achievement of national minimum standards of service for primary healthcare, and are linked to pre-defined outputs/outcomes. Money from the Health Sector Basket Fund (see section 4.4.2.) comes in addition to government block grants. District health plans are agreed at council level, then scrutinised at regional level (against MoH-determined quality standards and expenditure ceilings), then consolidated and forwarded to PORALG for approval. Government and basket funds are released separately – on a quarterly basis, as far as the basket fund is concerned (Brown 2000, MoU 2003).

In theory, districts are supposed to set their own priorities and allocate funds accordingly. In practice however, *block grants for districts as well as basket fund grants are characterised by significant rigidities* [19], even though these were relaxed a little bit two years ago (and may have been justified by the need to initially adopt a risk-averse attitude). Nowadays, a minimum and a maximum percentage of total expenditure are still imposed for specific budget items, so that districts remain pretty much constrained in the use they can make of central funds. As a result, the preparation of most district health plans remains primarily an exercise aimed at complying with guidelines in order to obtain the necessary funds, rather than a strategic health planning exercise. Some observers estimate the procedures and guidelines on the use of funds could now be further relaxed.

For transparency purposes, all the income and expenditures of district health services must be channelled through a dedicated district health account (Hobbs 2001, HERA 2003). As far as financial reporting is concerned, "basket restrictions on expenditure necessitate separate accounting of funds to meet the audit requirements" (HERA 2003:29) – which causes difficulties in many councils, whether they operate manual or computerised accounting systems. This aggravates the administrative burden placed on local governments, and is a source of errors and delays. This duplication of efforts and procedures results from a failure to merge the accounting manual for the district basket fund with the local governments' general accounting manual (PEFAR 2005:37).

3.2.5. ROLE OF PRIVATE HEALTHCARE PROVIDERS [20]

At the latest count in 2003, Tanzania had "a total of 4,990 health facilities of which 3,060 (61.3%) are government-owned, 748 (15%) are owned by voluntary agencies, 205 (4.1%) by parastatals while 977 (19.6%) are privately owned" (HERA 2005:20). Exactly which share of services is provided by government and by the private sector is not known. One generally assumes a 60%-40% distribution, roughly matching the ownership of facilities – but this

[19] As far as grants from the district basket fund were concerned, they were restricted to "recurrent other [i.e. non-personnel] charges"; they could not be used for the purchase of medical supplies, nor for capacity building measures. They had to be allocated in fixed, very strict proportions to six cost centre categories: 10% for the Council Health Department, 35% for the council hospital, 10% for urban health centres, 15% for rural health centres, 15% for dispensaries, 5% for community initiatives – with only 5% not pre-allocated (Hobbs 2001). Other rules applied to the block grants disbursed out of government budget, but they were also quite rigid. Procedures on the use of funds originating from government budget and the basket fund have only recently been harmonised.

[20] Main source for this section : HERA (2005).

estimate may be incorrect; some believe real private sector involvement may be greater than this estimated 40% (HERA 2005:26).

In the private sector, not-for-profit *faith-based organisations* (FBOs) play a prominent role, since they have been operating for decades alongside government infrastructure. In some cases, they get public grants [21] to support the provision of the essential health package, particularly where they operate facilities that fill a "gap" in public facility coverage (e.g. "designated district hospitals" (DDHs) in districts that do not have a government-operated hospital). With the exception of DDHs however, public grants are usually insufficient to cover the cost of providing services, and in view of increasing costs (plus the fact that foreign financial contributions are shrinking), more and more FBO-operated facilities feel they have no other choice but to charge user fees. Non-faith-based NGOs are also active in the delivery of some services – with a growing presence in HIV/AIDS-related activities. FBOs and other NGOs provide a mix of preventive and curative services.

Private for-profit health providers (hospitals, laboratories, pharmacies, maternity homes, …), only allowed since 1991, are growing fast, primarily in urban areas – and now play a significant role in curative service delivery. Private facilities are often owned or operated by government health workers, who have a foot in each sector. This may give rise to conflicts of interest.

Finally, *traditional medicine* remains important since an estimated 60% of the population still uses traditional medicine for day-to-day health care (NHP 2003). It is partly regulated through a Bill on Practice of Traditional Medicine.

The GoT is increasingly coming to recognise that the public healthcare system cannot cater for the needs of all Tanzanians while ensuring adequate quality. *Public-private partnerships* were the focal theme of the latest annual sector review. Public health authorities are now encouraged to seek synergies with private service providers, and notably to develop service agreements with some of them. Yet, this is likely to take some time as the various players in the health sector are not yet very familiar with each other, and tend to distrust each other.

3.3. Establishment and working modalities of the SWAp

3.3.1. FIRST STEPS

The formal decision to adopt a sector-wide approach to health sector reform goes back to June 1998, when the MoH and donors signed a *Joint Statement of Intent* to this effect. This followed a less formal agreement already made on the occasion of a *SWAp Workshop* held in March 1998. It seems *the initiative to adopt a SWAp can be credited to a few donors* who were early adopters of this new concept – but they obviously had no difficulties in persuading their government counterparts of the merits of the approach. The establishment of a SWAp was very soon followed (in 1999) by the setting up of a joint funding mechanism (basket fund) involving some of the donors.

[21] Including a share of the money allocated to councils by the district basket fund, as far as DDHs and other voluntary agency hospitals are concerned. Some of the public grants are in the form of staff grants.

3.3.2. SWAP INSTITUTIONS AND WORKING MODALITIES

3.3.2.1. THE DPG HEALTH

Twenty-three development partners are involved in the DPG Health, a donor-only coordination forum. DPG members meet on a monthly basis without the presence of government, in order to coordinate their views and activities.

The WHO provides the secretariat of the DPG Health, but not its leadership – which as far as we could figure out is collectively exercised by a few "hard core" members, i.e. a few donor representatives that are more deeply involved than others, notably through active participation in the Technical Sub-Committee and in various sub-sectoral task forces and working groups (see further). SDC currently chairs the Group.

The DPG mechanism has created a more concerted way for donors to exercise influence over policy. It has helped foster a convergence of donor policies on many aspects of sector reform, although some issues escape convergence. The implications of this mechanism in terms of government leadership and ownership, as well as efficiency (reduced time spent on coordination on the government's side), are reviewed further.

3.3.2.2. THE SWAP COMMITTEE

The SWAp Committee constitutes the "official", formal coordination forum of the SWAp; its role is to coordinate all donor-supported activities in the health sector. The SWAp Committee is chaired by the Permanent Secretary of the MoH, and includes representatives from the DPG Health – which usually delegates a limited number of its members. It also includes representatives from the private sector and NGOs. The Committee meets twice a year.

3.3.2.3. THE BASKET FINANCING COMMITTEE (BFC)

The BFC is co-chaired by the MoH's and PORALG's Permanent Secretaries. It meets on a quarterly basis (see section 4.4.2.3. for more details).

3.3.2.4. THE HEALTH TECHNICAL SUB-COMMITTEE, TASK FORCES AND WORKING GROUPS

The Health Technical Sub-Committee, including representatives of donors as well as the MoH and PORALG, is a "semi-formal" forum that started as a sub-committee of the BFC, and has now more or less informally developed into an interface between the DPG Health and the MoH/PORALG. Membership on the donor side is no longer limited to basket fund donors (although they still tend to constitute the "hard core" on the donor side); interestingly, membership is also open to other stakeholders, and a few NGOs have been invited to participate in the committee's work.

The Technical Sub-Committee meets according to needs (up to weekly at the time of preparation of the Joint Annual Review, as little as quarterly in more quiet times) to work on the substance of specific technical issues. Its meetings usually attract much fewer participants than the DPG Health… reportedly because participation in it requires a lot of work to be carried outside meetings! Much of the work of the Technical Sub-Committee is in fact carried

out by issue-specific task forces. Selected donor and government representatives, and sometimes other stakeholders, participate in these less formal working groups. Donor representatives participate according to a "division of labour" agreed between them.

3.3.2.6. THE JOINT ANNUAL REVIEW (JAR)

The JAR aims to share information on key developments and the sector's achievements (notably against previously agreed milestones), discuss the conclusions and recommendations of the preceding Technical Review (during which all the preparatory work is carried out), and agree on milestones and priority actions for the next fiscal year. This exercise takes place in April; it has been organised every year since the inception of the SWAp.

The JAR itself, with an increasing number of participants (government, donors, NGOs and civil society organisations, private providers of health services, …), is reported to have become more of an annual "jamboree" than a forum in which actual work is getting done. It nevertheless remains the official forum in which all partners, after reviewing actual expenditures and achievements of the past year against the plan, agree on a new, detailed implementation plan for the coming fiscal year – based on the confirmation of development partners' contributions. The timing of the review, in March-April, allows participants to take into account the indicative budget allocation to the sector for the next three years, as specified in the budget guidelines; it also takes place in time for newly pledged donor contributions to be taken into account in the budget cycle (WB 2003:10).

3.4. Health policy and strategy

The latest official update of the *National Health Policy*, available on the government's website, is dated October 2003. It outlines the mission and objectives of the health policy, the organisation and structure of health services, some HR management and financing principles, and objectives in terms of monitoring and evaluation.

The government's long-term strategy to implement the PRS in the health sector is presented in the *Health Sector Development Strategy 2000-2011*, which is notably being supported by a World Bank credit; its focus evolves over time, across three successive phases (WB 2003:21). A more specific, medium-term strategy is also formulated in the *Second Health Sector Strategic Plan* (HSSP II), which covers the period July 2003-June 2008. The HSSP describes the roles and responsibilities of all institutions involved in the management of the health sector, and is very much focused on improving the quality of care (thus corresponding to the priority assigned to Phase II of the long-term term strategy). Both strategies were conceived to meet the requirements of the first PRSP, and may thus require some adjustments to be made compatible with the new one.

3.5. Sector performance monitoring system

The national sector performance monitoring system consists in a complex patchwork of events, processes and data collection systems that, in the opinion of our interlocutors, still need to be stitched together to form a coherent framework.

Official monitoring and evaluation forums include the sector's annual reviews, the meetings of the SWAp Committee and BFC, the annual PER and MTEF processes, and the annual review of plans and reports submitted by district councils (HSSP 2003:58, WB 2003). At the local level, the National Institute for Medical Research (NIMR) performs an annual evaluation of district council performance, based on aggregated data collected at facility level.

As far as indicators are concerned, government and development partners have agreed on a monitoring framework known as the *Health Sector Performance Profile*, which includes:

- twenty-two "annual indicators" (i.e. indicators that are supposed to be updated annually); out of these, 7 are input indicators, 4 are process indicators, 4 are output indicators, 5 are outcome indicators, and 2 are impact indicators;
- eleven "periodic indicators" (i.e. indicators that are updated less than annually, on the basis of periodic surveys); out of these, 3 are outcome indicators and 7 are impact indicators.[22]

Some of these indicators, and in particular six long-term impact indicators, have been integrated into the PRSP monitoring framework (WB 2003:5, 23).

Sources of information for these various indicators include the National Population Census (conducted once a decade), Demographic and Health Surveys (conducted every four years), the demographic sentinel surveillance systems set up under two pilot projects (TEHIP and AMMP), systems established under the Poverty Monitoring Master Plan, data collected by two research centres (NIMR and Ifakara), Household Budget Surveys, health sector PERs, the health sector MTEF, and other periodic or ad hoc surveys (eg. the report on the "State of Health in Tanzania", and the recent "ten-district study"[23] (MoH 2005, WB 2003:30-31).

At district level, data collection requirements have been somewhat streamlined. District councils are now requested to collect and aggregate (for the various facilities they supervise) routine service data allowing them to produce a set of 19 indicators, and to report on their evolution on a quarterly basis. These indicators should notably allow the monitoring of progress made against their plans, as well as the monitoring of services delivered (HSSP 2003:58, WB 2003:10-11). However, the quality of data collected at local level is still considered poor. More rationalisation is also needed as far the collection of epidemiological surveillance data at facility level is concerned (there are currently distinct, non-harmonised reporting requirements for each programme or disease).

For a few years, the MoH has been working on the development of a reliable, comprehensive health management information system (HMIS) that should ultimately provided a unified, more coherent framework for sector performance monitoring. Technically, the current HMIS just aims to collect and organise route health facility data. A longer-term strategic objective is to integrate this HMIS with other sources of data, so as to create an Integrated Disease Surveillance system (NHP 2003:31).

[22] For more details, please refer to (HSSP 2003:60-62 or MoH 2005:8).
[23] See, respectively, STI (2005) and Makundi et al. (2005).

4. Health sector financing

4.1. The health sector's PER, MTEF and budgetary process

The budgetary process for the health sector [24] actually consists of two processes: one managed by the MoF (which allocates its resource envelope among national priorities and the requests of line ministries including the MoH), and one managed by PORALG (which allocates its resource envelope among all the decentralised activities it supervises). The overall envelope for the health sector thus results from two separate (but coordinated) budgetary exercises, and is supplemented with resources originating from the budgets of LGAs. As from FY 2005/06, with the new Strategic Budget Allocation System in place, the MoH and PORALG have been asked to divide their budget bids (i.e. budgetary requests) between "NSGRP items" and "non-NSGRP items" – with the former standing a better chance of getting funded than the latter. Since the bulk of the MoH's budget is labelled as PRS-related, however, the impact of this measure has been limited so far.

A specific PER for the health sector has been conducted since 2001 – and the exercise has been conducted jointly by the MoH and PORALG since 2003. The two institutions now also jointly prepare and review the sector's MTEF, and jointly report on health sector progress in the context of PRSP monitoring (WB 2003:56). Health sector PERs are generally considered exemplary, as they are very comprehensive and thorough, "designed and commissioned with full involvement of key sector staff and relevant stakeholders", and "established, over the course of several years, as a key input for the annual health sector review, providing a critical forum for scrutiny of its findings" (PEFAR 2005:23). What they do not do so well, it seems, is providing key inputs for budget preparation (HSPER 2005).

The health sector MTEF has a three-year planning horizon, and it is updated annually on a rolling basis. It encompasses the following resources:

- *government funds* ("G funds", including external funds originating from general budget support);
- the health sector basket fund ("B funds") and other *"on-budget" external resources* (i.e. external resources disbursed through the exchequer system);
- "other funds" or *"off-budget funds"*, i.e. external funds not disbursed through a government mechanism, as well as domestic extra-budgetary resources (namely, "cost-sharing revenues", i.e. user fees and payments into the Community Health Fund).

MTEF preparation is firmly in the hands of the MoH and PORALG but, over the past few years, donors have been invited to review draft budgets and submit their inputs prior to final document approval.

4.2. Overall sector resource envelope (as per MTEF)

The table below shows the overall sector resource envelope (capital and recurrent expenditure) as covered by the MTEF, including off-budget contributions:

[24] For an overview of the general budgetary process, please refer to section 2.2.1.

Description / Fiscal Year	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 (budget)
Total MTEF resource env. (bn TZS)	**132.91**	**180.13**	**221.62**	**237.13**	**310.37**	**453.2**
- "on budget"	71.38 (53.7%)	103.27 (57.3%)	141.01 (63.6%)	176.36 (74.4%)	220.10 (70.9%)	312.81 (69.0%)
- "off budget"	61.53 (46.3%)	76.86 (42.7%)	80.61 (36.4%)	60.77 (25.6%)	90.27 (29.1%)	140.33 (31.0%)
Total MTEF resource env. (mn USD)			**237.3**	**236.9**	**287.9**	**406.3**
Total MTEF resource envelope per capita (real, TZS at FY01 prices)			**6,331**	**6,296**	**7,698**	**10,466**
Total MTEF resource envelope per capita (nominal, USD)			**7.11**	**6.88**	**8.12**	**11.57**

(Source: Health Sector PER updates FY04 and FY05)

From this table, it appears that the share of the MTEF resource envelope that is "on budget", i.e. disbursed through the national exchequer system, is stagnating at around 70%.[25] In other words, *external financing disbursed through donor-specific mechanisms seems for the time being to stagnate at around 30% - a much higher share of the total resource envelope than had been envisaged a few years ago*.[26] Note however that significant uncertainties remain concerning both off-budget external contributions and cost sharing revenues. In particular, the fact that off-budget external contributions have not decreased over the past three years may be partly attributable to the fact that they get better reported than in the past. Cost-sharing revenues, on the other hand, may be under-reported (Schwerzel et al.).

The table also shows that the resource envelope available for public health is increasing steadily (strong increase in real per capita resources). Still, per capita allocations to public health remain well below those advocated by the Commission on Macroeconomics and Health.[27]

4.3. Sources of financing

4.3.1. BUDGET

As a reminder, note that public health expenditure is financed by a combination of MoH, PORALG and LGA budgetary resources. Note also that government spending is not synonymous with domestic funding, since a sizable share of the government's budget originates from external budget support.

[25] Cost sharing resources are minor compared to off-budget foreign aid: 7.5 bn TZS in cost sharing resources in 2003/04 and 2004/05 against, respectively, 82.8 and 132.9 bn TZS in foreign aid (MoH 2005:14).
[26] The projected resource envelope included in the 2003-2008 HSSP tentatively estimated that off-budget foreign assistance would contribute 17.1% of overall resources in FY 2003/04, 8.3% in FY 2004/05 and 5.3% in FY 2005/06! (HSSP 2003)
[27] WHO (2002) – *Commission on Macroeconomics and Health: Investing in Health for Economic Development,* Geneva: World Health Organisation. The Commission advocated per capita health expenditures of 30-40 USD (at 2002 prices) for covering essential interventions in low-income countries, including HIV/AIDS-related interventions.

Description / Fiscal Year	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 (budget)
Total public expenditure on health (nominal, bn TZS)	**81.2**	**100.7**	**142.1**	**186.1**	**216.2** ***(218.2)***	**290.4**
Total public expenditure on health (real, bn TZS, FY01 prices)		***100.7***	***135.6***	***170.6***	***192.0***	***245.3***
Total public expenditure on health (as a % of GDP)	**1.2%**	**1.3%**	**1.6%**	**1.9%**	**1.9%**	**2.3%**
Total public expenditure on health (as a % of total public exp.) [28]	***8.8%***	***10.6%***	***11.0%***	***10.4%***	***9.7%***	***10.1%***
Per capita spending (real, TZS at FY01 prices)		***3,109***	***4,060***	***4,957***	***5,412***	***6,707***
Per capita spending (nominal, USD)		***3.73***	***4.56***	***5.42***	***5.71***	***7.42***

(Sources: IMF 2005b:26 / MoF; *in italics: Health Sector PER update FY05*)

The table shows the following trends in public financing for the health sector: [29]

- total public expenditure on health is increasing in real terms and as a share of GDP;
- health expenditure as a share of total public expenditure increased in the beginning of the decade, but seems to have peaked in FY2001/02 (in the wake of the adoption of the first PRSP); after declining in 2002/03 and 2003/04, it went up again in 2004/05, under intense donor pressure, to 10% of total expenditure; although this is better than the allocation of five years ago, this is still far below the mark of the commitment made in the Abuja Declaration [30] – which was to dedicate at least 15% of government resources to improving the health sector.

The "side agreement" signed by government and basket fund donors on the occasion of the JAR 2005 calls for "the share of the public budget going for health, excluding the financing of the HIV/AIDS Care and Treatment Plan", to be "at least restored to the level of FY02 (i.e. 11% excluding CFS)" by FY 2005/06 (MoH 2005, Annex 7). We were not able to check whether this condition has been met, since it was not possible to obtain comprehensive health sector budget information for FY 2005/06 in a format that would allow such calculation (or any comparison with the figures of previous years).

4.3.2. EXTRA-BUDGETARY DOMESTIC RESOURCES

In order to gradually reduce the health sector's dependency on external funding, and to improve budget sustainability while allowing for the provision of quality services, the health sector strategy relies on the introduction of three mechanisms that, over time, should help cover an increasing part of health expenditures on the basis of non-budgetary, domestic resources:

[28] Health expenditure / total GoT budget excluding Consolidated Fund Services (CFS, i.e. excluding debt and interest payments). This makes the figures representative of healthcare spending as a share of the 'discretionary budget' within which government has room to define its spending priorities (HSPER 2005:5).
[29] Muti-sectoral financing for TACAIDS in not included in the table's figures.
[30] Declaration adopted by African leaders (heads of State and Government of member countries of the Organisation for African Unity) during a summit on HIV/AIDS, tuberculosis and other infectious diseases held in Abuja on 24-27 April 2001.

- *user fees*: [31]

  The charging of user fees in public hospitals was introduced in 1993, and later at lower level public facilities (notably in rural districts, as from 1998, alongside the introduction of the Community Health Fund). The bulk of services at public facilities remains financed by the government and donors, but the additional income generated by user charges is retained locally and supplements the resources local government dedicates to healthcare (Joint Statement 2005). Two problems exist in relation to user fees:

  - the amounts collected are below expectation and, although they can significantly add to local government resources, user fees make a very small contribution to overall health sector resources;
  - the system poses a problem of equity, to the extent that it restricts or prevents access by the poor, who are supposed to be exempted but often are not.

- *Community Health Fund (CHF)*:

  This is a pre-payment scheme complementary to user fees, by which households in a rural community pay an annual membership fee in order to constitute a fund, the use of which is then determined by those who contributed. CHF members can obtain free access to some facilities, drugs or services financed by the fund – whereas those households that opt out have to pay fees for the same services. The system is also supposed to include a fee waiver system for those unable to afford nor pre-payment nor scheduled fees, but it is not working well either. Government or donors provide a "matching grant" which doubles the amount collected by a CHF. The system started in 1995 on a pilot basis, and is now supposed to be expanded nationwide (WB 2003). However, progress has been very slow, and membership remains low.

- *National Health Insurance Fund (NHIF)*:

  The establishment of a health insurance system for civil servants and their families was enacted in 1999, and payments into the fund started in 2000. The law was amended in December 2002 to extend coverage to local government employees and other parastatals. The system works on the basis of accreditation of health facilities and pharmacies – including some private ones (WB 2003:66). NHIF's membership is growing but "is still limited to about 250,000 people (about 1 million people including dependents)" (HERA 2005:22). Note that the NHIF's service package includes more services than those defined in the national Essential Health Package (HSPER 2005:15).

4.3.3. EXTERNAL FINANCING

Description / Fiscal Year	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 (budget)
Total donor exp. on health (bn TZS)	**70.64**	**98.24**	**119.76**	**119.16**	**142.31**	**250.62**
Total donor exp. on health (mn USD)	**95.46**	**125.09**	**128.22**	**119.04**	**132.01**	**234.01**
Off-budget donor expenditure as a % of total donor exp.	**85.0%**	**76.3%**	**66.3%**	**49.6%**	**58.2%**	**53.0%**
Donor contribution to total on-budget health exp. (%)	**14.9%**	**22.5%**	**28.6%**	**34.1%**	**27.0%**	**37.6%**

[31] '*Cost sharing*' is also used, to represent both user fees and contributions to the CHF. The cost-sharing scheme at hospital level is know as the Health Service Fund (HSF).

Description / Fiscal Year	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 (budget)
Donor contribution to recurrent on-budget health exp. (bn TZS)	1.36	10.63	21.57	32.27	19.18	53.22
Donor contribution to recurrent on-budget health exp. (%)	2.3%	12.4%	18.4%	22.5%	11.1%	22.1%
Donor contribution to on-budget capital health exp. (bn TZS)	9.24	12.61	18.82	27.78	40.34	64.54
Donor contribution to on-budget capital health exp. (%)	76.8%	71.1%	78.9%	83.6%	86.2%	89.9%

(Source: Health Sector PER updates FY04 and FY05)

The table shows total donor expenditure earmarked for the health sector [32] is overall increasing – although if accounted for in USD, it dipped in FY 2002/03; FY 2004/05 was in any case marked by a spectacular increase in external resources allocated to the sector.

Secondly, the share of *"off-budget" donor financing, i.e. the share of aid that is not disbursed through the national exchequer system but through donor-specific mechanisms,* although lower than the 60-65% that prevailed in the beginning of the decade, *seems to be "plateauing" at 50-55% of total external financing for the sector.*

In fact, these figures capture only sector-specific external funding – in other words, the share of sector financing that indirectly comes from general budget support is assimilated to domestic financing. On-budget donor expenditure consists primarily of contributions to the basket fund (i.e. sector budget support) plus on-budget infrastructure projects; most of the rest is off budget. The fact that some donors have started shifting some or all of their sector budget support to general budget support may partly explain the fact that off-budget health financing does not appear to decrease in relative importance: it may actually show a relative decrease if contributions to PRBS "reinjected" in the health sector were taken into account. Still, *off-budget donor expenditure remains considerable and keeps growing in value.*

Figures show that *health spending remains very dependent on external resources, which consistently represent over 50% of total resources* (with the exception of FY 2003/04, in which external funding "dropped" to 45.9% as a result of DFID moving from sector to general budget support).

Finally, it is noteworthy that external financing still accounts for a much larger share of capital expenditure (85-90% of on-budget investment in recent years) than of recurrent expenditure (10-20% in recent years) – even though the SWAp and more specifically the basket fund have allowed a significant increase in donors' contribution to recurrent expenditure. Again, donors' real contribution to the financing of recurrent expenditures would be higher than appears in the above table if indirect financing (through PRBS) were taken into account.

4.3.4. PRIVATE FINANCING

So far we have looked into public health financing and the resources accounted for in the MTEF. In fact, a significant share of total health expenditure is financed by private sources.

[32] The share of general budget support that indirectly finances the sector is not shown here, since it would be difficult to establish it objectively.

We have not come across recent data – but a study conducted on the basis of the 1999/00 National Health Accounts [33] established that household expenditure accounted for nearly half of total national health expenditure; if the contributions of NGOs and firms are added, private expenditures amount to over half of total expenditure.

4.4. Donor support to health sector financing: modalities

4.4.1. DONOR-FUNDED PROJECTS

The project instrument, which makes the bulk of "off-budget" external financing, is less important than it used to be but has not disappeared. What has changed for the better is that a significant proportion of projects, although still managed using donor-specific procedures, are now integrated in the health sector programme, and appear in the sector's MTEF.

Interviews revealed that even those development partners that have a marked preference for budget support keep financing a limited number of projects. They believe there is a justification for supporting:

- *innovative projects*, that allow testing new ways of doing things on a pilot basis (with a perspective of national deployment at a later stage if a project is successful) *(projects as a "leverage mechanism")*;
- *district-level and community-based projects*, that allow donors to stay in touch with reality in the field and to measure the actual effects of sector reforms – and thus to pursue a more relevant policy dialogue *(projects as a "periscope" into the sector)*;
- projects that *strengthen capacities* where they are weak, or keep donors directly involved in areas where, without an external presence, corruption and related problems could easily occur (e.g. the distribution of drug supplies);
- projects that *support areas or tackle issues a donor believes are a little bit neglected* in the HSSP (even though this "clashes" with ownership and prioritisation principles).

4.4.2. THE HEALTH SECTOR BASKET FUND (HSBF)

4.4.2.1. HSBF COMPONENTS

Although this report generally refers to "the HSBF" or "the basket fund", the HSBF actually consists of *two baskets*, which finance respectively:

- central MoH recurrent expenditures ('*central basket*'), as planned in the sector programme and the MTEF;
- local government expenditures ('*district basket*'), through district grants that can be spent by district councils on "*non-personnel recurrent expenditures*" made in the context of district health plans. In fact, by initially just adding 0.5 USD/capita/year to the resources made available by government, these grants helped double the amount of non-personnel recurrent budget available for district health services – which in turn prompted government to increase its own allocation of funds to district-managed services. [34]

[33] Unfortunately, we were not able to find the exact references of this study.
[34] As a result, the part of external aid dedicated to the 'district basket' is considered to be truly additional.

Without this contribution from the HSBF, some consider the decentralisation of primary healthcare would not have been possible.

The baskets are managed, respectively, by the MoH and PORALG. [35]

4.4.2.2. HSBF DEVELOPMENT

The HSBF was set up at the initiative of a small group of donors in 1999, very soon after a decision was made to adopt a SWAp. The process of developing this joint financing mechanism was "intensive, time consuming but rewarding". Among the frustrations related to this process was the fact that "MoH has felt under pressure to complete the process of system development faster than it would like". There were concerns about the "the speed at which donor money became available once the system had been agreed", and the first, late disbursements (both from the basket fund and from government budget) led to delays in the implementation of the Plan of Action 1999-2000 (Brown 2000:15). There was also an initial problem of under-spending (WB 2003). Nevertheless, *these "teething problems" have to a large extent been overcome*: disbursement delays persist, but to a lesser extent, and under-spending is no longer an issue. As a result, none of our interlocutors mentioned these issues as a noteworthy feature of the SWAp.[36]

The initial contributors were: DANIDA, DCI, GTZ, the Netherlands, SDC, and the UK; they were soon joined by NORAD and (to a lesser extent than now) the World Bank. One could have expected the number of contributors to increase over time, as both the SWAp and the basket fund are generally considered successful mechanisms. However, this has not happened: *two of the initial contributors have now withdrawn* [37], and *out of twenty-three DPG partners, only seven currently contribute to the HSBF*: DANIDA, DCI, GTZ, the Netherlands, SDC, UNFPA, and the World Bank (IDA).

In fact, the HSBF, rather than remaining an intermediate device preparing the ground for sector budget support (as was initially intended), has become *the* mechanism by which the bulk of sector budget support is delivered. The central basket fund is not earmarked for any specific purposes: it is just used as a complement to government financing. Grants from the district basket fund are restricted for some uses (they can only be used to support "non-personnel recurrent charges") but, in practice, fungibility ensures that they contribute to overall district health financing.

Various reasons are invoked by those development partners that do not contribute:

- some agencies are barred by their regulations from providing budget support or mixing their funds with others; the most extreme case is USAID; [38] JICA does not provide funding, only technical assistance and technical cooperation; UN agencies also used to

[35] As from 2004/05, the HSBF also supports PORALG's Rehabilitation Fund, used to rehabilitate primary healthcare facilities at district level, with a priority for poor districts. As from FY 2005/06, the basket fund also provides small amounts to PORALG and RHMTs, to support monitoring activities (MoH 2005:15).

[36] Whereas delays in basket fund disbursements to central government are no longer a problem, general delays in disbursements (of government as well as basket funds) are still experienced by district councils; further delays can occur between district councils and district medical officers (HERA 2003:28).

[37] DFID as it switched to general budget support; NORAD as it refocused its priorities to HIV/AIDS.

[38] The agency feels that accountability to Congress prevents them from both mixing their funds with others' and counting on joint monitoring and evaluation procedures. Furthermore, USAID's funds are to a large extent tied to global supplies and TA contracts concluded by their HQs – which is an obstacle to the pooling of funds.

have restrictions on the pooling of funds, but these seem to have been at least partly eased, since UNFPA is now contributing to the basket fund;

- small donors are afraid of not making any difference if they provide budget support; Belgium, for instance, is only a very minor donor to the health sector – so it believes it would have practically no weight either in the SWAp Committee or in the DPG Health, and prefers to finance small projects in selected areas;
- some development partners may still refrain from pooling their funds with others for attribution and visibility reasons;
- DFID used to make significant contributions to the basket fund, but has now shifted to general support in accordance with new agency-wide policies.

4.4.2.3. OVERVIEW OF MANAGEMENT ARRANGEMENTS

Management arrangements for the basket fund are formally presented in a *Memorandum of Understanding* (MoU), which was updated in 2003 when the World Bank joined the mechanism. *Side agreements* are signed every year to capture each donor's annual commitment of funds. Detailed financial procedures are presented in an accounting manual.

The basket fund runs under government procedures (for contracting, disbursement, reporting and auditing) – although some concessions had to be made as far as procurement procedures are concerned, so as to make the World Bank's contribution possible. [39] Development partners' contributions are transferred to a holding account opened by the MoF in the Bank of Tanzania through the government's exchequer system (WB 2003:9). Accounting systems and internal control procedures are those of the MoF and PORALG (for, respectively, the central and the district basket fund) – and are deemed appropriate even by demanding donors such as the World Bank. The government's *Platinum/Epicor* information management system is used to track expenditures and produce reports in the MoH; a "mixture of computerized and manual systems" are used in PORALG, while computerisation is under way (WB 2003:42). Auditing of the HSBF is performed by private audit firms, following government procedures.

A Basket Financing Committee (BFC) including representatives of government (MoH, PORALG, MoF), participating donors as well as a WHO representative, was set up for overseeing the management and use of joint funds. The Committee meets on a quarterly basis.

The BFC has so far got involved in management in quite a detailed manner. The initially designed procedures were very heavy, in particular as far as *district grants* are concerned: the BFC was supposed to approve transfers to councils district by district, based on a review and approval of individual district plans and district quarterly and annual reports. [40] Detailed supervision requirements were probably justified in the first one or two years of operation, even if they made the BFC look very much like a "project monitoring system" (Brown 2000:17-18); they have now been somewhat relaxed.

[39] Large contracts are governed by WB procurement rules and subject to prior review by the Bank. The Bank performs a general audit of health sector procurement on a yearly basis.

[40] In practice, this rule has never been fully enforced: reviewing district plans and reports for conformity with national standards and regulations was left to regional medical officers, regional secretariats and to civil servants in central administration (PORALG in collaboration the MoH), and the BFC followed their recommendations. Since the beginning of this year, it has been admitted that only sample checks are performed at central level.

Generally speaking, a lot of rigidities were built into the basket funding mechanism which made sense initially (to ensure donor-provided funds would not be misused), *but now prevent the fund's necessary evolution.* They are notably deemed to prevent a sensible reallocation of the fund's resources over time – between the central level and districts, on the one hand, and between staff and non-staff spending, on the other hand.

4.4.2.4. HSBF FINANCING

Here are the contributions made through the basket fund:

Description / Fiscal year	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
Total contributions (bn TZS)			29.15	37.11	26.05	70.93	50.36
Contribution to total public health budget	7.3%	13.9%	18.2%	19.0%	11.8%	22.7%	
Contribution to recurrent health spending	9.7%	17.9%	18.4%	22.5%	11.1%	22.1%	

(Sources: Health Sector PER updates FY04 and FY05; FY 2005/06: MoH 2005, Annex 7)

The importance of the basket fund to sector financing decreased considerably in FY 2003/04, following DFID's withdrawal in favour of general budget support; it increased again in FY 2004/05, with a new significant contribution from the World Bank – which however will be phased out by the end of the current fiscal year (see next section).

4.4.2.5. THE FUTURE OF THE BASKET FUND

Two years ago, DFID created a stir by announcing it would discontinue its contribution to the basket fund (16 million GBP per year) *and replace it with general budget support*. This move is not sector- or country-specific: it reflects DFID's general policies. At the same time, DFID negotiated with the MoF to ensure that a good chunk of their GBS would be allocated to the health sector. This happened, but only to some extent: the *overall health sector allocation turned out to increase less than expected* [41] - which resulted in frustration within the MoH, and a marked loss of influence of the UK in the health sector dialogue.

Among donors convinced of the opportunity of moving towards GBS is the Netherlands. Dutch official policy is to withdraw from sector-specific financing in favour of GBS. Nevertheless, the Embassy of the Netherlands in Tanzania has obtained to continue financing the HSBF for another four years, on the grounds that sector-specific support remains useful in the current context.

The World Bank is another big contributor to the HSBF which plans to move to GBS in future - while recognising that "strong sectoral programmes", which build up confidence and develop sectoral capacities, "are a precedent to using this approach". [42] Under the Second Phase of the Health Sector Development Project (2004-2007), the Bank supported the HSBF with 9 million USD in FY 2003/04, 30 million USD in FY 2004/05 and 20 million USD in FY 2005/06 (MoH 2005: Annex 7, WB 2003).

[41] The health budget for FY 2003/04 was 220.40 billion TZS, against 195.40 billion TZS budgeted for FY 2002/03 (less was actually spent). This 12.8% increase was less than, for instance, the 22% increase of the previous year.

[42] The strategic framework for the World Bank's assistance to Africa plans to ultimately move to PRSCs, i.e. general budget support, in health and education (WB 2003:8).

In future, at the government's request and if everything goes according to plan, the Bank will shift its support to the health sector to adjustment lending, by means of a non-sector-specific Poverty Reduction Support Credit. (The Bank would nevertheless remain involved in sector policy dialogue, capacity building and monitoring of the sector.) *A condition for this shift is that the gradual withdrawal of the Bank from HSBF financing is compensated by increases in government budget allocations to the health sector.* Specifically, by 2007, the government's health budget (including allocations to the NHIF) is expected to have raised to the equivalent of 9 USD/capita (WB 2003).

The future of the basket fund in the medium term is thus uncertain. The money pledged so far [43] amounts to approx. 27 million USD for FY 2006/07 and 24 million USD for FY 2007/08 (MoH 2005: Annex 7) – i.e. approx. half the amount provided in FY 2005/06. *Unless new donors decide to join (maybe by converting some project financing into sector budget support), the basket fund's importance for sector financing is likely to decline gradually.*

4.4.3. "HYBRID" FORMS OF ASSISTANCE AND TARGETED BUDGET SUPPORT

A number of donor initiatives are "hybrids" between project support and budget support – in the sense that contributions are made to very specific programmes or activities, under agreed conditions – but once the conditions have been agreed, donors transfer part or most of their contribution [44] to a *programme-specific bank account*, from which the money is disbursed according to government procedures. It is thus closely associated with targeted budget support – a modality that is actively promoted by government as a way of channelling additional donor resources through the exchequer system (ESRF 2005:49).

4.4.4. TECHNICAL ASSISTANCE AND TECHNICAL COOPERATION

A distinction should be made between the two modalities. *Technical cooperation* (TC) can defined as the use of (usually long-term) experts to work alongside local people in projects, and learn together, out of experience in the field, how to do things in a specific environment; *technical assistance*, on the other hand, can be defined as the use of (usually short-term) experts to perform, based on their experience, tasks that local people are deemed unable to perform, or for which not enough skilled local people are available. [45]

Technical assistance remains a popular aid modality with some donors – and one that is contested by the IMG as "continuing to be supply-driven", characterised by "tied procurement", and contributing little to capacity building. "The matter is worsened by the absence of government policy on TA" (ESRF 2005:8). The exact amounts of aid spent through these modalities are hard to estimate, as they are not necessarily reported comprehensively to the MoF. This is the case, in particular, with TA for Tanzania that is contracted by development agency headquarters, rather than their local representative office (ESRF 2005:50).

[43] Subject to the renewal of SDC's support beyond FY 2005/06.
[44] The overall contribution also frequently includes technical assistance and technical cooperation, and donors may retain their own procedures to finance specific operations, such as large procurement – hence our use of the term "hybrid". If money is just provided to the budget, but for a very specific purpose or programme, the instrument is targeted budget support.
[45] Thanks to Dr. Bergis-Ehry Schmidt for attracting our attention to this important distinction.

4.4.5. SUPPORT FOR NGOS

Many DPG members also support the work of some NGOs active in the health sector – in the form of grants for their activities and/or their institutional strengthening, and sometimes in the form of "joint advocacy" (by taking up and backing some of the topics promoted by NGOs in official discussion forums). It seems however that aid provided to the health sector in the form of NGO grants is not systematically accounted for in the MTEF.

It also appears that with the advent of the SWAp, as much more donor funding is spent in the form of budget support, funding available for NGOs has declined markedly. We were told that large international NGOs and those led by experienced, internationally connected people are still doing fine – but small, local NGOs are suffering.

4.4.6. SUPPORT FOR MULTILATERAL ORGANISATIONS AND INITIATIVES

Many bilateral DPG Health members, in addition to the direct support they provide for the sector, make financial and sometimes technical contributions to the work of multilateral organisations (such as UNAIDS, UNFPA, …) and multilateral initiatives (such as the GFATM). Some of these contributions indirectly finance health projects and activities in Tanzania.

PART II: ANALYSIS

5. "Breadth and depth" of the Health SWAp

In its "Guidelines for European Commission Support to Sector Programmes", the Commission identifies six "typical components" of a sector programme – the sector programme itself resulting from the adoption of a sector-wide approach. [46] These components are the following:

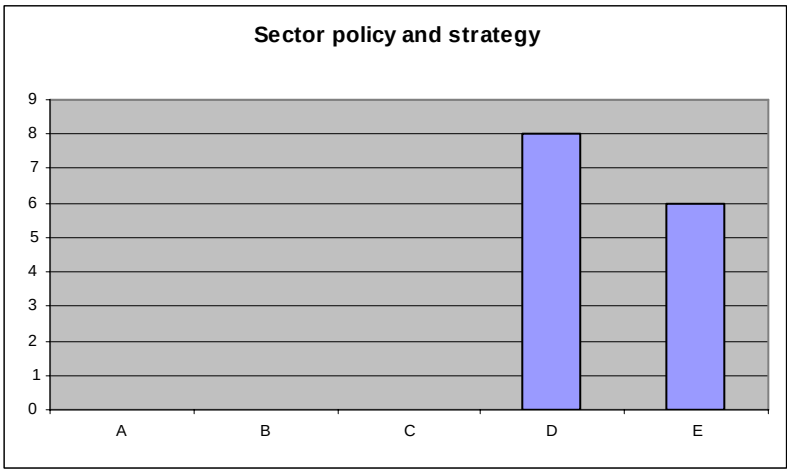
- "a clear policy and strategy […];
- a sectoral medium term expenditure programme, based on a comprehensive action plan, to clarify what is the expected level of available internal and external resources and how these resources will be utilised in pursuit of the policy;
- a performance monitoring system to measure progress towards the achievement of objectives and targeted results […];
- a formalised process of donor coordination;
- an agreed process for moving towards harmonised systems for reporting, budgeting, financial management and procurement;
- and a systematic mechanism of consultation with clients and beneficiaries of government services and with non-government providers of those services" (EC 2003:15).

We use an assessment of these six components to analyse the "breadth and depth" [47] of the Tanzanian Health SWAp. Each section starts with the results of our survey, followed by comments and information allowing to interpret them.

[46] Other authors consider the first five of these components as constitutive of the SWAp itself. See for instance Foster (2000) and Walford (2003).

[47] The notion of "breadth and depth" is borrowed from Walford (2003). She defines "breadth" as the existence of all constitutive elements of a SWAp, and "depth" as the degree of effectiveness in the implementation of these elements.

5.1. Sector policy and strategy



Number of respondents: 14

Possible replies:

A : There are informal discussions on sector policy and strategy
B : There are formal discussions on sector policy and strategy
C: There is a sector policy and strategy document
D: There is a sector policy and strategy document – which is accepted by all significant donors to the sector
E: Same as D + there are no longer pressures from development partners to impose their vision on sector policy and strategy

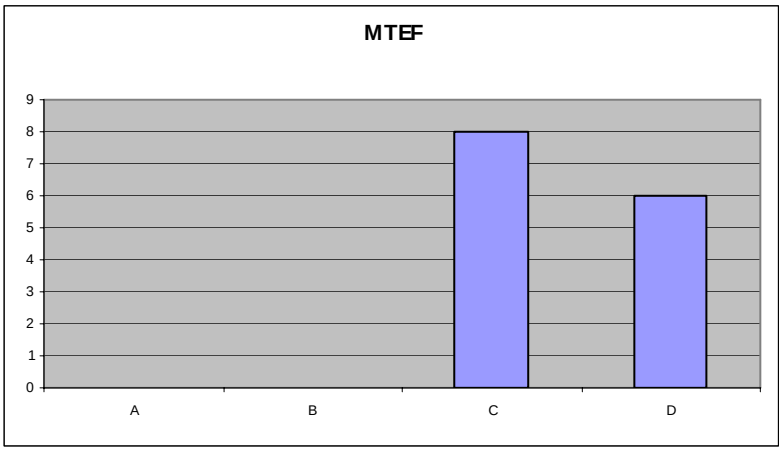
The replies are not mutually exclusive - of course, some formal and informal discussions are still taking place even though there is an agreed sector policy and strategy - notably as a result of new challenges, new information, changing external circumstances. In case of multiple answers, we retained the one reflecting the "highest" level of achievement.

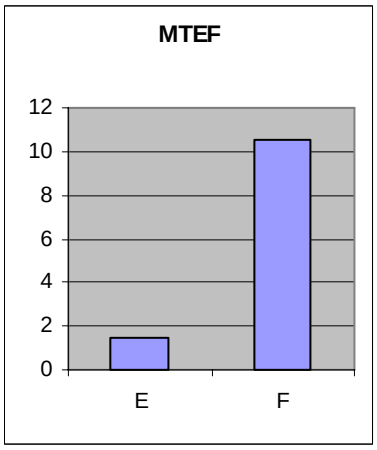
A short overview of the documents founding the sector policy is provided in section 3.4.

Sector policy and strategy are well accepted by all significant donors to the sector. Of course, policy and strategy are still the subject of formal and informal discussions, because they cannot be set in stone and have to evolve with new challenges facing the sector. But several respondents go to the point of declaring that "there are no longer pressures from development partners to impose their vision on sector policy and strategy"… which might be a bit optimistic, but testifies to the high level of maturity of the SWAp on this count.

One exception to this overall positive picture is that official sector policy and strategy tend to be ignored or challenged by new players in the field, namely unintegrated global initiatives such as those related to HIV/AIDS and immunisation.

5.2. The Health sector MTEF





Number of respondents: 14 (12 for the sub-question)

Possible replies:

A: There is no MTEF for the Health sector
B: There is a MTEF covering only expenditures financed by domestic resources
C: There is a MTEF covering expenditures financed by domestic resources as well as some external resources
D: There is a MTEF covering exp. financed by domestic resources as well as all (or at least all significant) external resources

E: The existing MTEF is not very realistic; actual sector exp. tend to be quite different from those planned in the MTEF
F: The existing MTEF is realistic; actual sector expenditures tend to be close to those planned in the MTEF

In case of split answer between C and D ("most" external resources): 0.5 was point attributed to each. In case of split answer between E and F ("realistic for year 1, much less so for years 2-3"): 0.5 point attributed to each.

A short introduction to the health sector's MTEF is provided in section 4.1.

Respondents to our survey were shared as to whether the MTEF covers expenditures financed by "some" or "all (or at least all significant)" external resources. This is easily explained by the fact that although most donors to the sector are getting better at reporting their off-budget contributions, some of them still "escape" declaration. More significantly, potentially considerable amounts from international vertical programmes are not included, either because they have not yet made any effort at integrating with the MTEF process, or because even if they have, there are huge uncertainties as to the amounts and timing of disbursements.

Also, the MTEF does not include funds provided to the sector by NGOs/FBOs (unless they originate from donors who report them) and by private sector companies. The MoH would be interested in having a more systematic overview of activities and contributions by such organisations (including, possibly, in-kind contributions), but the question of how to organise reporting has not been resolved. Overall however, the proportion of external funds not accounted for in the MTEF is deemed to have significantly decreased over recent years, and

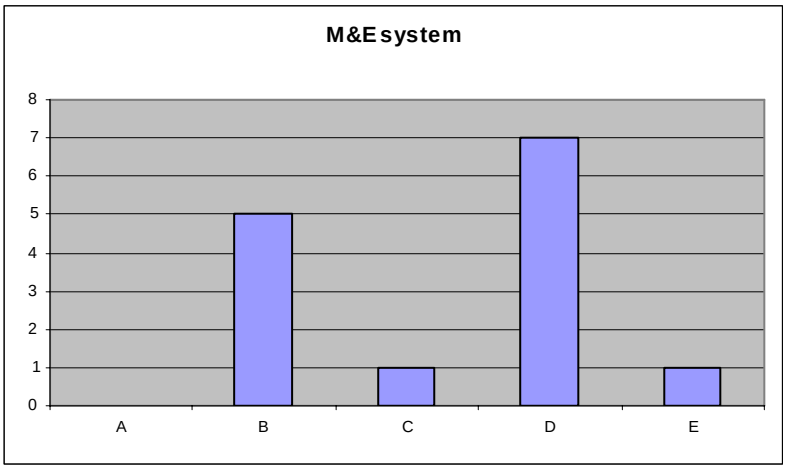
the document can be considered rather comprehensive. This has much to do with the creation by the MoF, in FY 2001/02, of a database of donor-funded projects, which is updated annually on the basis of a questionnaire sent by the MoF to all donors. [48]

The MTEF can be considered reliable in the sense that it provides a realistic picture of actual sector expenditures – but this reliability is of course much higher for the first year in the planning horizon than for the next two. This has to do with the fact that once voted into the budget, estimated expenditures for "year 1" in the rolling plan are not easily re-allocated – whereas forecasts for years 2 and 3 are both less detailed and subject to revision in the next exercise.

Another aspect in the quality of a MTEF is the prioritisation of expenditures. Some of our interlocutors estimate that although progress has been made, the practice of "incremental budgeting" has not disappeared (but has it anywhere?), and the allocation of public health expenditures is still not enough prioritised in view of achieving the sector's objectives.

[48] Some development partner funds still tend to escape inclusion in the MTEF: resources spent on cross-sectoral issues (and therefore not easy attributable to one specific sector); technical assistance (in particular the TA that is contracted by headquarters rather than local representation offices); and some in-kind aid flows.

5.3. The sector performance monitoring system



Number of respondents: 14

Possible replies:

A: There is no national sector performance monitoring & evaluation system
B: There is a national sector performance M&E system, but it is not very reliable, so donors tend to conduct their own, separate M&E
C: There is a reliable national sector performance M&E system – however most donors still conduct their own, separate M&E
D: There is a reliable national sector performance M&E system, which has been adopted by most donors
E: All significant donors to the sector use the national sector performance M&E system, and only this system

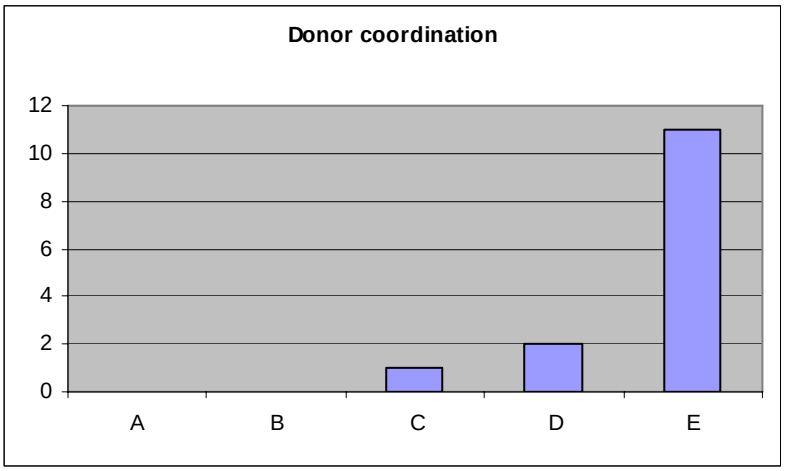
If B and D were chosen simultaneously ("adopted by most donors" but "not reliable"), D was retained.

Overall, monitoring and evaluation (M&E) remains a rather weak component of the health sector programme, as the framework in which data are collected and indicators are being followed still has to be unified (see section 3.5). Historical reasons are invoked.[49] A couple of our interlocutors believe that government, called to act on so many other emergencies, tends to give less priority than most donors to sector performance monitoring – so that the issue has not been very high on the agenda. Still, for a few years, the MoH has been *working on the development of a reliable, comprehensive HMIS* that should ultimately address these weaknesses. Some of our interlocutors believe the process could be accelerated if the sector programme gave it higher priority (and thus, if more financial resources were dedicated to it). What is remarkable is that *in spite of the system's weaknesses, most donors have adopted it, and generally support the gradual development of a reliable national system rather than conducting their own M&E operations*.[50]

[49] Since the health sector was very much ahead of other reform programmes, it adopted an initial set of performance indicators in the context of the SWAp before the PRSP and the decentralisation process were finalised; both these processes determined other indicators to be followed, and the whole framework had to be adjusted.

[50] The reason why five respondents considered that "donors tend to conduct their own, separate M&E" has much to do with the fact that the project instrument remains widely used by some.

5.4. A government-led coordination mechanism



Number of respondents: 14

Possible replies:

A : There is no donor coordination process
B: Donors coordinate their activities by means of informal meetings
C: Donors coordinate their activities by means of formal meetings, without the MoH
D: Donors and MoH coordinate by means of formal meetings, with leadership provided by one donor/group of donors
E: Donors and the MoH coordinate by means of formal meetings, with leadership clearly provided by the MoH

In case of multiple answers, only the score reflecting the "highest" level of achievement was retained. Donor-donor coordination coexists with MoH-donor coordination.

Tanzania's Health SWAp is characterised by a rather complex coordination mechanism, which was described in section 3.3.2.

All significant donors to the health sector now officially support the SWAp and its coordination process. Inevitably, in practice, some are viewed to be more supportive than others. Those who contribute to the basket fund, and bilateral donors in general, tend to be considered the most supportive. Among bilateral donors, JICA and USAID are often singled out (in spite of their claims to the contrary, in particular as far as JICA is concerned) as less keen than others on aligning their activities with the sector programme. USAID [51] was described by one respondent as "constructively participating in sector policy dialogue", but

[51] Note that USAID is part of the DPG HIV/AIDS but not of the DPG Health, except for participation in a sub-group dedicated to reproductive health. They work closely with two "parallel" donor groups that are not directly associated with the DPG Health (but "feed information" to it once they have reached internal agreement):
- the child survival partnership group (with UNICEF, the WHO, the World Bank, …);
- the contraceptives security group (notably with the WHO).
The setting up of these "extra-SWAp" forums may be no stranger to the perception that USAID and UN agencies in general are not very dedicated to joint coordination mechanisms under the SWAp.

otherwise operating strictly according to its own logic and procedures. [52] The perception that the United States operates on its own is reinforced by the fact that new initiatives from the USA (PEPFAR, Clinton Foundation, Gates Foundation, …) are not coordinated with the SWAp, and are viewed to undermine the process.

According to several of our interlocutors, the least keen on coordination and harmonisation of all are UN agencies (with the exception of UNFPA, which now contributes to the basket fund). The WHO, in particular, although providing the secretariat for the DPG Health, is perceived as very reluctant to coordinate its activities with others and fit them within the sector programme. (Needless to say, this is not how the WHO representatives we interviewed perceive the situation.) International vertical initiatives also tend to "boycott" the coordination mechanism (see further).

As far as leadership is concerned, there is a near-unanimous recognition that *the MoH (jointly with PORALG, where appropriate) is exercising real leadership in the health sector coordination process, conducting it firmly and competently*. This leadership is apparent in all SWAp-related activities, including SWAp Committee and Basket Financing Committee meetings, the PER process, MTEF preparation, and the Joint Annual Review.

The few who think otherwise refer to the dominant role of the donor-donor coordination process: the fact that *donors coordinate their positions without the presence of government* is indeed an outstanding feature of the Tanzanian context, which entails risks in terms of government leadership. Some observers believe that the donor-donor coordination mechanisms may have been over-developed in comparison with donor-government mechanisms (OECD 2003b:39). However, most of the people we met do not see it as a problem.[53]

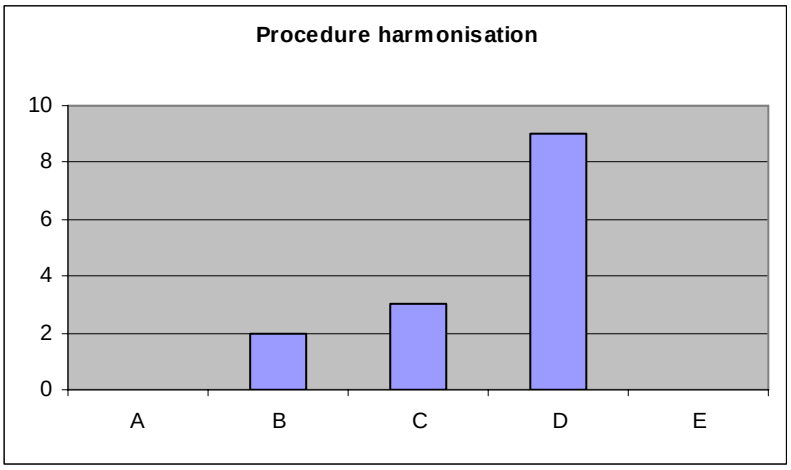
A second reservation is that *government leadership and the coordination process have been put under considerable strain by the arrival of a few international vertical initiatives*, including GAVI, the GFATM, the Clinton Foundation, PEPFAR and the WHO's "3 by 5" [54] (see section 7.4. for further information).

[52] USAID does not actually believe in SWAps, and describes them as "totally ineffective". The agency prefers a project-based approach, considering that in order to be effective, one has to narrow down the focus of activities to very concrete issues, and deliver on them.

[53] Economic literature supports the view that inter-donor cooperation and coordination is beneficial, both when donors pursue different objectives (Murshed & Sen 1995, quoted by Paul 2005) and when they pursue similar priorities (Halonen-Akatwijuka 2004, quoted by Paul 2005).

[54] Three million people under ARV therapy by 2005. Interestingly, the latest UNAIDS/WHO "AIDS epidemic update" carefully avoids mentioning this initiative, probably in recognition that the target was over-ambitious (The Economist 2005).

5.5. The procedure harmonisation process



Number of respondents: 14

Possible replies:

A: There is currently no procedure harmonisation in the management and disbursement of donor funding
B: Some donors use a common set of procedures – but these are not government procedures
C: Some donors use government procedures, but most use their own procedures
D: Most donors, including the most significant donors to the sector, use government procedures
E: All donors use government procedures

If reply "between C and D" ("some do, some don't"): 0.5 point was attributed to each.

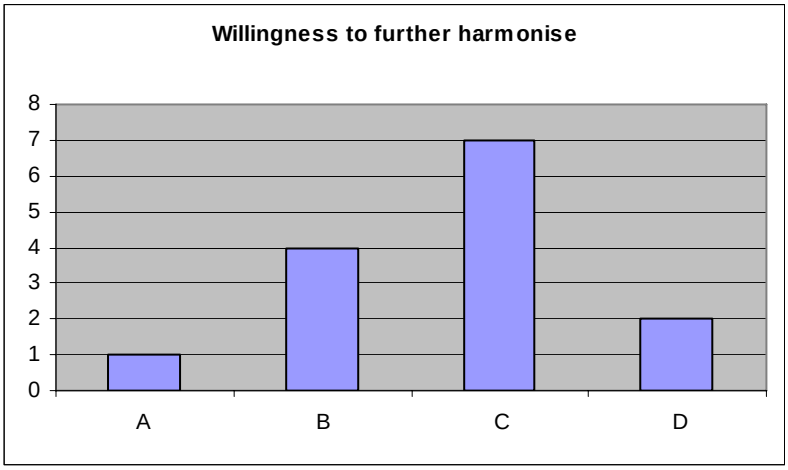
As far as disbursement procedure harmonisation is concerned, most of the efforts undertaken in the context of the SWAp can be attributed to the joint financing mechanism (HSBF): this allowed to establish joint procedures and systems for procurement, disbursement, financial management, auditing, reporting, monitoring and evaluation – all of which rely to a large extent on government procedures (although World Bank procedures apply to large procurement items, a concession that was necessary in order to allow the Bank to contribute to the fund). Financial management and reporting rely entirely on the government's *Platinum* IPFM system, which produces quarterly reports. Monitoring and evaluation is performed jointly by all concerned parties in the framework of the Basket Financing Committee.

At the same time, alignment on government budgetary procedures is not universal, since a significant share of external contributions are still disbursed "off budget". Some aid is disbursed in "hybrid" forms that draw partly on government procedures. Otherwise, development partners continue to apply their own procedures to a more or less sizable share of their contribution, and to perform their own, project-specific monitoring and evaluation in relation to their off-budget activities. At least, the earmarking of funds that persists with projects happens in a more "orderly", coordinated way than before, around a coherent work programme for the sector.

Overall however, *development partners are increasingly relying on common processes*, notably the annual PER (for expenditure analysis and, to some extent, planning), the sector's Joint Annual Review (for overall sector monitoring), and the work performed in the context of

the SWAp Committee and the Technical Sub-Committee (for policy and technical dialogue). The SWAp, together with a willingness among most donors to streamline aid operations and rely more on labour division, has definitely made a positive contribution to harmonisation in these areas.

To conclude this section, here are the results of the question on harmonisation in the second part of our small survey:



Number of respondents: 14

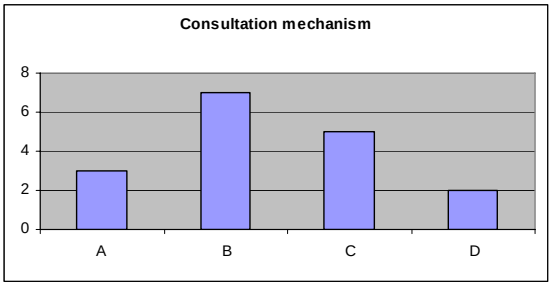
Perception of the statement: "There is a true willingness, among donors, to move further and deeper towards procedure harmonisation"

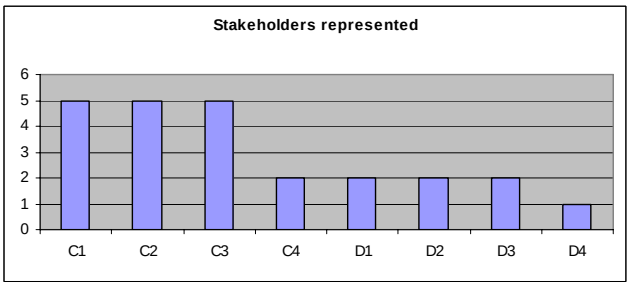
A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

Although some interest in further harmonisation is declared, the scope of this commitment is rather unclear, as "procedure harmonisation" seems to mean different things to different donors; it is also obvious is that some development partners are more committed to it than others. One interviewed person noted that the harmonisation agenda receives a lot of attention at the headquarters level – but is usually not a priority at the technical/operational level. Harmonisation issues, we were told, are now hardly ever discussed in DPG meetings. Some feel that moving towards greater harmonisation can only be achieved via budget support [55], others resist this idea (especially when it comes to general budget support). Finally, many feel that unless strong measures are taken to integrate them with existing coordination mechanisms, the return of large vertical programmes threatens to disintegrate many achievements of the SWAp (see section 7.4 for more details).

[55] One of our interlocutors proposed the following harmonisation agenda : "as a first step, get more project aid converted to sector budget support; as a second step, convert sector budget support into general budget support".

5.6. Consultation mechanisms





Number of respondents: 14

Possible replies:

A: There is no structured health service user and provider consultation mechanism
B: Surveys are occasionally conducted to consult health service users and/or providers
C: There is a structured consultation mechanism
D: There is a structured consultation and decision mechanism

Stakeholders represented in C or D:

C1/D1: civil society
C2/D2: public health service providers
C3/D3: private health service providers
C4/D4: health service users

Multiple replies were admitted. In case of inconsistent replies (A + C): only A was retained. If C and D: only D was retained ("highest" degree of achievement).

In 2000, one observer of the process noted that "*participation in the development of the health reform programme has been limited*. Although there have been efforts to develop internal consensus within the MoH amongst senior staff who are implementing the programme, there has been little consultation beyond this". The September 1999 appraisal mission report stated that "the reform programme is poorly understood outside those in the MoH who have been preparing the reform" (Brown 2000:13-14).

Five years later, things have improved somewhat. PRSP preparation acquainted Tanzania with the concepts of "participatory process" and "stakeholder dialogue". Their adoption by the health sector, although rather slow, has no doubt been facilitated by the SWAp. *Civil society, public sector providers, private sector providers, health service users are all part of nascent consultation mechanisms* (some of them set up in relation to the SWAp, some on the basis of other ongoing reform processes) – but the degree and depth of their involvement varies, and *it seems premature to talk about a "systematic", structured consultation mechanism*.

Representatives of civil society, public and private sector providers have all been given seats in the *Joint Annual Review* – but this large official forum primarily relies on technical work performed earlier "behind the scene", and although it gives a short talking time to all groups of stakeholders, not much actual work can be carried out in the plenary session. Still, *involving these actors in the JAR is a first and positive step towards the establishment of a more structured consultation mechanism*, that could ultimately lead to their increased

participation in health sector planning and management. This, in turn, would make the SWAp more "sector-wide" and help better address cross-sectoral issues.

Note that as far as *service users* are concerned, they are "indirectly" consulted (for instance on their use of and satisfaction with services, or on how much they spend on health) through occasional surveys: PRSP-related consultations, participatory poverty assessments, household expenditure surveys, service delivery surveys, ... On top of these "official" surveys, quite a number of surveys are also conducted by NGOs.

Now that responsibility for primary healthcare has been devolved to district councils, local user and provider consultation mechanisms are in the process of being established, with the creation of Council Health Service Boards and Health Facility Committees. *The development of local consultation and coordination mechanisms involving community representatives and non-governmental service providers is a promising development, which could (if properly managed) lead to increased participation and ownership at the grassroots level.*

5.7. Other features

One frequently analysed dimension of SWAps is whether the *sector definition* retained is wide or narrow, which determines the *scope of the SWAp*. *The Tanzanian Health SWAp started with a narrow definition*. Under-developed areas in the initial sector programme included "multi-sectoral issues, some vertical programme work, and the contribution of NGOs and the private sector. Outcomes at regional and district level are also not reflected in the [Plan of Action], as these are the responsibility of the Ministry of Regional and Local Government [56] […]" (Brown 2000:8).

In general, the SWAp still focuses on activities that are under direct control of the MoH – with one large exception: the decentralisation of primary healthcare to LGAs, under the responsibility of PORALG, *is firmly within the scope of the SWAp*. In this regard, one can say that the SWAp is now in the hands of both the MoH and PORALG – even if the MoH is the ultimate coordinator. Also, some areas originally identified as "underdeveloped" (Brown 2000:8) are more and more closely embraced by the SWAp:

- in the context of HIV/AIDS-related matters in particular, multi-sectoral issues are gradually getting encompassed;
- vertical programmes, although the process is not smooth, are also increasingly getting addressed in the SWAp forums;
- the contribution of NGOs and the private sector was the focal point of this year's sector review.

The SWAp's scope is thus evolving from an initially narrow position to a wider and wider embrace.

[56] Now known as PORALG.

6. "Acquis" [57] and impacts of the SWAp

In this section, we attempt to review the contributions the Health SWAp has made – or, in a few cases, failed to make – to a number of processes, outcomes and impacts that are frequently associated with SWAps. Please note that it is not easy to ascribe any of the health sector's achievements specifically to the adoption of a SWAp – and to retroactively determine which improvements would or would not have happened without it. Other processes are at work in the country (civil service reform, poverty reduction strategy, …) which have a direct impact on the sector's operations, and may or may not have been more successfully integrated by the health sector thanks to the SWAp. For instance, government capacity in terms of health sector financial management has definitely increased – but this change would probably have happened anyway, in the context of general financial reform and PFM improvement in Tanzania.

It is also important to understand that a SWAp can affect evolutions in the sector in two ways:

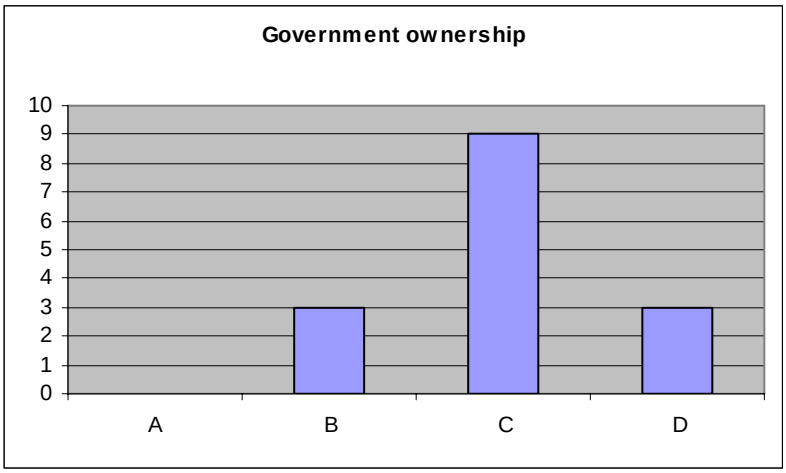
- directly, thanks to the very process of cooperation involved (e.g. improvements in government leadership and ownership, as well as some capacity improvements, may derive directly from the process itself);
- and indirectly, through support for a sector reform programme that itself generates changes (e.g. improvements in areas such as quality of care and HR management do not result from the SWAp process, but may be enhanced if the SWAp leads to the adoption of better sector reforms than would otherwise be the case).

In most cases, there is no way of isolating and "quantifying" the SWAp's specific contribution. We thus simply rely on the subjective perception of interviewed people as to what role the SWAp might have played.

As in the previous chapter, each section starts with the results of our survey, followed by comments and information allowing to interpret them.

[57] What has been acquired, secured – by analogy with the EU's 'acquis communautaire', the body of laws and regulations that result from fifty years of integration, and must be adopted by new Member States.

6.1. Government ownership



Number of respondents: 15

Perception of the statement: "So far, the Health SWAp has allowed to increase government ownership of health policies and strategies":

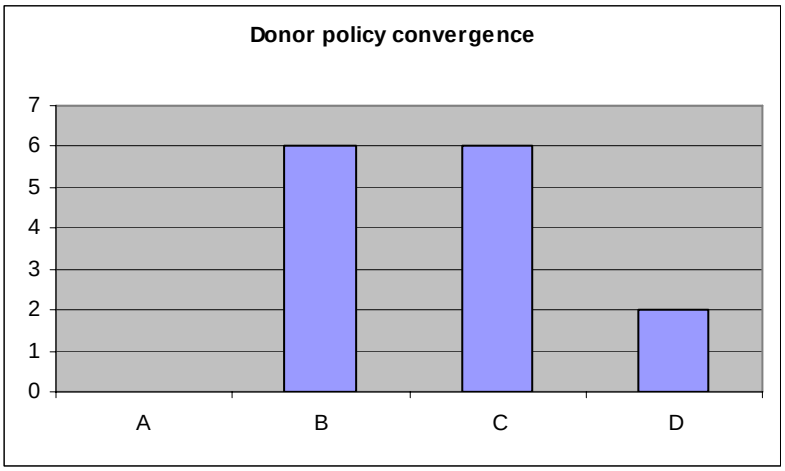
A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

At the time when the basket fund was set up, concerns were raised about potential negative effects in terms of ownership of sector reforms. It was feared that basket fund donors would try to "micro-manage" the health sector, and exercise undue influence over government policies (Hobbs 2001:41-42).

These concerns have now to a large extent been eased: even though donors still provide policy advice through sector dialogue, most of our interlocutors consider that *national authorities firmly own the policy and strategy development process*. This increased ownership could be achieved thanks to a combination of continuing capacity strengthening, increased self-confidence, and the exercise of leadership over the sector dialogue process. Of course, government remains subject to attempts to influence its policies, and is in a difficult position when donors with potentially large amounts of funding try to impose their own policies (as is the case with some international vertical initiatives). Nevertheless, most interviewed people said that government is actually "doing quite well" in maintaining ownership, given the pressures exercised.

Whereas government ownership is by and large not in doubt, the existence of wider social ownership of the health sector reform programme is questionable. The private sector and the population at large have not yet been very much involved in sector dialogue. Even within the public sector, due to very restrictive planning and financing guidelines, "ownership of the council health plan by the local government is still limited" (HERA 2003:18). This situation calls for more structured, more systematic, truly "sector-wide" consultation mechanisms.

6.2. Convergence of donor policies



Number of respondents: 14

Perception of the statement: "So far, the Health SWAp has allowed to stimulate a convergence of donors' policies and strategies for the development of the health sector":

A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

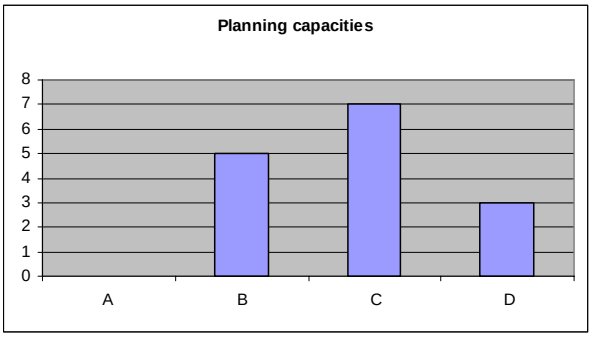
The SWAp process has no doubt favoured a certain convergence of donor policies – a mechanism reinforced by the rather unusual mechanism (not specific to health) of setting up sectoral donor groups that meet without government presence.

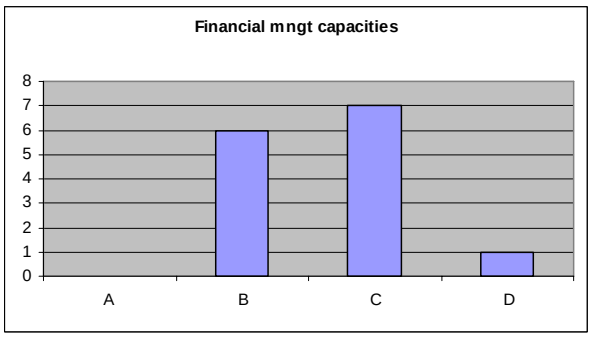
A convergence of donor policies and strategies can be a positive development, reinforcing consistency in policy advice and reducing the fragmentation of approaches to development cooperation. However:

- the convergence of donor policies should not be so strong that it ends up reducing government leadership and ownership of policies;
- a excessive focus on convergence of donor policies may result in a weakening of sector dialogue and the emergence of a form of 'pensée unique'. A SWAp requires a balance between (i) on the one hand, cooperation, coordination, harmonisation, convergence; (ii) on the other hand, the ability for participants to express their views on policies, strategies and objectives (including dissenting views), remain critical – and put pressure on government and development partners to keep improving things. *Some feel that the Health SWAp in Tanzania has reached a point at which the balance is tilting too much on the side of consensus, to the detriment of partners' ability to be critical*.

In any case, if there ever was such a risk, it may be reduced by the fact that *convergence now seems to break up over several issues*: ARV therapy (probably the most contentious issue), but also user fees (the subject of a recent controversy between basket fund donors and some other development partners) and sector financing modalities (SBS via the basket fund vs. GBS).

6.3. Strengthening of national capacities





Number of respondents: 15 to the first question, 14 to the second one.

Perception of the statement: "So far, the Health SWAp has allowed to reinforce government capacities in terms of health sector planning / health sector financial management":

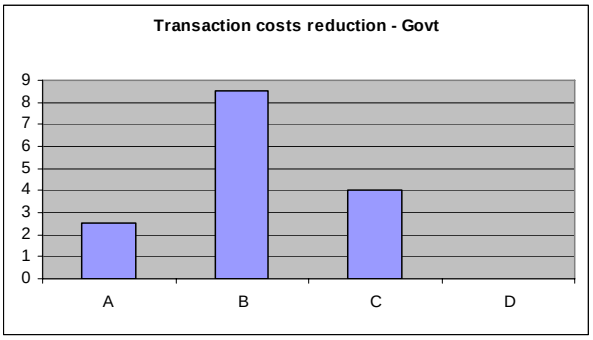
A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

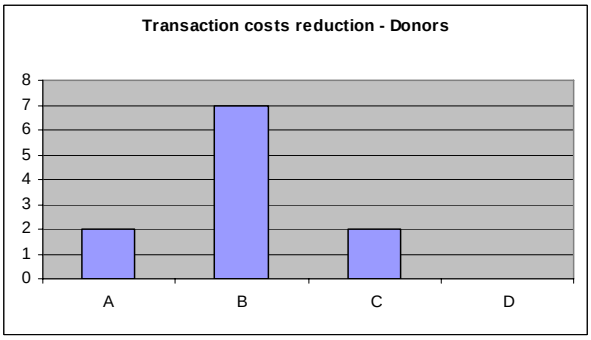
There is general agreement that even if there is still a long way to go in terms of capacity building in the health sector, the SWAp has contributed to *significant improvements in institutional capacities, both in central and in local government*, across a wide range of competences (notably planning, budgeting, financial management, procurement, and general management – while medical skills have not been forgotten).

In fact, *the local capacity strengthening effort started a bit late*. Decentralisation of primary healthcare was launched before local training needs had really been evaluated, and in Phase I of decentralisation at least, the training of CHMTs in relation to their new responsibilities often started after the official transfer of responsibility had already taken place. Guidelines for district planning and budgeting were issued late, and training in their use also occurred later than it should have. *However*, these problems were gradually eased, and *the results from the local capacity development effort are now apparent, although not uniformly across districts*. For instance, audits of district council reports are slowly getting better; the quality of council health plans is generally improving; so is the local supply of drugs and commodities.

All in all, a majority of respondents to our mini-survey believe planning as well as financial management capacities have improved "to a large extent" or even "100%". Those with a more moderate opinion agree that improvements have occurred, but point out to the length of the road still ahead – in particular as far as local government authorities are concerned.

6.4. Transaction costs





Number of respondents: 15 to the first question, 11 to the second one.

Perception of the statement: "So far, the Health SWAp has allowed to reduce aid management costs from the government's perspective / from the donors' perspective":

A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

Let us first of all define what exactly we intend by "transaction costs". The European Commission proposes the following definition: "The concept of transaction costs aims to capture the aggregate cost of the administrative activities involved in managing development assistance, which have no value either to the recipient government or to the donor other than to permit an aid transfer to take place" (EC 2003a:12). In fact, a comprehensive approach to transaction costs must take into account not only flows of expenditures, but also the opportunity costs of both the money and the time spent on aid management, as well as the agency costs resulting from "informational asymmetries" and "the misalignment of donors' activities with the recipient country's priorities" (Paul 2005, based on Cordella & Dell'Ariccia 2003). One of the declared objectives of SWAps is to reduce "unproductive" transaction costs, and in general to reduce the transaction costs supported by the partner government.

Whether there is "no value" to such typical transaction costs as aid coordination meetings, for instance, is discussible: they take time, but there may be "positive externalities" if they help reinforce mutual trust and understanding. It is not our purpose, however, to go into a theoretical discussion of the nature of transaction costs in this report. [58] Rather, let us review different aspects raised during interviews.

6.4.1. TRANSACTION COSTS IN GENERAL

A 2003 OECD report notes that "the number of co-ordination mechanisms creates a burden in terms of transaction costs for both government and donors" (OECD 2003b:19). It is also not to be expected that transaction costs can be much reduced by further streamlining coordination and M&E mechanisms, since the OECD advocates "increased partnerships with civil society and private sector" which "are staff-intensive and increase transaction costs for donors and government" (OECD 2003b:19).

[58] Transaction costs are the subject of specific research in the context of the GRAP-SWAP project. See notably Vandeninden (2005).

The general impression is that *the SWAp has somewhat reduced overall transaction costs in the health sector – but definitely not in a spectacular way*. *The nature of transaction costs may have changed more than the overall burden*: a lot of work is required to run the SWAp, there is still a lot of reporting to do, considerable efforts must still be deployed to get money flowing into the basket fund, and there are still plenty of projects going on in addition to budget support. Also, unsurprisingly, those heavily involved in sector coordination and technical work tend to take a more "pessimistic" view than those who are a less involved.

6.4.2. COSTS SUPPORTED BY GOVERNMENT

A reduction in the transaction costs associated with the management of external aid is one of the objectives pursued by the TAS. The government is trying to reduce transaction costs by a variety of means, such as establishing "'quiet periods' of four to five months during the budget preparation and approval process, when officials can focus on managing the Tanzanian economy rather than responding to donors" (OECD 2003b:18).

Donors often take a more optimistic view of the decrease in government transaction costs made possible by the SWAp than government people themselves. Of course, the fact that donor-donor coordination takes place without attendance by government saves some time for the latter. The coordination mechanisms and joint review processes have *reduced the number of bilateral meetings and individual evaluation missions. However, these achievements are fragile*: for instance, bilateral dealings have gone up again in relation to the new global initiatives, which make no or little use of existing coordination mechanisms. As one donor representative put it, *transaction costs on the government side are only likely to drop if more donors get "on board"* (of the SWAp, and of the basket fund) – and if "old" aid modalities are further abandoned.

Transaction costs on the government side may nevertheless have decreased more than government people themselves believe, if one sticks to a strict definition. At central government level, there are many coordination forums but not all of them are related to aid management. For instance, high-ranking officials in the MoH are constantly in meetings – but a significant share of these meetings have to do with the decentralisation process, civil service reform, "normal" inter-sectoral coordination and other processes related to general government reform processes. Also, *the time spent by MoH officials on technical work in task forces and working groups*, even if these forums include some donors, *should not be accounted for as transaction costs as long as these forums work on issues of substance on which government should be working anyway*, rather than on aid management as such.

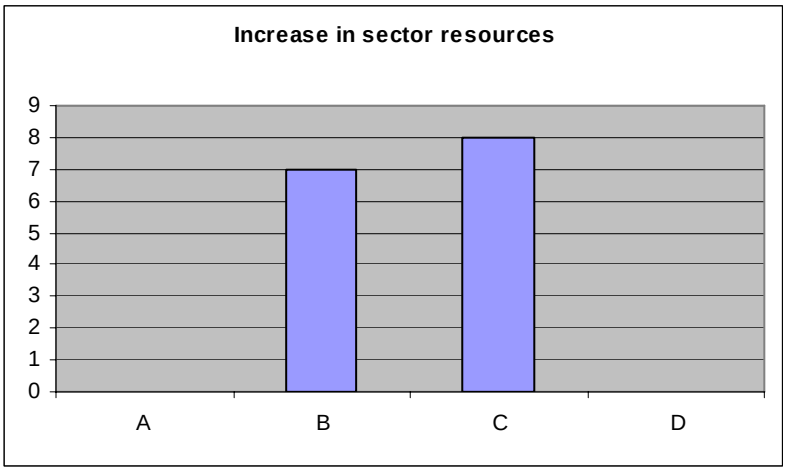
One of our interlocutors also reported that transaction costs had hugely increased at district level, due to the heavy reporting requirements imposed on councils. It is unclear, however, whether this indeed considerable burden has much to do with the management of aid: most reporting requirements are simply related to the decentralisation process. Still, there is no doubt that *the basket fund's provision of grants to districts has indeed aggravated the administrative burden imposed on district councils*. [59] On the other hand, increased data collection requirements (epidemiological data, routine service data, …) are part of the "normal" running of a health system and have technically nothing to do with transaction costs.

[59] Until recently, the rules for managing basket fund grants (expenditure ceilings, authorised and unauthorised expenditures, …) differed from those applicable to central government block grants. Most absurdly, even now that rules have been harmonised, it seems that specific reporting on the use of district basket funds, separate from general expenditure reporting, is still required… (PEFAR 2005:37).

6.4.3. COSTS SUPPORTED BY DONORS

The factor that most contributes to the (reportedly very limited) reduction in transaction costs on the side of donors is the new division of labour and specialisation made possible by the SWAp. For the rest however, DPG coordination and harmonisation is difficult and time-consuming – especially for those donors that accept to chair an official forum, or get involved in technical working groups. One donor representative mentioned the new modalities might entail some reduction in the financial costs (disbursements) associated with aid management (e.g. reduced needs to hire project managers) – but definitely not in the time dedicated by local representation staff to the process.

6.5. Financing available to the sector



Number of respondents: 15

Perception of the statement: "So far, the Health SWAp has allowed to increase the amount of resources dedicated to the health sector":

A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

The sector budget figures shown in sections 4.2. and 4.3. show *steady progress in the allocation of funds to the health sector*, in real absolute terms, per capita and relative to GDP. Both government and donor contributions have increased over time – with a massive increase on the side of external contributions. *Most observers attribute this trend, to a large extent, to the success of the SWAp*, which has increased donors' confidence in the government's management of the sector, and thus made them more willing to contribute to sector financing. *The establishment of the basket fund, in particular, has contributed to an increase in external aid to the sector*.

The *basket fund has notably helped double the amount of non-personnel recurrent budget available for the health sector at district level, when decentralisation started*. This prompted government to increase its own allocation of funds to district-managed health services – thus making the decentralisation of services possible. *This was a remarkable and significant contribution of the basket fund (and thus of the SWAp) to health sector reform.* It may be a bit unfortunate that the district basket has subsequently not grown as fast as the central basket – but this should not hide the significant benefits generated by the setting up of the fund.

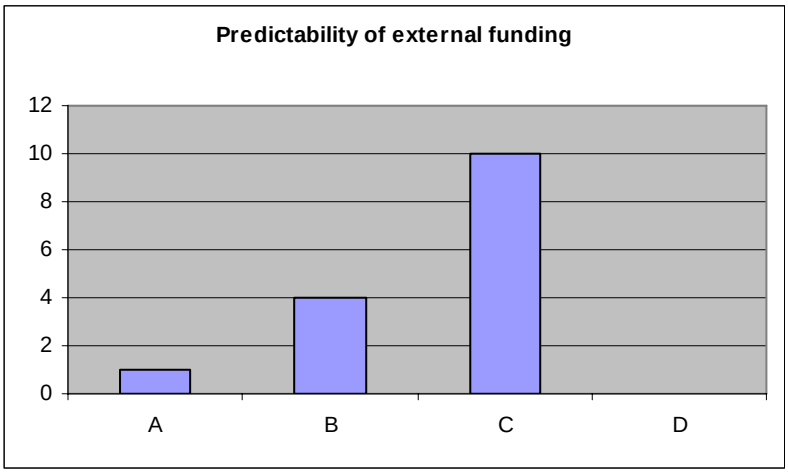
Still, *the needs are growing even faster than the available resources* – notably because of the costs induced by AIDS care and treatment, the use of more sophisticated vaccines ("forced upon" Tanzania by GAVI), the switch to artemisinin combined treatment for malaria, and the need to recruit more staff and rehabilitate infrastructure. As a result, a "major resource gap" still exists (MoH 2005:17).

There are also concerns that although the nominal health budget increases every year, *the share of health in total public expenditure has tended to stagnate, or even regress, since the peak reached in FY 2001/02*. This may explain why, in spite of remarkable increases in sector financing so far, just under half of respondents to our mini-survey declared that the SWAp

had promoted an increase in the amount of resources available to the sector "to some extent" rather than "to a large extent". [60] There are now concerns that if too many donors switch to general budget support and the government does not maintain or increase the current level of commitment to the sector, the available resources could actually contract – if not in absolute terms, then at least in relative terms (as a share of GDP and government expenditure).

[60] Also, other factors than the SWAp are at play to force the observed increase in health spending, not least participation in the HIPC initiative. It is likely that increased spending would have occurred anyway.

6.6. Predictability of external financing



Number of respondents: 15

Perception of the statement: "So far, the Health SWAp has allowed to improve the predictability of external funding to the sector":

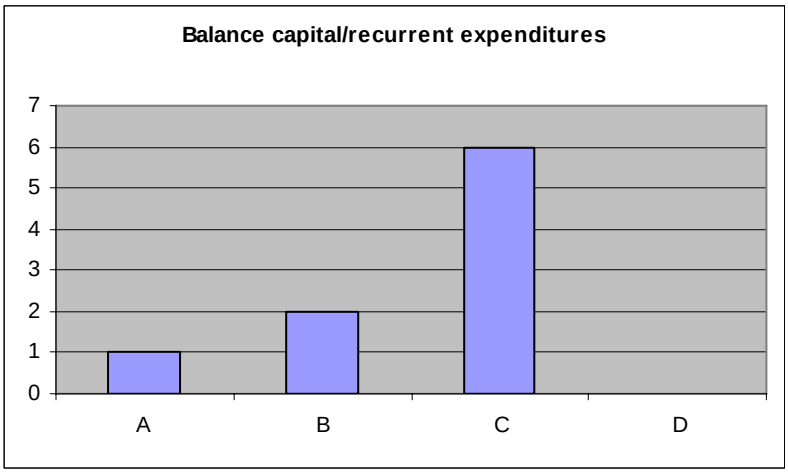
A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

A study published in 2000 identified improving donor fund predictability as "one of the main challenges to the Government of Tanzania and partners", resulting from "over-optimism about the flow of commitments and disbursement to the budget" as well as "under-reporting of projects outside the budget" (Brown 2000:19). The second part of the problem has to a large extent been solved. Concerning the first one, most of our interlocutors concur that *significant progress has been achieved* – thanks to the combined benefits of the PER/MTEF process and the SWAp. For instance, *most donors to the sector now strive to plan three years ahead*, especially those who provide budget support.

Nevertheless, *the issue of the predictability of external funding has not disappeared* – and is unlikely ever to disappear completely, for the following reasons:

- more and more aid to the sector (and in general) is provided in the form of budget support; this is fine as long as the relationship between government and donors is good – but budgetary aid is also considered more volatile than project aid; it can be suspended or withdrawn massively and at short notice, not just in case of disagreement over sector policy, but also in case of other political disagreements (e.g. over contested electoral results – this happened a few years ago when all aid to Zanzibar was withdrawn following dubious election results) or if a country is declared "off-track" by the IMF;
- the new "vertical" international initiatives are upsetting the improving trend of the last years: they come up with huge commitments in the short and sometimes the medium term, but the predictability of these funds is lower than that of other external resources (both because administrative and political hurdles make the actual moment of disbursement erratic, and because vertical programmes, which depend on annual calls for funds to replenish their reserves, are often "fashion-prone" and thus sensitive to changes in priorities among donors).

6.7. Balancing of recurrent and capital expenditure



Number of respondents: 9 (6 preferred not to answer this question)

Perception of the statement: "So far, the Health SWAp has allowed to rebalance the health sector budget in terms of investment and recurrent expenditures":

A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

All the people interviewed who had an opinion on this subject agreed that *there is too little, rather than too much* (as in many other countries) *emphasis on capital expenditure*: the health sector budget is very much skewed in favour of recurrent expenditures. The problem stems from the fact that funds available for the sector are still much too low with regard to needs, so there has been a tendency, in the past few years, to give priority to recurrent expenditures so as to deliver the needed services. This move has been amplified by the publication of studies that denounced excessive infrastructure investment by many developing countries – which prompted governments to slash capital investment under pressure from donors, sometimes a bit indiscriminately.

The following figures confirm that, over the past three years, the share of health expenditure dedicated to capital investment, which used to be approximately one third, has shrunk considerably:

Description	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 (budget)
Health expenditure (bn TZS)	81.2	100.7	142.1	186.7	216.2	290.4
Recurrent expenditure (bn TZS)	53.9	70.3	90.9	149.1	180.3	244.4
Recurrent expenditure (as a % of total health expenditure)	*66.4%*	*69.8%*	*64.0%*	*79.9%*	*83.4%*	*84.2%*
Development expenditure (bn TZS)	27.3	30.4	51.2	37.6	35.9	45.9
Development (as a % of total health expenditure)	*33.6%*	*30.2%*	*36.0%*	*20.1%*	*16.6%*	*15.8%*

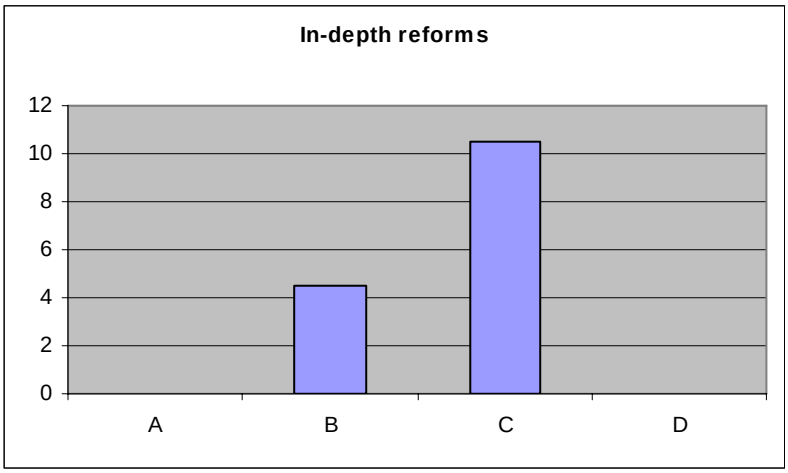
(Source: IMF 2005b:26 / Ministry of Finance)

It is now recognised that this policy has been pushed a bit too far. The balance is tilting again in favour of some increase in capital investment – in particular in the form of selective,

prioritised rehabilitation of existing infrastructure (the building of new infrastructure is still frowned upon) and equipment replacement. The Joint Rehabilitation Fund, set up in 2004, supports this, and it is reflected in the FY 2004/05 development budget (increase in nominal terms, although not as a share of total health expenditure).

In conclusion for this point, *in spite of the positive view of some respondents, official figures do not provide much evidence that the SWAp has so far played any significant role in balancing the sector's capital and recurrent expenditure*. Still, the SWAp has at least provided a forum in which the existing imbalance could be discussed and addressed – and this resulted in the decision to co-finance the Joint Rehabilitation Fund out of the district basket fund.

6.8. Health sector reform in general



Number of respondents: 15

Perception of the statement: "So far, the Health SWAp has allowed to carry out in-depth reforms of the healthcare system":

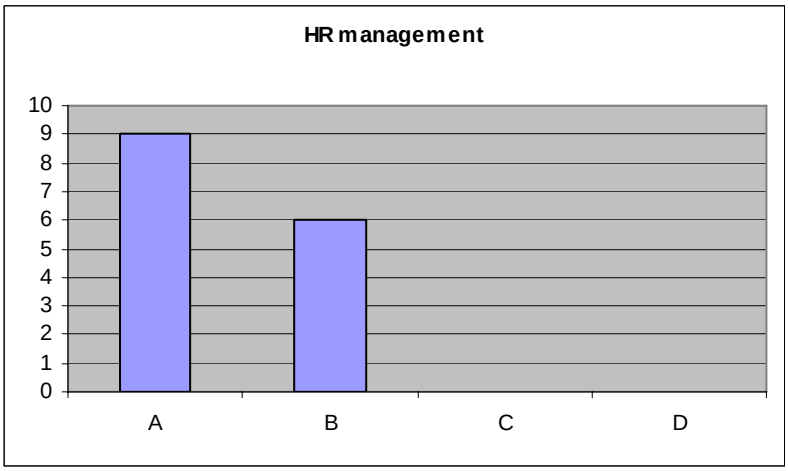
A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

It is clear, for a majority of respondents to our survey, that *the SWAp has made a significant contribution to the overall success of health sector reforms* undertaken since its inception. Even though marked improvements in the quality of care and the health status of the population are not yet evident, most people agree that the reforms undertaken since the late 1990s are helping things "move in the right direction".

The decentralisation of primary healthcare, in particular, has been implemented over a short period, and all in all relatively smoothly if one considers the huge obstacles and constraints it faced (notably in terms of institutional capacities). [61] The SWAp, and more specifically the HSBF (with its modest but crucial contribution to district grants), can certainly be credited for part of this success – even if much remains to be done in order to consolidate the decentralisation (see section 9.5.).

[61] As one interviewed person put it, "contrary to what happened in some other countries, service delivery has not worsened with decentralisation, and it may actually be improving".

6.9. Human resource management



Number of respondents: 15

Perception of the statement: "So far, the Health SWAp has allowed to improve human resource management in the sector":

A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

HR management is <u>the</u> area in which, according to our interlocutors, *the least progress has been achieved since the adoption of the SWAp.* HR problems are acute everywhere in the public sector, but are particularly visible in the health sector. The HR crisis has been a permanent feature of the health sector for many years, affecting not just public sector facilities but FBO-run facilities as well. It is more acute in rural areas than in urban ones. Most agree there has been no improvement at all [62] – whereas so many other things have moved in the right direction. This lack of progress is attributed to the fact that so far, nobody has lobbied hard enough to resolve this crisis, neither in government nor among donors – perhaps because it is so complex to tackle. Thus, *the SWAp has so far not helped address this issue properly* – and it constitutes one of the major challenges for the sector in years to come (see section 7.3.).

[62] One of our interlocutors cynically noted that "the HR crisis was recently upgraded to HR emergency… but nothing gets done about it".

6.10. Quality of care

Number of respondents: 15

Perception of the statement: "So far, the Health SWAp has allowed to improve the quality of healthcare":

A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

The quality of care is generally deemed to have improved in some regards since the inception of the SWAp (notably as far as the availability of drugs, basic equipment and medical supplies is concerned) – *but to remain, overall, much below acceptable standards*.

The latest "State of Health in Tanzania 2004" report (STI 2005), the recent "ten-district study" (Makundi et al. 2005) and the latest update of the Health Sector Performance Profile (MoH 2005) show a mixed picture (please refer to these documents for more details). A recent report on "Reviewing Health Progress in Tanzania", looking at long-term trends, states that "very poor routine data make it difficult to judge performance in health service delivery", but "since 2000, the few routine data indices available show good improvement in selected service indices. EPI coverage, Vitamin A supplementation, malaria and TB treatment completion have all show gains" (Smithson 2005:8). The "State of Health" report concludes that "even though shortcomings persist, the health care delivery system is in better shape than before" (STI 2005:6).

The "persisting shortcomings" are usually attributed to:

- first and foremost, the HR crisis;
- the dilapidated state of much of the country's public health infrastructure;
- ineffective referral systems;
- insufficient support provided to district health authorities and practitioners;
- the insufficient skills of part of the staff;
- a culture of health managers (in particular CHMTs) that is not yet enough oriented towards quality of care, and a lack of quality-related incentives and quality assurance systems (HERA 2003).

In spite of this, the recent study conducted by Makundi et al. (2005) shows unexpectedly high rates of satisfaction among users (the most important criterion for a positive perception of health services being the availability of drugs, which is known to have improved).

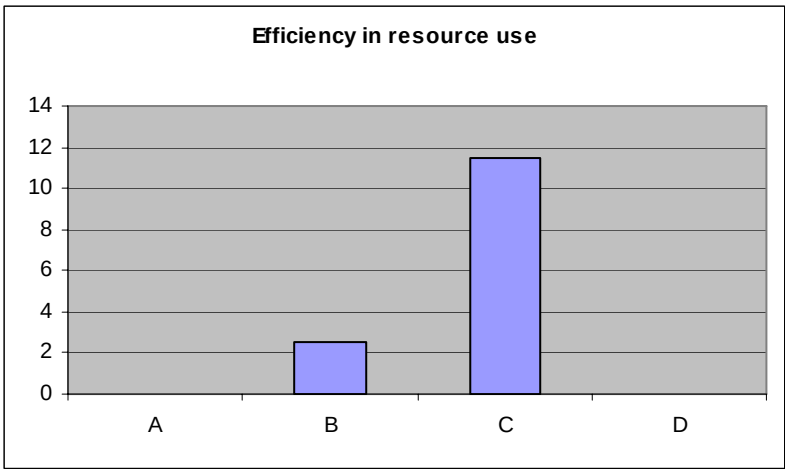
In fact, *many interviewed people offered the view that one cannot expect a SWAp to have a short-term impact on the quality of care, even less on health outcomes*. Once a decision is made to adopt the process, the first years are spent improving general structures, processes and systems – both in the health system in general and in relation to the SWAp. Only when these have reached a satisfactory level of quality and maturity does the focus move on to improving the quality of care, which in turn is expected to contribute to improved health outcomes. [63] *The shift in focus to quality of care happened in 2003* (that is, five years after the idea of implementing a SWAp was adopted – when quality of care was made a priority in the HSSP and raised as a major issue in the annual sector review). SWAp protagonists believe quality improvements are now gradually gaining ground.

As for *health outcomes* (which were not raised as a specific topic for evaluation in our questionnaire), not everybody agrees they should be studied as indicators of achievement of a Health SWAp or health sector reform programme. Indeed, "in many cases [they] remain indicators of factors outside the control of the health system". In view of persisting poverty and ignorance, budgetary constraints, economic shocks, and the devastating impact of the AIDS epidemic, "in many countries donor assistance may no longer result in improved health status but merely in a less steep decline" (Schleimann et al. 2003:45-46). Still, following health outcome indicators remains a must. The interpretation of impact indicators focused on health outcomes should of course be prudent, and take into account their multiple determinants – but analysing them remains indispensable: they are a useful indicator of the success or failure of overall development efforts, as well as a tool for policy formulation in health and other sectors.

[63] This view is consistent with the phased priorities of Tanzania's long-term health strategy, formulated as follows: Phase I (2000-2003) is focused on structural healthcare reforms (notably decentralisation) and the strengthening of sector management systems, as well as capacity building and the improvement of resource management; **Phase II** (2003-2007) is **focused on improvements in the quality of services**; Phase III (2007-2011) will focus on institutionalising output-based management, further improving the quality of care, and achieving sustainable improvements in the population's health status (WB 2003:21)

6.11. Efficiency in the use of resources

Allocative efficiency consists in "maximis[ing] total utility by redistributing resources between different objectives/programmes, i.e. choosing the right intervention". *Technical efficiency* consists in "minimis[ing] the use of resources to obtain the agreed upon service, or maximis[ing] the production of the agreed upon service within a given amount of resources, i.e. implementing the chosen interventions well" (Schleimann et al. 2003:31). In our questionnaire, we did not provide definitions nor discriminate between the two types of efficiency.



Number of respondents: 14

Perception of the statement: "So far, the Health SWAp has allowed to improve efficiency in the use of financial resources":

A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

It appears that even if further improvements are necessary, *significant progress has been made in resource management and efficiency since the inception of the SWAp. This progress can be attributed to the synergies between the SWAp, the PER process and the adoption of MTEF planning*: "The analysis demonstrates the continuing cost-effectiveness of the chosen programme approach (sector-wide, moving towards basket funding). The analysis also demonstrates commitment to prioritising cost-effective interventions given the burden of disease, as reflected in the larger proportion of the basket fund (more than 70 percent in FY00/01) spent on preventive and promotive health services" (WB 2003:14).

Considering overall spending (not just the spending of basket fund resources), expenditures on preventive and promotive care raised from 33% (in FY 1999/00) to over 40% as from FY 2001/02); simultaneously, the share of expenditures on hospital services declined, from 60% in FY 1999/00 to 40-45% in the past few years:

Budget allocations by destination:	1999/00	2000/01	2001/02	2002/03	2003/04
Preventive/Primary care	33%	41%	48%	44%	42%
Secondary/Tertiary care (hosp.)	60%	50%	43%	41%	44%
Administration [64]	7%	9%	10%	16%	14%

(Source: Health Sector PER updates FY04 and FY05)

[64] Central MoH, NIMR and Tanzania Food and Nutrition Council.

These "allocative efficiency" trends should be watched carefully however, since the last year for which data are available (FY 2003/04) shows an increase in the share of spending on hospitals alongside a decrease (for the second consecutive year) in the share of primary healthcare.

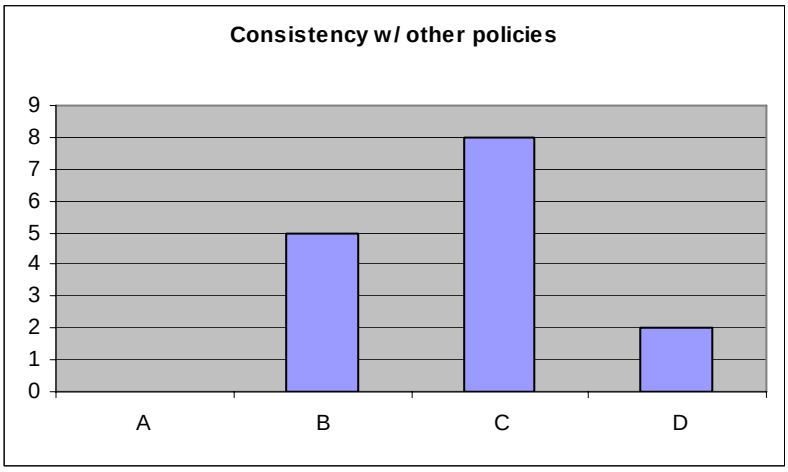
Also worth noting is that *the share of recurrent expenditure spent on non-personnel charges has increased* (from 33% in FY 1997/98 to 52.6% in FY 2001/02 and 54.1% in FY 2004/05). *This is considered by some as a sign of improved allocative efficiency* (WB 2003:60-61) – *but maybe it should not*, since very low salaries and understaffing are the main causes of the HR crisis which is itself widely considered as the main cause of the lack of significant improvements in the quality of care and health outcomes. The fact that "payroll expenditure is not keeping up with 'other' charges" was mentioned as a cause of concern in the latest JAR (MoH 2005:iv, 16).

At the district level, efforts to improve cost-effectiveness are also under way. Between 1993 and 2003, a research project entitled TEHIP (Tanzania Essential Health Interventions Project) [65] tested the hypothesis that improving the match between health expenditure allocation and the local burden of disease, on the basis of epidemiological evidence, would allow a significant and cost-effective reduction in mortality rates. A pilot implemented in Morogoro and Rufiji districts came to the conclusion that the hypothesis was valid. [66] Although this project started before the SWAp and was financed in the context of "traditional" bilateral cooperation, it benefited in its last years from the extra money provided by the district basket fund. The SWAp may create a favourable context for the rolling out of some of the tools, procedures and practices developed under this project to other districts in the country – although we were not able to ascertain this point during our visit to Tanzania.

[65] The project was the result of collaboration between the MoH and the International Development Research Center (IDRC) of Canada. It was supported by CIDA. For more information, please refer to de Savigny et al. (2004).

[66] Provided improved budget allocation was coupled with capacity strengthening and a very modest increase in overall health spending.

6.12. Consistency of health policies with other policies, and contribution to the PRS



Number of respondents: 15

Perception of the statement: "So far, the Health SWAp has allowed to improve the consistency of health policies with other policies (e.g. poverty reduction strategy, …)":

A = "not at all", B = "to some extent", C = "to a large extent", D = "100%"

As already mentioned, *health policies have definitely been designed and implemented in a way consistent with decentralisation and the local government reform programme. Efforts are also made to make them consistent with overall efforts to tackle the HIV/AIDS issue, and with the poverty reduction strategy*. Our mission to Tanzania was too short to try and establish in detail the extent to which health sector reform is coherent with and supports other government policies. We could nevertheless gather some information about the stakes of health sector reform in terms of poverty reduction, and the sector's contribution to the PRS.

The health sector strategy is deemed by the MoH "fully consistent" with the NSGRP (MoH 2005:14). *In practice* however, *the integration of poverty and equity concerns takes time*, and district plans in particular have not so far proposed explicit PRSP targets (HERA 2003:17). Furthermore, meeting poverty reduction and equity objectives has "major implications for human and financial resources", and "the health sector will not be able to attain its goals if the resource gap cannot be narrowed" (MoH 2005:14).

Awareness of equity issues[67] *has prompted the MoH to revise the formula for allocating block grants and basket fund grants to districts*. Initially, they were awarded on a strictly per capita basis. The new formula also considers under-five mortality, geographic distance to health facilities and poverty count to determine the allocation going to each district council, with the less favoured (in terms of poverty, geography and/or burden of disease) getting higher per capita allocations than the more favoured. Revising the budget allocation formula is not

[67] Inequity in access to health services has an important geographic dimension in Tanzania (WB 2003:59-60). Yet in comparison with many low-income countries, "Tanzania's health coverage, outputs and outcomes are more equitable than most. (…) The composition of disease burden does not differ markedly between poor and non-poor" (Smithson 2005:16).

expected to resolve inequities entirely ("staff deployment, care-seeking behaviour and provider attitudes also need to be addressed") (WB 2003:60), but at least it is a step in the right direction – and *it may have been facilitated by the gradual opening of sector dialogue to FBOs and NGOs in the context of the SWAp*. *Efforts are also made under specific programmes to reach out to the poor*: for instance, a voucher programme supports the purchase of insecticide-treated bednets by pregnant women; the programme is not specifically targeted at the poor – but in practice, it mainly benefits the poor, as it lifts the financial constraint that prevents them from purchasing bednets to protect pregnant women and newborn children.

Last but not least, the question of *user fees*, now requested at all levels of care, is critical as far as poverty and equity are concerned. *An exemption system is supposed to be in place but does not work as it should*. Some NGOs have done research to identify the constraints faced by the poor in accessing health services, and have concluded that user fees are the most significant obstacle.[68] Yet, the charging of user fees remains official policy of the MoH, and is supported by a group of influential donors (see section 7.6.).

[68] See notably Save the Children (2005) and Women's Dignity Project (2004).

7. Current issues and challenges

7.1. Introduction: institutional aspects and elements of stakeholder analysis

Before moving on to a review of the current issues and challenges facing the Tanzanian Health SWAp, we would like to briefly highlight some institutional aspects that are of relevance to the SWAp's dynamic, and introduce a few elements of "stakeholder analysis" that may facilitate the understanding of the issues discussed further in this chapter.

7.1.1. MoH-MoF relationship

Several of our interlocutors pointed out that while relationships between the MoH and PORALG have much improved since the beginning of the process of healthcare decentralisation, and are now deemed satisfactory, *the relationship between the MoH and the MoF still needs strengthening*.

One aspect is that *the MoF remains insufficiently involved in the Health SWAp*. Although it is officially a member of the Health SWAp Committee, it seldom sends a senior representative to the meetings (if it sends one at all).[69] This is a bit surprising, as government in general strongly supports the SWAp process. We were not able, during our short mission, to establish the reasons for this apparent lack of interest on the part of the MoF.

Another (probably not unrelated) aspect is that *the MoH's connections with the MoF still seem to be too weak to guarantee appropriate budget allocations for the health sector* without a bit of "behind-the-scene" help from donors. We were told that donors regularly act as intermediaries between the two ministries, facilitating dialogue and coordination within government – a role they are not supposed to play. Whether this lack of direct connections between the MoF and the MoH can "spontaneously" be resolved by donors switching their assistance from sector to general budget support, as hoped by GBS promoters, remains to be seen.

7.1.2. Donor-donor and donor-government relationships

In the beginning of the SWAp, some feared that the process would be entirely dominated by DANIDA and DFID, the two largest donors to the sector at the time. However, these fears have now been assuaged: if anything, *small donors who are ready to invest time in technical work now have more of a say than they used to before the SWAp process was established*, notably thanks to an agreement on the "division of labour" between donors by which even small donors can make a significant contribution to policy dialogue on specific topics (through close collaboration with the MoH in the framework of technical task forces).

Also, *the introduction of a joint funding mechanism did somewhat strain relationships between donors*, depending on whether they joined or not. At the time the basket fund was set

[69] It is for instance symptomatic of a lack of communication that, during the plenary session of the JAR 2005, "it became clear that the Ministry of Finance is not fully aware of the gravity or urgency of the [HR] problem" (MoH 2005:13).

up, there was a degree of frustration among non-basket donors who felt that basket donors had easier access to government and more influence over health policy. Some of the basket donors feel it is indeed the case, and find it appropriate: they see the basket fund as an "inner-circle, fast-track" instrument that should give its members some kind of privileged access to government. DFID however, while contributing to the establishment of the basket fund, has always been in favour of the more "inclusive" approach that seems to predominate to these days. [70]

This is not to say that some donors are not more influential than others. Influence in the SWAp can be gained: (i) by bringing large amounts of money to the sector; (ii) by investing time and efforts in the nitty-gritty, time-consuming technical work (which gives "depth" to the relationships, and allows strong personal connections to develop both between donors and between donors and some civil servants). We were not under the impression that the mere fact of contributing to the basket fund, if one at least of the other two "ingredients" is not simultaneously present, can earn special influence within the MoH. *The special influence that basket fund donors do indeed seem to enjoy appears to be more related to their commitment to technical work than to the choice of the financing modality*.

7.1.3. INSTITUTIONAL ARRANGEMENTS FOR MANAGING HIV/AIDS-RELATED ACTIVITIES

For the past few years, responsibility for managing and coordinating the national HIV/AIDS programme has rested with *TACAIDS*, a department of the Prime Minister's Office. This *responsibility* was *previously exercised by the National AIDS Control Programme (NACP)*, a branch of the MoH created in 1988 to tackle the epidemic. [71] TACAIDS was set up because the response to the HIV/AIDS epidemic is not just a medical issue, and requires a coordinated multi-sectoral response – and probably also because the size of the funds at stake is such that the President's Office feels it should have overall control of the situation.

On whether the shift of coordination responsibility to TACAIDS was a good move:

- most interviewed people think it was a good idea – notably because it relieved the NACP from the coordination burden, and thus freed up time and resources that are best dedicated to the medical aspects of the problem (which is where the NACP's competences are);
- a few people seem to regret the change, believing that AIDS is primarily a health issue, and that the focus on cross-sectoral interventions, although justified in theory, has in practice blurred lines of responsibility and made things more confused.

As far as cooperation is concerned, HIV/AIDS-related matters are also handled in a rather complex way. They are *managed, to a large extent, separately from other health-related matters*, and *do not have a prominent place in the Health SWAp* – even though discussing their impact on public health services is unavoidable. Donors have set up a separate DPG sub-group on HIV/AIDS and, although many of them are part of both groups, some donors are members of one group without participating in the other. *Coordination between the DGP Health and the DPG HIV/AIDS looks a bit patchy*. The DPG HIV/AIDS has various sub-committees, of which one dedicated to health issues – which tries to keep up with what is happening in the DPG Health and create a link between the two groups.

[70] This inclusive approach results to a large extent from the government's position, which in spite of its clearly expressed preference for budget support, aims to make all participants to the Health SWAp feel equal.
[71] Within the MoH, the NACP operates with a certain independence. HIV/AIDS-related activities are managed as a programme.

To make things more complicated, a few donor agencies who are not members of the DGP Health but participate in the DPG HIV/AIDS, including Belgium, actually support nearly exclusively some medical components of the HIV/AIDS programme.

7.2. Aid financing modalities

The choice of financing modalities for supporting the Health SWAp is the subject of regular discussions among donors and between donors and government authorities. Three aspects command particular attention.

7.2.1. OFF-BUDGET CONTRIBUTIONS

A significant share (over 50%) of donor support is still disbursed on the basis of donor-specific mechanisms and procedures, which is in contradiction with the commitments to "alignment" (on partner government procedures) made in the Paris Declaration (OECD 2005). Of course, the share of projects in total external financing for the health sector is actually smaller than appears in official statistics, since money originating from PRBS is assimilated to "government budget". Still, *in absolute terms, the amounts spent on projects and other off-budget instruments get larger every year*. Without denying that projects still have a role to play (notably to test innovative approaches to the planning and provision of healthcare), one would nevertheless expect their share in total sector financing to decrease more markedly in coming years, as more aid is channelled through government systems.

7.2.2. THE EARMARKING OF FUNDS

There is a persistent tendency among donors to earmark funds. The report of the latest JAR notes that "a substantial portion of new money coming into the sector is tightly earmarked. Flexible, discretionary resources remain highly constrained (…)" (MoH 2005:iv). International vertical initiatives have a significant responsibility in this situation (see section 7.4), but the continued use of the project instrument also contributes to the problem. Quite obviously, efficient prioritisation among many pressing needs is made more difficult by the shortage of discretionary resources. Health sector officials would have an easier task (and possibly do a better job) if the share of untargeted budget support (in the form of unearmarked SBS or, indirectly, GBS) in total external aid would further increase.

7.2.3. SECTOR BUDGET SUPPORT VS. GENERAL BUDGET SUPPORT

If an increased share of aid is to be unearmarked (at least within the sector) and disbursed through government systems, a choice has to be made between sector budget support (for which the most prominent instrument is currently the basket fund) and general budget support. *A debate over the respective merits of GBS and SBS is currently raging* among participants in Tanzania's Health SWAp.[72] The pros and cons of each modality are summarised in Annex 4.

[72] The debate is of course not limited to this forum: it concerns other sectors in Tanzania, notably the education sector, and is taking place in other countries, in international donor forums and inside individual donor agencies.

As far as Tanzania's Health SWAp is concerned, the debate started two years ago, when *DFID decided to withdraw the significant contribution it had made so far to the HSBF and increase its GBS contribution instead* – while lobbying for additional government resources to be dedicated to health. The move resulted in a lower-than-expected year-on-year budget increase for the health sector. Simultaneously, DFID removed their technical advisor to the health sector and moved their TA to a higher level, to a role of "social sector" advisor providing comprehensive support for the health, water and education sectors.

This resulted, according to several of our interlocutors, in a *marked loss of influence of the UK in the health sector dialogue*: even though DFID remains part of the DPG Health and the SWAp Committee, personal connections within the MoH have, we were told, to a large extent been lost, and several observers feel that DFID's capacity to influence both donors and government in relation to health sector issues has been reduced. [73] The stronger focus of the agency on its relationship with the MoF has thus gone hand in hand with a deterioration of the relationship with the MoH. These unintended consequences seem to weaken DFID's argument that "sector dialogue without money" is possible (although one should not draw conclusions from this specific case alone).

DFID's move is all the more perceived as a threat by the MoH since the agency, on the ground that SBS undermines GBS, is actively trying to convince other donors to go their way. The Netherlands has also opted for GBS (although the application of this decision to the Tanzanian Health SWAp has been deferred by a few years), and the World Bank is phasing out its contribution to the basket fund in favour of the PRBS facility – provided government increases the share of the budget it allocates to the health sector.

In fact, *with external funding contributing over 50% of total public health resources, it is quite likely that the large amounts of aid dedicated to the sector, through fungibility mechanisms, discourage government from investing too much of its own resources in the sector*. That a reduction in sector-targeted donor support would result in a commensurate increase in government funding is the bet DFID and others are ready to make. The MoH, on the other hand, currently fears it stands to lose from it.

DFID is now trying to repair the relationship with the MoH and re-establish itself as a valid interlocutor in the health sector dialogue. Meanwhile, *opponents to a rapid phasing out of SBS argue that* if GBS is *in theory* the ideal aid financing mechanism, in practice *Tanzania*, although implementing good reforms and achieving progress, *is not ready for a "GBS-only" approach*. In the specific case of the Health SWAp, they support this view with the following arguments:

- a move to GBS "seems rather premature in a situation where sector budget support is still in a consolidation phase" (Schleimann 2003:39);
- in spite of the undeniable strengthening of capacities within the health sector, sector dialogue, supported by direct contributions to the sector and further capacity building, remains useful to help the national authorities "steer" through the huge challenges that still face the sector;
- if too many donors withdraw from direct sector financing, the SWAp and sector-specific dialogue forums, in which the views of many are confronted, are in danger of unravelling;

[73] Interestingly, no such difficulties are reported in the education and water sectors. The likeliest explanation is that, as DFID never provided SBS to these sectors, they had less to lose from the new approach.

this may lead to a reversal to bilateral dialogue and, from the moment the MoF becomes the main interlocutor to the detriment of the MoH, PORALG and other sector stakeholders, to a lack of broad-based national ownership of health policies and strategies in future;

- the MoH is still weak in arguing its case when negotiating budget allocations from the MoF; it is right in theory that donors should not interfere in negotiations between ministries – but in practice, the MoH (and other "social sector" ministries, such as the MoEC) still need donor support to argue the value of social service expenditures. [74]

7.3. The human resource crisis

There are some historical explanations for the current HR crisis. For a variety of reasons, a brain drain has been going on practically since independence (GTZ 2001:49) – and the erosion of salaries that accompanied the economic crisis and the structural adjustment process has made medical professions (in particular in the public sector) quite unattractive for two decades. The lack of drugs, equipment and supplies, the deterioration of infrastructure, the lack of supervision and training also generated by this crisis "resulted in demoralization of the health workers", so that "an exodus of experienced staff to the private sector and even abroad occurred" (GTZ 2001:58).

These problems have persisted until these days (and are hardly unique to Tanzania). Unlike the situation prevailing in many other sub-Saharan African countries, the brain drain towards foreign countries offering better conditions is not a dominant issue (Smithson 2005:12). *Very low salaries for medical staff are the most prominent factor advanced for explaining the HR crisis*: people with medical training tend to look for work in other sectors that pay better; if they choose to practice in their field, they are attracted to better-paid positions in the for-profit private sector [75] and tend to look for positions in the more developed areas of the country, where working and living conditions are better. With no special incentives for rural posts, it is difficult to fill positions in some rural areas. Government has so far refused to use external (i.e. short-term) resources to finance personnel expenditures, both out of principle and for fear that these resources might dry up at short notice and leave it incapable of paying salaries. This makes it extremely difficult to raise salaries and/or provide special salary incentives for workers posted in the least developed areas.

On the other hand, an extensive (and expensive) system of allowances is in place that results in a significant "topping up" of some salaries, on a variety of grounds. They often benefit senior staff who already enjoy other privileges, or are linked to routine activities for which no extra remuneration is justified. This is "an inefficient way to alleviate the problem of low pay in public service" (PEFAR 2005:20). For the same level of expenditure, it should be possible either to increase all salaries in a more equitable way, or to design a performance-based incentive system (HERA 2003:34, PEFAR 2005:20).

[74] The IMG rather vehemently rejects this argument, talking rather of "vested interests" and "collusion with [development partners]" leading to "exaggeration of mistrust on MoF and engagement of lobbies to delay changing the system for the better" (ESRF 2005:31). In a more moderate tone, the IMG report notes that the leadership in sectors that rely on basket funding in the context of SWAps "have tended to put greater trust in donors than in their own government's budget system" (ESRF 2005:32).

[75] Faith-based organisations pay roughly the same salaries as the public sector – but have increasing difficulties attracting and keeping staff as other working conditions (equipment, infrastructure, …) are now generally worse in FBO-run than in government-run facilities (HERA 2005).

Decentralisation and civil service reform have just made things more complicated, as the respective roles and responsibilities of central and local government in hiring and managing health staff were not clearly defined in the beginning at the outset. The MoH, PORALG and PO-PSM all exercise some responsibilities in health sector HR management. *Due to a hiring ban in the public sector, district councils still need to obtain special authorisations to fill vacancies – which considerably slows down recruitment.* Central government remains the official employer of district medical staff, and "Council's authority on staff matters is still very limited. There is no incentive for Councils to manage human resources efficiently, as savings made (e.g. running a service with less but more competent staff) are still kept centrally" (HERA 2003:31).

Another issue is that the staffing levels established by the MoH five or six years ago in the context of a five-year HR development plan may not be adequate any more, especially as they do not take into account "the possible very different patient loads in different health facilities. This can lead to relative overstaffing in one health centre or dispensary at the expense of health workers in another health facility" (HERA 2003:30).

Finally, the HIV/AIDS epidemic has severe consequences in terms of human resources, both because of the additional workload it entails and because it affects primarily productive individuals, including medical staff.

There is a consensus on the fact that *things are unlikely to improve until HR reform gets a few influential champions, both in government and among donors*; only then, with a lot of political will and support, can things improve. HR management is a very complex and cross-sectoral issue – which cannot be solved at the health sector level only, but must be tackled in the general context of civil service reform. Developing countries, and Tanzania in particular, should not be blamed for not having solved this problem: among donors, until very recently, nobody has wanted to get seriously involved, even though awareness of its existence and consequences has been present for many years. *The HR problem in healthcare has until recently not really been on the agenda of development cooperation agencies.*

In Tanzania, this is probably about to change: the HR crisis was officially acknowledged in the 2004 health sector review (without much being done to tackle it, admittedly) – and it was declared an emergency in the 2005 sector review. Five immediate priorities were identified (including the – probably unrealistic – phased recruitment of 20,000 staff over five years), as well as four medium-term actions (including a renegotiation of health sector remuneration and the creation of incentive packages for hardship posts). It was also proposed that the HR issue be made the focal topic of next year's sector review. *This long-standing issue is thus finally being taken up on the agenda…* partly as a result of the huge HR requirements of administering HIV treatment and managing other vertical initiatives.

7.4. Integration of vertical programmes into the SWAp

Vertical programmes, focusing on a specific disease or a sub-sectoral challenge, can easily be incompatible with a SWAp and are unlikely to achieve sustainable results if they are managed out of context, as single projects (Brown 2001). Yet, eliminating them completely can be just as bad: one of our interlocutors mentioned the example of Zambia's failed "ultimate

horizontalisation" agenda, in which attempts at full integration of good vertical programmes led to their collapse.

Tanzania is "a prominent country within many global initiatives" (WB 2003:14), notably GAVI, Roll Back Malaria, and the Global Fund for AIDS, Malaria and Tuberculosis (GFATM). It is also a country that, in the wake of the last decade's health sector reform, has reasonably successfully integrated national vertical programmes (in particular, the National Malaria Control Programme and the TB/Leprosy Control Programme) into existing health structures. This was achieved by ensuring that the services provided in relation to these diseases are no longer delivered by parallel, programme-specific structures, but by general-purpose healthcare and logistical structures.

For Tanzania as for many other countries, the main risks and issues associated with international vertical initiatives include the generation of budgetary distortions; a loss of government leadership and ownership; the undermining of sector coordination mechanisms; and the establishment of parallel implementation structures, as well as parallel planning, monitoring and evaluation structures. All these elements can seriously undermine a SWAp and its achievements. On the other hand, the injection of funds in support of pre-existing national priorities, and the fact that global initiatives may provide an incentive to tackling the HR crisis, constitute opportunities and may generate some benefits. For a more detailed review of these risks and opportunities, please refer to Annex 5.

The situation in Tanzania may be summarised as follows:

- TACAIDS, the MoF and the MoH are thrilled at the financial opportunities offered by new global initiatives;
- the MoH is, at the same time, acutely aware of the risks and challenges they pose, and making significant efforts to avoid undermining the achievements of health sector reform over the past decade;
- development partners could be positioned along a continuum going from severe pessimism to over-optimism as to the capacity of the Tanzanian health sector to withstand the "external shock" of global vertical initiatives.

The question of budgetary distortions introduced by global initiatives was a particular cause of concern in the 2005 sector review. It is feared that:

- such initiatives, which are usually funded only for the first few years, may leave Tanzania with an unbearable burden as external funding dwindles and donors expect the government budget to take over;
- resource might be displaced away from national priorities in favour of global initiative priorities (MoH 2005:iv, 16).

In particular, concern was expressed as to whether ARV funding (largely associated with global initiatives) might be reducing the funding available for other initiatives. The basket fund donors made it an explicit condition for the continued support that the implementation of the AIDS care and treatment (C&T) plan be "financed from additional resources (…) and not by re-allocating away from other existing priority programmes in the sector" (MoH 2005: Annex 7). Their expectation is that additional resources are made available not just for ARV drugs, but also for the additional staff and equipment required by the C&T plan.

Implementing vertical programmes without destroying basic health structures is very much a learning process; knowledge on how to do this will gradually develop as experience grows. It also very much depends on political will. It is not impossible: Uganda and Mozambique were reported by some of our interlocutors to have integrated GFATM-sponsored activities into their Health SWAps, and the process is well under way in Tanzania too. The *National HIV/AIDS Care and Treatment Plan* that is now integrated into Tanzania's own health strategy was initially developed by the Clinton Foundation according to its own agenda, before it was "taken on board" by the MoH within the wider context of the SWAp, at the insistence of a few DPG Health members. [76]

It would thus be foolish to outright reject vertical initiatives – but they must be "controlled". *Whether costs or benefits ultimately weigh most in the balance will depend very much on the extent to which vertical programmes get integrated into existing health structures, programmes and processes* (including planning and M&E processes such as the MTEF and the PER). This, in turn, depends on how strongly TACAIDS, the MoH, the MoF and government in general:

- insist on such integration;
- are willing to stand up to the promoters of vertical programmes in order to impose their views and policies during negotiations on the use of funds;
- are prepared to resist the temptation of accepting funds that would not "fit" with national strategies and priorities, and might therefore have destructive effects on the achievements of past and current sector reforms; this is no mean feat for a poor, aid-dependent country such as Tanzania.

The next section treats the question of ARV therapy separately, although it is related to vertical programme integration – as this is an aspect that poses specific and considerable challenges of its own.

7.5. HIV/AIDS care and treatment

HIV/AIDS care and treatment, and more specifically the provision of ARV therapy to a significant proportion of infected people [77], *probably poses the biggest challenge to the health sector since the major decentralisation exercise. It is also one of the most divisive issues in sector dialogue, and one on which there is no convergence of donor policies or opinions.*

ARV therapy in Tanzania started in 2000, with private funding. Government funding started in 2004, when ARV therapy became available in some public hospitals and clinics. A unified *National HIV/AIDS Care and Treatment Plan* is currently in the deployment stage. As of June 2005, staff had been trained and ARV drugs were available in 96 facilities across the country;

[76] One of our interlocutors actually offered the view that under the principles of leadership and ownership, the government of Tanzania should remain free to talk on a bilateral basis to whomever it wants – and that the integration of vertical programmes into the SWAp, however desirable it may be, should occur at the initiative of national authorities, not at the initiative of donors. While respecting the sovereignty of Tanzania, we believe this strict interpretation of the leadership principle ignores that SWAps are also based on partnership, sector dialogue and on a comprehensive approach to a sector. We therefore see nothing wrong in the initiative of a group of development partners to bring back into the "fold" of the SWAp an issue of such considerable importance for the whole sector, especially as this initiative enjoys some internal backing within the MoH.

[77] For a review of the pros and cons of wide-scale ARV therapy, please refer to Annex 6A.

105 additional sites were designated to become operational within one year. ARV treatment is provided both by public and by (accredited) private hospitals and other facilities. The current plan is to have 400,000 Tanzanians under ARV therapy by the end of the decade [78] – a hugely ambitious target if one considers that only approx. 5,000 people were receiving treatment as of June 2005. [79]

The MoH is doing its best to favour integration by the following means:

- the HIV/AIDS strategy, spelled out in a Health Sector HIV/AIDS Strategic Plan published in February 2003, is integrated in the HSSP 2003-2008. Specific guidance is notably provided to districts, so that issues related to the epidemic are properly addressed in district health plans
- ARV therapy as well as all other HIV/AIDS-related interventions are and will be delivered by existing structures at all levels, thus avoiding the "trap" of creating parallel, disease-specific structures for delivering care;
- a uniform approach to ARV therapy will be adopted throughout the country, whatever the status of the facility delivering it; protocols, guidelines, staff requirements, training systems and programmes, reporting systems and requirements are the same for all accredited C&T centres.

However, dedicated staff and equipment will have to be used. [80]

Unsurprisingly, *the HR issue will be the worst source of headache – and the one that may bring down the whole sector if it is not managed properly*. HR requirements are huge: to actually treat the planned 400,000 patients, the MoH has calculated that 10,000 more staff should be recruited in the health system (both public and private facilities) by 2009! It seems highly unlikely that the existing targets (in terms of number of treated patients) can be reached while maintaining the adopted standards. *The balance of positive and negative effects is likely to depend on three crucial factors:*

- *the possibility of using the additional "vertical" resources for a general improvement in the quality of care* – which in turn implies that: (i) overall health system strengthening is given precedence over the number of people treated; and (ii) vertical programmes accept that a "reasonable" share (to be determined!) of the funds they provide are used for general-purpose improvements in health systems; this is a strong assumption;
- *the beginning of a resolution of the HR crisis* that is currently plaguing the health sector, on a sustainable basis (i.e. definitely not by topping up the salaries of staff involved in AIDS C&T, while other staff's salaries remain unchanged);
- *the mobilisation of all possible resources in Tanzanian society*, including NGOs, FBOs, community-based organisations and non-medical staff, *in support of the development of home-based care initiatives* – which allow to greatly increase the number of people treated, compared to a facility-based only approach. (How home-based care projects can work in practice, and what they can achieve, is presented in Annex 6C).

[78] 1.1 million people are presently deemed to be HIV-infected.
[79] Source : interview in UNAIDS. The (now missed) target was to have 45,000 people treated by the end of June 2005.
[80] Annex 6B presents Tanzanian staffing norms for ARV therapy. As far as equipment is concerned, vertical programmes will finance the purchase of additional equipment for the labs associated to C&T centres: CD4 counting machines (these cannot be used for anything else), but also equipment to test liver and kidney function (which will be available to all patients in need of such tests… provided laboratory staff and consumable supplies are also available for non-HIV related purposes!).

7.6. User fees

Alongside the shift to general budget support and ARV therapy, the user fee question is currently one of the most controversial in the health sector's policy dialogue – and one that deeply divides some donors within the DPG Health.

At a policy level, the government is very committed to increasing domestic resource mobilisation for health sector financing through alternative (i.e. non-budgetary) financing mechanisms. Cost sharing is one of the pillars of this policy, and it features prominently in the HSSP. At the moment, user fees contribute very little to overall health budget financing.[81] In order to ensure the accessibility of essential services for the poor, a system of exemption stipulates that no fees should apply to children under five, mother-and-child care (including immunisations), the treatment of TB, leprosy, paralysis, typhoid, cancer and AIDS, nor in the case of epidemics (Joint Statement 2005). However, everybody acknowledges that the exemption system does not work – maybe in part due to the fact that health facilities that grant exemptions do not get compensated by government.

Defenders of user fees, found notably among high-ranking MoH officials but also among donors, FBOs providing health services, and district councils, believe that given the existing budget constraints, it is simply not possible to make healthcare entirely free. They also argue that:

- from the moment users pay even low fees, they feel more like real stakeholders, are more entitled to express their opinion, and are generally in a better position to require quality services; user fees are seen as a tool for empowering health service users and improving accountability;
- "there is no evidence that fees are the main deterrent to utilisation of primary services by the poor" – nor that they are the main cause of household impoverishment resulting from illness (Joint Statement 2005);
- user fees may be small compared to overall healthcare budgets, but they are an important source of funding for local health authorities (as well as FBOs), and thus support the decentralisation process. [82]

Partisans of cost recovery are of course not unaware of, nor insensitive to the difficulties of the poor. What distinguishes them from opponents, on this point, is that they believe it is possible, if there is a will, to create an effective and equitable exemption system for those who cannot afford to pay fees. They also argue that eliminating fees for all, including those who can afford to pay, may actually increase rather than reduce inequities; they favour approaches that tackle the non-financial reasons that prevent the poor from using healthcare services (e.g. preference for traditional medicine, discriminatory health worker behaviour) (Joint Statement 2005).

Opponents to user fees are to be found among donors (in particular DFID) and NGOs but also, we were told, in government and within the MoH (although the official policy is in

[81] Cost-sharing resources, i.e. user fees plus CHF resources, amounted to an estimated 7.5 billion TZS in FY 2003/04 and 2004/05. This amounted to, respectively, 2.4% and 1.7% of the total resource envelope (MoH 2005:14).

[82] A recent study estimates that on average, user fees and CHF contributions represent 10.5% of district health budgets (Schwerzel et al. 2004). They represent an even bigger share of non-salary recurrent expenditure and of discretionary funds at facility level (Schleimann et al. 2003 :13).

favour). They point out to the challenging equity issues associated with the perception of user fees: even modest fees may make public health services virtually inaccessible for the poor – especially for those who suffer from chronic illnesses, as was demonstrated by a recent survey carried out by Save the Children. [83] They do not see any way of making the exemption system work properly so that it effectively reaches its target groups. They consider charging user fees all the more unacceptable since the quality of services is bad and, in some places, keeps deteriorating. [84] They point out that much more money is lost to corruption than is collected from user fees, and government has its priorities wrong. They also point out to the experience of Uganda, which saw an increase in the use of health services by the poor and an improvement in equity indicators following the abolition of user fees.

Whether or not user fees should be maintained is a crucial and difficult question that would deserve a structured, open forum for dialogue – which NGOs feel does not really exist at the moment. Smithson (2005:14) notes that "there is an urgent need for empirical evidence to examine the validity of claims by protagonists and detractors alike". *The question of how to manage an exemption system so that it actually works as intended remains an unresolved question* (not just in Tanzania) – *but one that will need to be addressed if user fees are to be maintained and contribute to sector financing while PRSP-related equity objectives are pursued*. Some research aimed at identifying problems and proposing solutions is actually taking place, and may usefully inform this important debate in which economic sustainability must be traded off with equity and poverty reduction. *The SWAp should be able to provide a structured framework for organising such research, debating and disseminating its conclusions.*

7.7. Role of NGOs and grassroots organisations in the Health SWAp

We have seen in section 5.6. that a structured, systematic consultation mechanism, involving health service providers, health service users and their representative organisations is not yet in place in Tanzania. This is definitely an aspect that could be developed, now that a certain level of maturity and "routine" has been reached in the management of other aspects of the SWAp. The question of the role of NGOs in a wider consultation mechanism, although not as "burning" as the other issues reviewed in this chapter, is an important one for the Health SWAp.

"Health NGOs" in Tanzania are an extremely diverse lot, including small community-based organisations, welfare organisations, service delivery oriented groups, advocacy groups, etc. Some primarily represent the interests of health service users (in particular, the poor); others are service providers. Only a limited number are currently involved in policy development.

Generally speaking, although relationships between government and NGOs are gradually thawing, there is still a long way to go before a constructive dialogue can be established and institutionalised (in the way the government-donor dialogue was institutionalised). Tanzania

[83] *The Unbearable Cost of Illness – Poverty, ill-health and access to healthcare – evidence from Lindi Rural District, Tanzania* (n.d.).

[84] As one interviewed person put it, making poor people pay for bad services is "adding insult to injury". The 2003 Technical Review team also emphasises that "health services can contribute to reduction of poverty, only if the services are effective and cost-effective. Poor quality health services, for which scarce household resources are spent at the expense of food and education, contribute to the cyclic relation between illness and poverty" (HERA 2003:37).

does not have a long tradition of breeding civil society organisations, and its government does not have a long tradition of talking to them, let alone taking their views into account. Relationships are still characterised by mistrust, and a certain lack of maturity, on both sides:

- on the official side, government still has to learn to "relax" in the face of challenges posed by NGOs, and be prepared to accept other people's views and engage in dialogue without feeling threatened; it also has to accept that activities it does not directly control are not necessarily subversive, and may usefully complement its own structures and activities (there are services that only NGOs can deliver at the moment);
- on the other side, NGOs too often fail to take into account the constraints (in particular, the budgetary constraints) faced by government, and many of them tend to focus on a single issue and forget that government has to tackle hundreds or thousands of issues which must be prioritised; NGOs also often fail to keep public authorities properly informed of their activities, possibly for fear of interference.

In spite of these difficulties, the voice of NGOs is gradually getting better heard in policy dialogue: *urban NGOs, in particular, are increasingly participating in policy processes*. The MoF is reported to become more open to dialogue with NGOs, and less afraid of criticism (whereas the MoH and the MoEC are perceived as opposing the strongest resistance!). Some NGOs are getting more professional, using the media to get popular attention on specific issues and build pressure from below, while also participating in policy forums.

In the health sector, the MoH is not very fond of NGOs (in particular international ones with a local representation) as they are perceived as "popping up" during annual review meetings, but not otherwise cooperating with the authorities. They are considered "unaccountable", and viewed as not making enough efforts to harmonise their activities with those of "official" healthcare providers. It is felt they should try to integrate their activities with national and local structures, and possibly work on a contractual basis rather than "do their own thing" – an idea that is perceived by NGOs as a threat to their independence (even if service agreements can be justified in some areas). *At the district level*, on the other hand, it seems collaboration between NGOs and local health authorities is less tense – maybe because grassroots organisations are very much integrated in the "social fabric" of the local community, and their activities are better known, understood and appreciated.

A few interfaces already exist between the NGOs and the SWAp:

- *a few seats are reserved for them in the Joint Annual Review* (in the latest meeting, ten very hardly negotiated seats out of 250); nevertheless, such is the pressure in favour of consensus, and NGOs feel so much like "outsiders" during these large meetings, given the small size of their delegation compared to other stakeholders, that there is *de facto* a kind of censorship which makes it difficult for them to express their views and do real advocacy work in this forum; furthermore, their speaking time is very much limited;
- *NGOs* (primarily representing private, non-profit providers of health services, such as faith-based organisations) *hold a few seats on the SWAp Committee*; one problem is that being appointed to the Committee by the MoH (on the basis of undisclosed criteria), few of them actually dare to do strong advocacy work, for fear of losing their seat;
- there are *two NGO seats on the Technical Sub-Committee*;[85] this and the task forces that contribute to the Sub-Committee's work are considered more promising forums for real

[85] NGO representatives are appointed by the NGO Policy Forum.

sector dialogue, since meetings are less formal, have fewer participants and are more focused on specific issues than JARs or SWAp Committee meetings. MoH representatives are reported to be "less defensive" in these forums, which favours dialogue and mutual trust building.

NGOs actually have mixed feelings towards the SWAp. The most mature and "well-connected" ones approve the SWAp process, as they realise nothing sustainable can be achieved on the basis of projects. Many NGOs, however, see the SWAp and budget support as detrimental to their activities, as funding is withdrawn from projects including NGO projects to be redirected to "bulk" sector financing. All insist that donors must continue supporting NGOs active in the sector.

For the past few years, policy-oriented NGOs have tried to organise themselves better. A sub-group on health has been created within the NGO Policy Forum, which gathers approx. eighty organisations and has published a booklet presenting joint statements on a variety of issues, including health-related ones. The health sub-group has produced key inputs to the PRSP, the PER, the health sector JAR, a healthcare financing workshop held in May 2005, etc. Building on this structure, and on existing interfaces with the SWAp (e.g. through increased participation in technical work), is probably the way to go. *Donor support for capacity-building activities within NGOs (including grassroots and rural ones), rather than just projects, would* also *help promote civil society participation in sector dialogue.*[86] In "exchange" for increased participation in this dialogue, *those NGOs that might so far have paid little attention to official health policies and strategies could be expected to make efforts to better "align" their activities with existing, widely approved goals and objectives* – and to look for synergies with other sector stakeholders.

[86] A fund entitled the Civil Society Foundation actually exists to finance the institutional strengthening of local NGOs. However, the Foundation's grants support only short-term, "short-output" projects, rather than the long-term, structural projects needed for truly promoting capacity building.

8. Extensions

8.1. Belgium's (non?-)support to the Health sector

Belgium's cooperation with Tanzania, the priorities of which are defined in the *Belgian-Tanzanian Indicative Development Cooperation Programme 2003-2007*, focuses on five "areas of concentration": primary education, the judiciary, HIV/AIDS (which gets 3.7 out of 40.25 million EUR), the environment and support to the decentralisation process (BTIDCP 2003).

As far as HIV/AIDS is concerned, the indicative cooperation programme specifies that "emphasis will be put on the social aspects of the epidemic"; there is nonetheless a medical component to Belgium's assistance. More specifically, Belgium supports the fight against HIV/AIDS:

a) through bilateral projects:
   - support to the STI/STD treatment component of the NACP in the Kilimanjaro and Ruvuma regions (2003-2007, 0.53 million EUR): training of medical staff and "peer educators" in dispensaries, awareness creation campaigns, provision of drugs;
   - AIDS awareness campaigns in primary schools: an identification mission took place in 2003, and a budget of 1 million EUR has been earmarked – but the start of the project has been delayed by coordination difficulties.
b) and through multilateral channels:
   - general contribution to the GFATM, without much involvement in monitoring;
   - support for a multi-country - Tanzania, Burundi, Mozambique - home-based care project, now coming to an end, via funding awarded to UNAIDS, which sub-contracted to the WHO and the NACP (2001-2004, 2.48 million EUR).

As far the *health sector in general* is concerned, Belgium is a very minor donor. Recently, two equipment-related micro-projects have been financed. A larger, longer-term project, financed by the Belgian Survival Fund, supports primary healthcare development in the Kagera district (2003-2008, 1.83 million EUR).

Belgium's interventions in the health sector thus *come primarily in the form of projects*. The main reason invoked for not participating in the DPG Health and the SWAp process and for not switching to budget support is that Belgium is a minor donor in this area, which would not carry much weight in the DPG Health, the SWAp Committee or the BFC. On the other hand, Belgium is a member of the DPG HIV/AIDS.

Another reason for choosing the project instrument in the health sector is that Belgium's current policy is not to grant more than 50% of its aid in the form of budget support. Since in Tanzania, Belgium provides budget support to the Education sector and will soon do so in favour of the Local Government Reform Programme (in both cases through contributions to a basket fund), there is no money left for budget support in other sectors. (As far as HIV/AIDS is concerned, the question has not arisen since there is currently no joint funding mechanism.)

Still, it is a bit puzzling to hear Belgian cooperation representatives declare that "we are not active in the health sector", when Belgium is still running the occasional health project, participates in the DPG HIV/AIDS, and actually dedicates a sizable share of its HIV/AIDS budget to support medical aspects of the HIV/AIDS programme. *One suggestion to avoid a lack of coordination with the health sector would be for Belgium to join the initiative of Norway, Sweden and Canada* – three countries that are also in the slightly awkward position of supporting HIV/AIDS-related medical activities (more specifically, care and treatment) without participating in the Health SWAp. These three countries have decided to attend the annual Joint Health Sector Review, and they send a common observer – from either of the three countries, according to availability – to the DPG Health.

Two more observations are called for. First, the usefulness of the "max. 50% budget support" rule is questionable. In our view, *decisions on how big a share of resources to allocate to each aid instrument would best be left to local representations* (with the necessary safeguards, of course, such as the provision of a clear and well-founded justification, and a regular review of the policy).

Second, the fear of smaller contributors "that their distinctive voice will be lost in the context of a larger and more comprehensive contribution" may be misplaced. The IMG notes that small donors often feel "the best way to maintain their individual 'leverage' is through projects" – yet "quite what they want to achieve through this individual leverage is not articulated, beyond general references to 'sector dialogue'" (ESRF 2005:23).[87] Yet we believe *there is room, in the Health SWAp, for small donors to express their opinion and get their voice heard* in the various coordination forums – and if they wish, to exercise influence on specific issues through participation in technical forums. *We see a priori no reason for considering the project instrument as the only suitable aid instrument for a small donor*.

8.2. The Education SWAp

It was not our purpose to investigate the Education SWAp– but we could get some information about it during our visit to Dar es Salaam, and it seems interesting to highlight (very briefly) some apparent differences with the Health SWAp.

The Education SWAp started approximately at the same time as the Health SWAp. Yet at first sight, it looks like a much less advanced, less "completed" process than the health-related one. The most striking feature is that it has failed so far to become anything more than vaguely "sector-wide" in scope. There are several possible reasons for this.

The first one is that the institutional setup is very complex and fragmented: besides the Ministry of Education and Culture (MoEC) (responsible for primary and secondary education) and PORALG (responsible for the decentralisation of primary education), other ministries are competent for higher education, vocational education and "child community development". Although some donors are unhappy with this situation and believe a SWAp would have more chances of being successful in a rationalised institutional framework, they cannot really express it since it touches on the sovereignty of Tanzania.

[87] The quotation from ESRF actually refers to the Education SWAp. However, we found it relevant to the situation of small donors in general, in any sector.

Another reason is that although the Education Sector Development Plan is supposed to provide a strategy for the whole sector, only the part relating to primary education has been really developed so far. A basket fund was set up to support (exclusively) a Primary Education Development Plan (PEDP) that turned out to be managed like a super-project rather than the embryo of a SWAp-supported sector programme. Being managed entirely by a small team working like a Project Management Unit, the PEDP suffers a lack of institutionalisation at the national level: there is no involvement from the various services and departments concerned by the programme, nor a clear allocation of roles and responsibilities.

Some efforts have recently been made to develop a strategy for secondary education, but only the government and the World Bank finance it so far, and it looks set to suffer the same problems as primary education, i.e. a lack of links both within the sector and with other sector reforms.

It is believed that *the choices made by development partners in terms of sector financing have not been neutral*. The decision to set up a *basket fund aimed at financing exclusively primary education contributed to the isolation of this programme* from the rest of the sector: had the basket fund immediately targeted the whole sector, there would have been much more pressure to develop its various components in a balanced way, and the creation of links and synergies between various types and levels of education would probably have been fostered. Also, *the joint financing mechanism only supports capital expenditure*, to the exclusion of recurrent expenditure; so it does not allow to balance the budget between these two types of expenditures (government still dedicates 90% of its education budget to paying teachers), which *induces a strong distortion into the sector's budget structure*.

Another characteristic of the Education SWAp is that it is only now starting to work on the development of a sector-wide performance monitoring system, the principles of which were to be presented at the sector's annual review in September or October 2005. Unfortunately, this crucial development process is entirely donor-driven.

A lot of frustration has resulted from this relative failure, on both sides. The MoEC feels that development partners are "too demanding, intrusive and interfering", and is frustrated at recurrent delays in the disbursement of aid – to the point that it has expressed a preference for aid provided in the form of general budget support, rather than basket funding (ESRF 2005:25)! Donors are frustrated at the perceived lack of capacity within the MoEC – and blame problems within the MoEC for the "disruption of resource flows into the sector" (ESRF 2005:21).

There is still hope that the Education SWAp will emerge from its current state of crisis and develop into a fully-fledged SWAp (a lot of hopes are notably placed in the new M&E tool). Some progress has been reported recently in the dialogue between government and development partners. Still, *it is surprising that two SWAp processes that started at broadly the same time, in the same spirit, and (roughly) with the support of the same development partners, have evolved in such different ways*.

9. Conclusions

9.1. "Breadth and depth" of the Health SWAp

The results of our mini-survey, corroborated by additional information collected in the context of the mission to Tanzania, confirm that the Tanzanian Health SWAp has considerable "breadth" (since it features all the elements that are recognised as characteristic of the existence of a SWAp), as well as significant "depth" (since the degree of achievement reached in the implementation of each component, although variable, is generally high). More specifically:

- all respondents consider that the *sector policy and strategy documents are accepted by all significant donors to the sector* – and several even consider that there are no longer pressures from development partners to impose their vision on sector policy and strategy, thus acknowledging a high degree of ownership by the Tanzanian government;
- *the sector's MTEF covers expenditures financed by domestic resources as well as a sizable share of external resources* – and the document is considered realistic by most respondents;
- *there is a national sector performance M&E system*; observers differ as to how reliable it is – but most donors have adopted it and support its improvement rather than trying to bypass it with their own systems;
- *there is a formal donor-MoH/PORALG coordination system, under clear government leadership* according to a majority of respondents; this comes *on top of a donor-only coordination mechanism*, which is a typical feature of development aid in Tanzania;
- opinions are somewhat divided as far as the *degree of procedure harmonisation* is concerned; still, *a majority of respondents estimate that "most donors, including the most significant donors to the sector, use government procedures"* – even though projects governed by donor-specific procedures still constitute a sizable share of aid to the sector; *harmonisation is more advanced in non-financial matters* (overall sector performance monitoring, policy dialogue, expenditure monitoring, …);
- a small majority of respondents estimate that *consultation mechanisms with other sector stakeholders are not yet very developed and structured* (whereas a large minority consider a structured consultation mechanism is already in place); *among stakeholders, health service users are the least consulted* (civil society, public as well as private healthcare providers being better represented in existing consultation forums).

To supplement this analysis of SWAp components, we have also briefly assessed to which extent the Tanzanian Health SWAp (which we consider successful) meets the conditions identified by the European Commission as "essential" or "important" for the success of a sector programme (EC 2003a:22). Let us start with the four "essential conditions":

1) *A strong and effective leadership at sector ministry level:*

   We consider this condition is met.

2) *A commitment to the SWAp process elsewhere in government, particularly in the MoF and at senior political level:*

This condition is also met. There is strong political support, at high level, for SWAps. One small reservation is that although it is supportive in principle, the MoF in practice is still showing little interest in getting involved in the workings of the Health SWAp (as testified by its poor attendance of SWAp Committee meetings).

3) *A broad consensus between government and donors on key policy and management issues for the sector:*

   This has been the case so far – but consensus now threatens to unravel over a number of issues, notably ARV therapy and the opportunity of charging user fees for essential services.

4) *A reasonable degree of macroeconomic and political stability, leading to a relatively high degree of budget predictability:*

   This condition is met.

As far as the "four important facilitating conditions" are concerned:

5) *A manageable framework for institutional relationships (i.e. budget responsibility of a single ministry for the sector programme):*

   The institutional relationship framework is definitely not "unmanageable", but it is complicated by two factors:

   a) the important role of PORALG and LGAs in the provision of district health services, not just in terms of supervision but also in budgetary terms (part of the money for the sector comes from PORALG's and LGAs' budgets);

   b) the role of TACAIDS in the overall supervision of AIDS-related activities, and in negotiations (notably bearing on financing issues) with global vertical initiatives.

6) *Existence among donors of an experienced "leader" (able to support the government in managing the process):*

   This condition is met. Generally speaking, the initial donors to the basket fund mechanism, and in particular DANIDA and DFID, were very experienced partners and provided the necessary support.

7) *Existence of incentives compatible with a sector-wide approach (does the chosen sector strategy provide incentives for all main stakeholders to "play along", or is it likely to result in obstructive behaviour?):*

   The SWAp as such did not create disincentives such as cutting staff or budget: restrictions on the hiring and remuneration of staff pre-existed and are not sector-specific; and the SWAp allowed for significant increases in the sector's budget, which definitely played an incentive role for national and local stakeholders. Where the SWAp has failed so far is in creating any significant incentives to retaining medical staff in the sector. Even though this is largely contingent on the civil service reform process, maybe some creative approaches to solving the HR crisis could have been developed.

8) *Possibility of achieving "quick wins" to raise commitment and support:*

   The intervention of the basket fund to top up district grants as from the first year of decentralisation might be considered as a "quick win" that gained commitment and support for the process. More generally, the setting up of a basket fund mechanism so soon after the decision to adopt a SWAp must have been a strong factor of motivation for the Tanzanian health authorities.

In conclusion, Tanzania's Health SWAp meets most of the conditions deemed essential for success – which is consistent with our findings concerning "breadth and depth" of the process.

9.2. Achievements of the Health SWAp

Overall, all the people we interviewed have a positive view of the Health SWAp, and no one seems inclined to go back to a project approach. Some are of course critical of certain aspects of the SWAp – but everyone considers the process has supported useful reforms and contributed, to varying degrees but almost always in a positive manner, to improvements in sector management and outputs.

Based on replies to our questionnaire, the Health SWAp's achievements can be tentatively "ranked" as follows: [88]

a) areas characterised by very substantial improvement:

According to 70% or more of respondents, the SWAp has significantly ("too a large extent" or "100%") contributed to:

- improving efficiency in the use of financial resources;
- increasing government ownership of health policies and strategies;
- carrying out in-depth reforms of the healthcare system.

b) areas characterised by noticeable improvement:

According to 50-70% of respondents, the SWAp has significantly contributed to:

- improving the consistency of health policies with other policies (e.g. poverty reduction strategy, …);
- rebalancing the health sector budget in terms of investment and recurrent expenditures;
- improving the predictability of external funding for the sector;
- reinforcing government capacities in terms of health sector planning;
- reinforcing government capacities in terms of health sector financial management;
- stimulating a convergence of donors' policies and strategies for the development of the health sector;
- increasing the amount of resources dedicated to the health sector.

And: there is a true willingness, among donors, to move further and deeper towards procedure harmonisation.

c) areas characterised by modest or no improvement:

Less than 50% of respondents believe the SWAp has significantly contributed to:

- improving the quality of healthcare;

[88] For each topic, we counted the replies that said that the Health SWAp had allowed to reach the proposed result "to a large extent" or "100%". Where such replies represent at least 70% of total replies, we consider the area is characterised by "very substantial improvement". Where the score of very positive replies is between 50% and 70%, we consider the area is characterised by "noticeable improvement". Areas that obtain a lower score of high-rating replies (less than 50%) show "modest or no improvement".

- reducing aid management costs from the government's perspective;
- reducing aid management costs from the donors' perspective;
- improving human resource management in the sector.

These results must of course be interpreted with caution, in view of the small size of the sample (fifteen respondents) as well as the difficulty of ascribing some of the improvements specifically to the SWAp. *In many instances, the SWAp modality should be viewed as a catalyst, rather than the direct and single cause, for positive changes occurring in the sector*. With this caveat, one could tentatively conclude that, over the first seven years of its existence, the Health SWAp has: helped increase the ownership of health policies and strategies; facilitated the implementation of in-depth sector reforms (most prominently, the decentralisation of primary healthcare); increased the resources available for the sector and efficiency in resource use; contributed to capacity building and institutional strengthening; and promoted a series of process improvements as far as aid management and sector management are concerned. On the other hand, it has so far failed to deliver marked improvements in the quality of care (notably by failing to tackle the human resource crisis); and has not resulted in any significant reduction in transaction costs.

Note, finally, that our survey did not ask respondents whether they believed the SWAp had contributed to improved *health outcomes*. Apart from the fact that the available data do not yet show substantial, sustained improvements in health outcomes [89], these outcomes have many determinants [90], of which only a few are directly under the control of the healthcare delivery system. Attributing any change in health outcomes to the SWAp (or rather, to changes in healthcare delivery systems induced by the SWAp) would require complex impact studies, that are beyond the scope and means of our research in Tanzania. Both government and donors, however, would be expected to show interest in this question. Yet Smithson (2005:18) notes that *"the effective absence of dialogue on health sector performance in terms of outputs or outcomes" in Tanzania is "most puzzling"*.

9.3. Perspectives for the Tanzanian Health SWAp

The health SWAp has come a long way and, in many regards, achieved remarkable and significant results. However, for the gains to be secured and enhanced, the SWAp needs to keep moving forward. Yet we were at times under the impression that the process had been a bit "static" of late, somewhat running out of steam, in the sense that many partners seem to be satisfied with the "balance" that has been reached and afraid of any developments that might upset it. The relationships between most donors and government are excellent, but as a result, there may be too little challenging of each other. There may be a bit too much emphasis among "hard core" SWAp participants on the importance of consensus over policies, with the danger of stiffening debate. Some reactions towards new initiatives such as global vertical programmes may be excessively defensive and focused on the damage they could do, rather than on the opportunities they also offer.

[89] Actually, some improvements have been noticed – but they will become more certain if they can be confirmed by further surveys. According to the latest DHS, some progress has been achieved in infant mortality (although there is still a long way to go to bring it down to "acceptable" levels), and also in immunisation rates – but no progress has been achieved at all on maternal mortality. (Yet, maternal mortality is considered by some to be more correlated to the quality of health services than child mortality.) Other recent sources on health outcomes include: Makundi (2005), Smithson (2005), STI (2005).

[90] See for instance Schleimann et al. (2003:5-9)

In spite of a positive overall assessment of the SWAp's achievements so far, a feeling of unease is perceptible, that may hide a latent crisis. Tensions come to the surface in the form of occasional contradictory policy statements, of upset and possibly exaggerated reactions to these statements, and of attempts to re-establish bilateral negotiations on some issues rather than opting for open, transparent, sector-wide dialogue. Some interviews left us with an impression of "fatigue" among some participants, of discouragement at the idea that after the considerable efforts made in the past seven years, so many fights still lie ahead just to avoid losing the ground that has been gained.

The main challenges the Health SWAp will face in the coming few years include:

- *resolving the human resource crisis* – possibly the thorniest of all issues, but one on the resolution of which many other outcomes depend;
- *integrating global vertical programmes and ARV therapy* into existing structures and processes, so as to avoid a return to fragmented approaches and the possible collapse of the still fragile health system as a whole;
- *demonstrating that improvements in health systems, sector management and sector coordination processes can lead to marked and sustained improvements in quality of care, with positive effects on health outcomes* (even if other determinant factors are at play).

In the longer term, another challenge will also consist in *reducing dependence on external resources for financing the sector* – which is one of the reasons that justify the new emphasis placed on developing public-private partnerships. Another reason for supporting these partnerships without any delay is that all possible resources available in Tanzanian society must be mobilised as soon and efficiently as possible if the other challenges identified above are to be successfully met.

A SWAp is a way of doing things, a process, so by definition it must be dynamic. The Tanzanian Health SWAp has been very dynamic so far. Astounding progress has been achieved in many areas. The decentralisation of primary services, in particular, has been conducted more successfully than in most other countries that made a similar experiment. The SWAp process itself has been through ups and downs and some crises (for instance, sector dialogue nearly broke down at the time of finalising and approving HSSP II). So far, obstacles have been overcome. *A new balance needs to be struck between preserving the achievements of the past and avoiding the trap of excessive resistance to change.* If this balance can be found, the Health SWAp will recover from its present "low-level depression", and continue to provide *the* framework in which all the described challenges can be tackled.

9.4. The right "mix" of aid instruments

The "mix" of aid instruments varies, sometimes significantly, across donors: not two agencies have exactly the same views on what the ideal combination of instruments might be. General budget support, sector budget support, projects, "hybrid" forms of assistance drawing on a mix of government and donor-specific procedures, technical assistance, technical cooperation, training and capacity building, support for NGOs, … are used in "dosages" that change across donors and, within each agency, evolve over time.

Donor agencies' headquarters seem to play a key role in determining this dosage – and their decisions in this regard seem to be very much driven by general policies (which are themselves driven by "fashions"). *The latitude of their local representations to influence the weight of various instruments in view of local circumstances seems to vary across agencies, but to be rather limited on average*.

In this context, it is difficult to draw definitive conclusions on what constitutes "the right mix of instruments". A number of provisional conclusions can be drawn, however.

9.4.1. THE PROJECT-BASED APPROACH

No one (with the possible exception of USAID) seems inclined to go back to a project-based approach, defined as an approach that uses projects as the main cooperation modality, without reference to a global or sectoral framework.

9.4.2. PROJECTS AS A FINANCING MODALITY

Projects as a financing modality integrated in a SWAp and accounted for in a MTEF, although gradually phased out by many donors, remain popular instruments; *their use "with moderation" can be justified in some cases*:

- as a way of "keeping in touch with sector reality", for donors who provide most of their support in the form of sector budget support but wish to keep a "periscope" in the sector's operations, so as to guide their political dialogue with the national authorities;
- as a tool for testing innovative approaches (pilot projects).

Using projects, even with moderation, as a way of supporting activities donors feel are a bit neglected or under-prioritised in a sector programme, may be justified but is more controversial, because it goes directly against the spirit of prioritisation inherent in a SWAp and a MTEF. Nevertheless, a small dose of such projects may be unavoidable as cooperation agencies pursue their own objectives, notably charitable and humanitarian objectives, for which they are accountable to their administrators or their country's taxpayers.

The IMG's latest report adds a number of requirements that should apply to the continuing use of the project instrument. Projects:

- "must operate within the government machinery, regulations and procedures;
- must be subjected to contestability of resources in the budget process;
- must be designed and implemented under the same conditions as other government funded projects" (ESRF 2005:8).

Whether donors are ready to accept all these conditions remains to be seen – but in a "mature" SWAp such as Tanzania's Health SWAp, striving to meet them should definitely guide the design of any new projects.

9.4.3. SECTOR BUDGET SUPPORT

Sector budget support is well suited for donors who wish to keep involved in "advanced" sector dialogue in a sector the management of which, in their view, has not yet reached full

maturity. SBS stimulates ownership, local leadership and the development of a sector's planning and management systems – while allowing development partners to have some influence on the strategic choices made by sector managers. *Efforts should be made to ensure SBS is sufficiently additional – i.e. it should not generate excessive fungibility and cause government to disengage from the financing of a sector*. To avoid a distortion in the allocation of resources, non-targeted SBS should also be preferred to targeted SBS (provided, of course, there is a broad agreement over resource allocation within the sector).

9.4.4. GENERAL BUDGET SUPPORT

General budget support is appropriate to empower partner governments, foster national planning capacities, and stimulate the development of general public finance management and accountability systems. It can be used to support macroeconomic stability, as well as overall development and poverty reduction strategies. It should not, however, be used indiscriminately, since any misuse of funds (either because of corruption, lack of competence or inefficient resource allocation) is likely, in the medium term, to severely backfire – resulting either in the suppression of a useful cooperation instrument, or in a reduction of aid budgets under pressure from the public opinions of donor countries.

We (and most of our interlocutors in Tanzania) *do not see any incompatibility between the simultaneous use of general budget support and sector budget support*, as long as the pursued objectives of each modality are clear. Even if some awkward situations occasionally arise (such as the case of a development partner suppressing support to a specific sector because of complaints with regard to its management, while it keeps supporting the sector indirectly through general budget support), overall the two modalities are more likely to be complementary than mutually destructive. Maintaining a presence in key sectors through sector budget support is, if anything, likely to improve the effectiveness of the other part of aid that is disbursed in the form of general budget support.

Only where general under-funding of the government's budget by domestic resources remains the single serious obstacle to development is it justified, in our view, to resort <u>exclusively</u> to general budget support – a stage that has not yet been reached by Tanzania, even if the country is "on the right track". Of course, this statement applies to external aid in general: in an age of "labour division" for greater efficiency of aid, one donor may very well use exclusively general budget support if it is confident that other development partners are doing a good job of strengthening individual sectors, and are helping the partner government address remaining weaknesses in the definition and implementation of development strategies. In this light, DFID's switch to GBS makes perfect sense, even if the agency's calls for other donors to follow suit "in bulk" look a bit premature.

9.4.5. TECHNICAL COOPERATION AND TECHNICAL ASSISTANCE

There is a debate, in the development community, as to whether *technical cooperation* should increasingly be preferred to *technical assistance*. Technical cooperation has advantages but can also turn out to be very expensive, fail to strengthen local capacity and distort local labour markets. As for TA, the problem is that it "has been tied to finance, packaged into projects, not necessarily demand driven, and sometimes has resulted in erosion or replacement of local capacities rather [than] building those capacities" (ESRF 2005:59).

Where *technical assistance* is really needed (the need is unlikely to disappear completely), it *should be hired at the request and under the supervision of the relevant national authorities, giving preference to national or regional skills where they are available*.

9.4.6. SUPPORT FOR NGOS

Support for NGOs in the form of grants [91] remains a very useful tool, and is not incompatible with any of the modalities described above – as long as overall consistency with the sector programme is kept in mind. While excessive interference with NGO activities by government should definitely be discouraged, it makes sense for donors who support NGOs active in the health sector to inform national authorities of these activities, and to the extent possible to get them accounted for in the MTEF. [92]

Support for NGOs that address issues currently not considered a priority by government, but deemed important by donors, is probably a better way of addressing "gaps" in national sector programmes than the direct setting up of donor projects. On the other hand, *with NGOs now emerging as a real partner in sector dialogue, they may also be expected to strive to "align" their interventions with national policies and strategies*, trying wherever possible to support national objectives and develop synergies with the actions undertaken by other stakeholders. To this effect, in addition to supporting "service delivery" activities by NGOs, *donors should help develop and finance comprehensive strategies for the institutional strengthening of NGOs and grassroots organisations*.

9.4.7. SIMULTANEOUS USE OF VARIOUS AID INSTRUMENTS

The simultaneous use of various aid instruments is sometimes viewed as a way of "spreading risk". More positively, it can also be considered as a way of *flexibly adapting aid modalities to the specificities of each country and sector in which development partners operate*. Provided it:

- fits local needs and conditions;
- results from an in-depth analysis of these needs and conditions, and a thoughtful decision process (rather than the application of inflexible rules dictated by headquarters);
- is respectful of the preferences and development policies of the partner government;
- complements rather than duplicates or undermines the action of other donors;
- meets the requirements of the international harmonisation and alignment agenda;

then the use of a "mix" of aid instruments is perfectly acceptable, and there is no reason to rush towards the adoption of general budget support as the *exclusive* aid financing modality.

[91] Where NGOs are hired to implement some activities defined by a donor, rather than supported in doing what they have themselves determined they should do, we consider the project modality is in use.

[92] How to do this without imposing an excessive reporting burden on NGOs, and without encouraging government to try and impose control on NGO activities rather than develop cooperation and coordination mechanisms, is a delicate issue and remains to be determined.

9.5. SWAps and decentralisation

In the early stages of development of the SWAp, some development partners were concerned that the SWAp and the HSBF were a centralising force at a time when decentralisation was promoted, and were dominated by central-level policy issues – which could lead to neglecting and under-funding district health interventions. Some believed there was an inherent conflict between the SWAp/HSBF (a "centre-led, top-down process") and decentralised health provision. They questioned the willingness to give districts enough flexibility (Hobbs 2001). Indeed, the least that can be said is that districts have not been given a lot of room for setting their own priorities. *Planning guidelines and expenditure ceilings have now somewhat been eased, but district councils remain very much in a "straightjacket", both in terms of planning and in terms of resources.*

Although all primary healthcare services are now provided by local government, *the bulk of the health sector budget is still controlled by central government.*[93] The fact that drugs and medical supplies procurement remains a centrally-exercised competence partly explains this. Other centrally registered resources, such as contributions to the NHIF, are partly channelled to other levels. Still, *even if official statistics poorly reflect the real share of expenditure going to local government, the share of resources it gets remains very low*, and this puts into question "the extent to which LGAs are being entrusted with full responsibility for their spending decisions" (HSPER 2005:14). The fact that "central government expenditure is expanding much faster than local government" was raised as a cause of concern in the latest JAR (MoH 2005: iv, 16).

This tendency to keep strong central control over district healthcare operations may have more to do with centralising tradition in general rather than with any "centralising forces within the SWAp". We consider that *Tanzania's Health SWAp demonstrates there is no inherent contradiction between adopting a SWAp* (which provides a general framework for health sector development) *and promoting decentralisation*. We actually believe *a smoothly running SWAp can be a crucial factor for the success of decentralisation reforms.* In Tanzania, it is likely that the decentralisation of health services would have happened anyway – but many also consider that *the support provided by donors in the context of the SWAp (in particular through the district basket fund) greatly facilitated the initial steps of the process*.

Now, the fact that not only central government funding, but also the central basket fund, grow faster than local government funding and the district basket fund, may be considered an anomaly. *In coming years, a failure to gradually increase the share of resources directly attributed to regions and local government (both in the government budget and in the basket fund) will increasingly look like a failure of the SWAp to support true decentralisation.*

[93] Breakdown of health resource allocations between the central and local level (actual expenditure may diverge by a few percentage points):

Description / Fiscal Year	2000/01 (budget)	2001/02 (budget)	2002/03 (budget)	2003/04 (budget)	2004/05 (budget)	2005/06 (indicative)
Central government	59%	64%	63%	62%	66%	*73%*
Regions	9%	6%	7%	7%	6%	*27%*
Local government	32%	30%	30%	31%	28%	

(Sources: Health Sector PER update FY05; *in italics: MoH 2005*)

Fiduciary questions, more than any alleged "lack of absorption capacity"[94], may be an important explanatory factor. Development partners concerned about promoting decentralisation and improving the quality of primary healthcare may have to *step up their efforts to reinforce local management capacities and fiduciary systems*.

Decentralisation of primary healthcare may also be made more effective by *reinforcing RHMTs*, to allow them to actually play their role of advisors and supervisors to district health officials. As for the *very tight planning and budgetary guidelines* imposed on local health authorities, they have been justified by the need to ensure adequate standards of care – but *should be relaxed in coming years, in line with improvements in local planning capacities*, to allow better taking into account the local needs and situations.

9.6. The harmonisation and alignment agenda : implications for development partners

The OECD's Development Assistance Committee is pushing for an ambitious agenda for further harmonising and aligning donor practices. The principles of this agenda were laid out in 2003 in a document entitled *Harmonising Donor Practices for Effective Aid Delivery* (OECD 2003a). They were recently reiterated in the *Paris Declaration on Aid Effectiveness*, which defines harmonisation and alignment as follows:

- *alignment*: "donors base their overall support on partner countries' national development strategies, institutions and procedures";
- *harmonisation*: "donors' actions are more harmonised, transparent and collectively effective" (OECD 2005).

Although high-level political commitments have been made in favour of further alignment and harmonisation, *we did not feel*, during our mission to Tanzania, *that this agenda had a high priority among development partners*. In the health sector, this relative lack of interest can be justified by the fact that there are more pressing concerns at the moment. It may also be that development agencies are uncertain about how to go ahead with the agenda's implementation – and therefore provide little guidance, or even contradictory signals, to their representative offices.

Still, *the drawing up of the JAS provides an opportunity to define a new, more ambitious alignment and harmonisation agenda*. Its implementation will require the creation of "internal incentives for harmonisation and alignment within donor agencies (…). Many are committed rhetorically, but have incentive systems of their own that undermine commitment to more radical approaches like a [Joint Assistance Strategy]. Donors wanting to engage in a JAS need to re-examine critically their own incentive systems and internal political drivers simultaneously. In this respect, GoT, especially some line ministries, will also have to revisit the incentive structures which draw action against harmonisation" (ESRF 2005:15). We concur that without such a revision of donor as well as government incentive systems, it will be difficult to move towards more alignment and harmonisation. We also believe the Tanzanian

[94] "It is our assessment that [absorptive capacity] problems are mainly due to ineffective financial procedures and to not allowing funds to be utilised to replace worn out vehicles and equipment as well as increasing salaries to a competitive level. It is hard to imagine that there is a major permanent absorptive capacity problem considering the gross lack of resources for minimal routine activities (…)" (Schleimann et al. 2003:12).

Health SWAp would greatly benefit from such an exercise, notably in terms of reducing transaction costs – a benefit that has eluded the SWAp so far.

9.7. Lessons for emerging Health SWAps

9.7.1. ON THE DYNAMIC NATURE OF SWAPS

A SWAp is a dynamic process: like a bicycle, if it becomes static, it is in great danger of collapsing. *SWAps have their ups and downs*, and this must be accepted as a fact of life; temporary difficulties must not lead to premature discouragement. *SWAps are also regularly confronted with new challenges*, that may occasionally threaten to ruin the achievements of several years of hard work if a new equilibrium is not found.

If *motivated and committed partners* to the SWAp can be found in all concerned groups, starting of course with government and donors (which remain the chief actors in a SWAp even if they are by far not the only stakeholders), it is possible to resolve differences and face up to new challenges. If there is goodwill on all sides, solutions can be found to most problems, even those that look intractable at first. *Informal communication and initiatives*, in case of "crisis", play a crucial role – even if formal structures and processes are also important.

9.7.2. ON THE IMPORTANCE OF PERSONALITIES

Like all human enterprises, what drives the success of a SWAp seems to be a mix of institutions and personalities. Adequate institutions, processes and procedures are of course important. But the *participation, in all stakeholder groups, of a number of open, co-operative, committed individuals*, seems to be equally important. Tanzania's Health SWAp has hugely benefited from the commitment of a small group of people who were ready to work very hard, in a collaborative spirit, in order to achieve progress on agreed priorities and overcome the obstacles that unavoidably arise in any such enterprise. These people are to be found in the "hard core" of the DPG Health, as well as within the government services in charge of managing and coordinating health sector reform; together, they constitute an *informal team of "insiders" who exercise significant influence over the SWAp process, and significantly contribute to its achievements.*

In view of the scarcity of human resources available both on the government's side and, to a large extent, also on the donors' side, *the reliance of the Tanzanian Health SWAp on committed personalities is likely to remain a dominant feature in coming years.*

Partners engaging in new SWAps anywhere should be aware of the importance of strong personal relationships and, while avoiding the trap of relying exclusively on them to make things work, should nurture a collaborative spirit. This may notably require an *adaptation of the profile of people assigned to the management and follow-up of SWAps* in the local offices of development agencies as well as the involved government agencies. However important technical skills may be (and they definitely are), social skills and dedication are equally important.

9.7.3. ON HUMAN RESOURCES

Tanzania has been seven years in a Health SWAp before it seriously started tackling the human resource crisis. *This issue should be number one on the agenda of any starting SWAp*, with the understanding that resolving it is the most difficult issues of all – but that it is also crucial to success, since *the quality of care may depend on it more than on any other factor*.

9.7.4. ON QUALITY OF CARE

We have mentioned that quality of care in Tanzania is deemed to have improved since the inception of the SWAp, but that most of our interlocutors believe there is still a long way to go before it reaches satisfactory levels in a majority of health facilities. Of course, one cannot expect things to change overnight in such a complex matter: time must be allowed for processes to take hold and deploy their full effects. However, it is clear that *real improvements in service delivery cannot be expected until the quality of care gets high priority in the SWAp process*.

In the case of Tanzania, it took approximately five years before the issue really came on top of the agenda; before that, more emphasis was placed on improving general structures, processes and systems – both in the health system in general and in relation to the SWAp. A strong emphasis was placed, in particular, on developing the planning capabilities of districts – with the initial effect that district authorities were bound by countless, sometimes contradictory, in any case very stringent and restrictive guidelines that may in some cases have prevented them from actually adapting services to the needs of the local population.

We understand that only when structures, systems and processes have reached a satisfactory level of quality and maturity can the focus really move on to improving the quality of care. We also understand that an initial focus on enhancing the planning, management and financial capabilities of officials at all levels in the public health infrastructure is a prerequisite for donors to be confident that the money they provide – increasingly in the form of budget support, in principle – is used effectively and efficiently.

Yet, the sooner quality improvement is made a core objective of the SWAp, the better. The need to reinforce structures, systems and managerial capacities should not be an excuse for putting so much emphasis on formal arrangements that the "core business" of providing quality services is neglected. It does not seem impossible to *"embed" quality-of-care objectives at an early stage in the design of institutional and structural reforms as well as management systems* – for instance, by creating innovative incentives for health practitioners, by including quality indicators in the sector's performance monitoring system, and by streamlining procedures from the beginning. Health sector managers and donors should never forget that "the time invested in planning, budgeting, reporting, supervision, training, data collection for HMIS, meetings, involving communities, etc. should primarily support service provision" (HERA 2003:45).

So *the promoters of new Health SWAps, and in particular the donors that support them, should be realistic about the time it takes to improve service delivery – but never get so mired in administrative, institutional and procedural details that they lose sight of the ultimate goal of positively influencing health outcomes through better quality of care*.

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Annexes

Annex 1: List of interviews

21/06/2005	Katrien Meersman	Embassy of Belgium	Assistante attachée à la coopération - Progr. de lutte contre le sida, éducation
22/06/2005	Dr Deborah Kajoka	MoH/NACP	Public Health Specialist, in charge of CTB-financed STD/STI AIDS project
	Mike Kiernan	BTC	Education Advisor, Primary Education Development Programme
	Dr Finn Schleimann	Embassy of Denmark	Regional Technical Adviser, Health
24/06/2005	Jacqueline Mahon	SDC	Health and Poverty Advisor / Chairing the Health DPG
27/06/2005	Dr Ahmed Hingora	MoH	Programme Coordinator, Health Sector Programme Support (HSPS)
	Dr Paul Smithson	-	Private consultant, former DFID officer in charge of the Health SWAp
	Colleen Wainwright	Embassy of Ireland/DCI	Development Specialist
	Herman Verlodt	CTB	Resident Representative
28/06/2005	Pippa Bird	DFID	Deputy Head, Programmes
	Gottlieb Mpangile	Family Health Int'l	STO/Deputy Country Director
	Pius Nambiza Wanzala	Embassy of Norway/NORAD	Programme Officer
	Prof. Philip Hiza	Nat'l Institute for Medical Research	Associated Researcher, Public Health Physician
	Emanuel Makundi	NIMR	Researcher, Social Scientist
29/06/2005	Michael Mushi	USAID	Project Management Specialist
	Dr Edward Maganu	WHO	Representative to Tanzania
	Dr Elihuruma Nangawe	WHO	National Programme Officer, MPN
	Takahiro Moriya	JICA	Assistant Resident Representative
30/06/2005	Dr Bergis Schmidt-Ehry	GTZ Health Coordination Office	Senior Policy Advisor
	Dia Timmermans	Embassy of the Netherlands	First Secretary, Health, HIV/AIDS, Water & Sanitation
1/07/2005	Emanuel Malangalila	World Bank	Senior Health Specialist
	Maggie Bangser	Women's Dignity Project (UTU)	Director
4/07/2005	Max Mapunda	WHO	National Programme Officer, Health Systems Development
	Nathalie Houlou	EU Delegation	
	Dr. Chilanga Asmani	Save the Children UK	Programme Coordinator, Health
	Martine Billanou	Save the Children UK	Programme Director
	Bernadettte Olowo-Freers	UNAIDS	UNAIDS Country Coordinator
	Marjorie Mbilinyi	Tanzania Gender Networking Progr.	Head of Programme - Research & Policy Analysis
	Mike Kiernan	CTB	Education Advisor, Primary Education Development Programme

Annex 2: Questionnaire on the Health Sector Wide Approach

Research Group on Cooperation Instruments in Support of Sectoral Policies
(Groupe de recherche sur les instruments de coopération en appui aux politiques sectorielles)
GRAP-SWAP

Tanzania, June 2005
Questionnaire on the Health Sector-Wide Approach

A sector-wide approach (SWAp) is a process, a way of working between a government and partners involved in a specific sector. A SWAp exists if a number of conditions are met, among which the most frequently mentioned are the following:

- *all significant development partners support a common, sector-wide policy and strategy;*
- *a medium-term expenditure framework (MTEF) supports this policy and strategy;*
- *government leads the coordination process, in the context of a sustained partnership with donors;*
- *common procedures and approaches are adopted to implement and manage the strategy and work programme;*
- *there is a commitment to evolve towards greater reliance on government management and reporting systems for the disbursement and monitoring of all funds.*

This questionnaire is being distributed to a large number of stakeholders involved in Tanzania's Health SWAp. Your answers will be dealt with in a confidential and anonymous way. The questionnaire should:

- give the research group an overview of the SWAP's status and achievements as of June 2005;
- highlight possible differences, among the actors involved, in the understanding of the SWAp concept.

The first part of the questionnaire aims to characterise the components of the Health SWAp in Tanzania and assess the "breadth and depth" of the SWAp process. The second part aims to assess the results achieved so far.

The research group thanks you for your cooperation, and will keep you informed of the results of this enquiry. Please return your questionnaire to the following address: catherine.paul@skynet.be.

Date of filling the questionnaire : ……

You work for : 0 the Ministry of Health
0 PO-RALG
0 the Ministry of Finance
0 a bilateral cooperation agency
0 a multilateral cooperation agency/international institution
0 an academic or research institution
0 a NGO or other civil society organisation
0 you are a healthcare provider
0 other (please specify): ……

Your e-mail address[95] :……..……..

[95] This will allow us to contact you in case of need. We guarantee confidentiality.

1. The components of the Health sector-wide approach in Tanzania

For each of the components below, please tick the box corresponding to the sentence that, in your opinion, best fits the situation of the Health SWAp in Tanzania *(please select only one reply per "block" of possible answers) :*

1.1 Sector policy and strategy

A	There are informal discussions on sector policy and strategy	
B	There are formal discussions on sector policy and strategy	
C	There is a sector policy and strategy document	
D	There is a sector policy and strategy document – which is accepted by all significant donors to the sector	
E	Same as point D + there are no longer pressures from development partners to impose their vision on sector policy and strategy	

1.2 Medium-term expenditure framework (MTEF)

A	There is no MTEF for the Health sector	
B	There is a MTEF covering only expenditures financed by domestic resources	
C	There is a MTEF covering expenditures financed by domestic resources as well as some external resources	
D	There is a MTEF covering expenditures financed by domestic resources as well as all (or at least all significant) external resources	

If there is a MTEF (you answered B, C or D above):

E	The existing MTEF is not very realistic; actual sector expenditures tend to be quite different from those planned in the MTEF	
F	The existing MTEF is realistic; actual sector expenditures tend to be close to those planned in the MTEF	

1.3 Performance monitoring & evaluation (M&E) system

A	There is no national sector performance monitoring & evaluation system	
B	There is a national sector performance M&E system, but it is not very reliable, so donors tend to conduct their own, separate M&E operations	
C	There is a reliable national sector performance M&E system – however most donors still conduct their own, separate M&E operations	
D	There is a reliable national sector performance M&E system, which has been adopted by most donors	
E	All significant donors to the sector use the national sector performance M&E system, and only this system	

1.4 Donor coordination process

A	There is no donor coordination process	
B	Donors coordinate their activities by means of informal meetings	
C	Donors coordinate their activities by means of formal meetings, without the MoH	
D	Donors and the MoH coordinate their activities by means of formal meetings, with leadership provided by one donor or group of donors	
E	Donors and the MoH coordinate their activities by means of formal meetings, with leadership clearly provided by the MoH	

1.5 Procedure harmonisation process

A	There is currently no procedure harmonisation in the management and disbursement of donor funding	
B	Some donors use a common set of procedures – but these are not government procedures	
C	Some donors use government procedures, but most use their own procedures	
D	Most donors, including the most significant donors to the sector, use government procedures	
E	All donors use government procedures	

1.6 User and provider consultation mechanism *(For this question, you may select more than one reply)*

A	There is no structured health service user and provider consultation mechanism	
B	Surveys are occasionally conducted to consult health service users and/or providers	
C	There is a structured consultation mechanism, in which the following stakeholders are represented: - civil society yes / no - public service providers yes / no - private service providers yes / no - health services users yes / no	
D	There is a structured consultation and decision mechanism, in which the following stakeholders are represented: - civil society yes / no - public service providers yes / no - private service providers yes / no - health services users yes / no	

2. The results of the Health sector-wide approach

To which extent do you agree with the following statements	*Not at all*	*To some extent*	*To a large extent*	*100%*	*No opi-nion*
So far, the Health sector-wide approach has allowed to:					
1 increase government ownership of health policies and strategies					
2 stimulate a convergence of donors' policies and strategies for the development of the health sector in Tanzania					
3 reinforce government capacities in terms of health sector planning					
4 reinforce government capacities in terms of health sector financial management					
5 improve efficiency in the use of financial resources					
6 increase the amount of resources dedicated to the health sector					
7 carry out deep reforms of the healthcare system					
8 improve human resource management in the sector					
9 improve the quality of healthcare					
10 improve the consistency of health policies with other policies (e.g. poverty reduction strategy, …)					
11 rebalance the health sector budget in terms of investment and recurrent expenditures					
12 reduce aid management costs from the government perspective					
13 reduce aid management costs from the donors' perspective					
14 improve the predictability of external funding for the sector					
15 There is a true willingness, among donors, to move further and deeper towards procedure harmonisation					

Annex 3A: Data collection grid "Health SWAp"

RESEARCH GROUP ON COOPERATION INSTRUMENTS IN SUPPORT OF SECTOR POLICIES

GRAP-SWAP

Data collection grid – « Health SWAp»

Tanzania

Specific questions to which some attention must be dedicated

- *Stakeholder Analysis :* identify difficulties experienced by donors and national players
- Specific stakes/issues in the sector (human resources, harmonisation, decentralisation, etc.)
- Belgian cooperation experience in the education sector (for comparison)

1. Key documents and data to be gathered

- National health policies and/or sectoral programme
- MoU and other official documents related to the SWAp
- Public Expenditure Review + Sector Annual Review Reports
- Existing impact analyses ?

2. Institutional analysis and prerequisites

- Health sector :
  - Map of the health sector, relations between key players
  - Evaluation of the institutional capacities of the various entities, notably in view of the increased responsibilities incurred as a result of the SWAp (in terms of programming, funds management and evaluation)
  - Capacities of, and incentives for, field actors
  - Definition of the health sector in the SWAp: wide or narrow ?
- Macroeconomic context and public finances *(see specific questionnaire)*

- Development partners :
    - Overview of their cooperation policy and aid budgets for the sector
    - Why they do/don't participate in the SWAp
    - Simultaneous macroeconomic and institutional support ?
    - Main priorities as far as harmonisation is concerned

3. Stakeholder Analysis *(cf. interview guide)*

- Issues and stakes (political, strategic and institutional) mentioned by donors / by national institutions

4. The sector-wide approach (process)

- History of the establishment of the SWAp (figure p. 20 EC)
- Components of the SWAp: see separate questionnaire
- Government leadership, leadership by some other party, involvement of the Ministry of Finance (MoF) and of the main donors
- Place of the SWAp in the overall political and budgetary context
- Civil society participation: in surveys – consultations – negotiations ?
- Test the EC's necessary and favourable conditions for SWAp success (pp. 25-26)
- Strategy used to adopt a MTEF (cf. EC 2003 (p.94) ?
- Coordination / relations with donors who do not participate in the SWAp
- SWAp features likely to foster success / failure

5. Sector strategy and sector programme

- Ownership by national authorities / by local authorities / by other stakeheholders
- Degree of coherence with the PRSP [National Strategy for Growth and Reduction of Poverty, NSGRP April 2005] / Inclusion of poverty reduction objectives

- Economic studies made prior to the definition of the sector strategy/programme ?

- Relevance of policy/strategy in view of needs and local situations ?

- Long-term, comprehensive vision + inter-sectoral aspects

- Are vertical programmes (dedicated to specific diseases, notably AIDS/HIV) compatibles with a comprehensive view of the sector (horizontal reforms) ?

- Tools for institutional strengthening and human resource development

- Implementation and management modalities

- Incentive structures in place (e.g. salaries, bonuses, career prospects, …)

- Financing: sources, with a distinction made between recurrent and investment expenditures and which sources finance which type of expenditures

- Part of sector funding used at regional/local level

- How are sector decisions integrated in the budgetary cycle ?

- Monitoring system / system for consulting service providers/users?

- Result indicators:

  - Nature : input, output, outcome or impact
  - Health indicators (technical effectiveness and impact)
  - Economic and financial efficiency indicators
  - Quality of care, accessibility and poverty reduction
  - Capacity building measures

6. <u>Support and cooperation instruments</u>

- Type(s) of financing privileged by donors: sector-specific or overall budgetary aid, targeted / non targeted, pool of funds, donor-specific procedures

- Harmonisation of financial management, implementation, and M&E procedures ?

- Changes required from development partners ?

- Additionality of donor funds?

- Technical assistance and tools for institutional strengthening / capacity building

- Any improvement in the predictability of aid ?

7. Transaction costs

- Evolution of transaction costs *(see specific grid)*

8. Other projects

- List of projects being run outside the SWAp ?

- Justifications invoked for upholding a project-based approach ?

- Strengths and weaknesses of projects and comparative advantages of a programme-based approach (SWAp) ?

9. Conclusions

Annex 3B: Data collection grid "Public finances"

RESEARCH GROUP ON COOPERATION INSTRUMENTS IN SUPPORT OF SECTOR POLICIES

GRAP-SWAP

Data collection grid – « Public finances»

Tanzania

1. Macroeconomic context and public finance management

- PRSP and HIPC initiative
- Poverty trends and profiles
- Macroeconomic situation, current and planned reforms
- Political context, overall governance context / fight against corruption
- MTEF and expected financing gap
- Decentralisation
- Overall budgets programmes and indicators
- Integrated system for public finance management
- Budget preparation: on the basis of which inputs ? Integration of donor data
- Budget execution: procedures, spending powers, etc.
- Internal landexternal budget control ?
- Dual budget: are recurrent expenditures and investment expenditures taken into account separately?
- Accountability
- Budget procedures manual / Manual for procurement operations
- Budgetary aid

2. Health Budget

- MTEF + Analys over time of government budget allocations to the health sector
- Changes brought about by the SWAp as far as public finances are concerned
- Programme budgets and indicators
- Financial management manual et guide to the implementation of the sector program
- Financing modalities : projects, sectoral budget support, etc., predictibility of aid flows
- Absorption capacity of aid funds, delays related to the transfer of expenditure information from the lower to the higher levels, contracting and disbursement rates

Annex 4: Pros and cons of general budget support and sector budget support

Arguments	General budget support (GBS)	Sector budget support (SBS)
In favour	- It reduces transaction costs even further than SBS.[96] - It allows to "scale up" aid operations (i.e. to disburse larger amounts, faster). - It promotes government leadership and ownership in the establishment of the budget, reinforces the relationship of line ministries to the MoF (rather than their relationship to donors), and reduces the budgetary distortions induced by earmarked sector financing. - It strengthens national accountability and promotes the development of PFM systems even better than SBS, thus contributing to sustainability. - It provides a better view of overall budget allocations (and thus helps prevent excessive fungibility).	- The stakes SBS providers have in a sector allow them to engage in advanced sector dialogue and maintain some influence on how the sector is managed – an advantage that is likely to be lost if they switch to GBS. - The earmarking of some resources for specific sectors, notably the "social sectors", remains useful as long as sector representatives do not have enough weight to obtain sufficient budget allocations without donor intervention. - Directly supporting the "social sectors" makes it easier for donors to justify that they support the achievement of the MDGs - It also enhances accountability towards the citizens/constituencies of donor countries
Against	- Advanced sector dialogue without the provision of sector-specific funding may in practice be difficult (especially for smaller donors) – yet it remains useful. - "Sector dialogue without money" entails a risk of reverting to bilateral dialogue, if SWAps and sector-specific dialogue forums unravel. - Accountability procedures are not uniformly developed across sectors. As long as accountability procedures for all parts of the budget are not fully satisfactory, maintaining at least some SBS in favour of priority sectors is preferable. - GBS has been used for a long time[97] – and it has proved effective.	- SBS distorts the budgetary process and undermines government ownership – since government builds a budget "around" money already earmarked for sectors by donors (without contesting its relevance to national priorities).[98] - SBS is fungible anyway – it just displaces government expenditure from the sectors that get it to other sectors; as a result, there is little additionality to SBS (i.e. it does not necessarily help increase the overall amount of funding available to the targeted sectors). - There is no justification for donors to maintain sector dialogue that addresses the details of sector management. Ownership requires donors to move away from the "micro-management" practices that still plague their interventions in sectors.

[96] Notably on the basis of a "division of labour" argument: as long as just a few donors remain involved in detailed sector dialogue, there is no need for all agencies supporting a sector indirectly through GBS to get involved in the details of sector management.

Some donors, notably the European Commission[99], actually favour the simultaneous provision of SBS and GBS – which in their view offers "the best of both worlds" as long as a country is not ready for receiving only GBS, i.e. until all sectors are well-managed and running well without close donor involvement, and under-funding is the only remaining problem. Unlike "purists" among the proponents of GBS (who believe SBS undermines GBS and donors undermine government systems and each other by using different financing modalities), some actually see no incompatibility, but rather synergies, in their simultaneous use of GBS and SBS, since they pursue different objectives (GBS supports macroeconomic and general reforms, including the implementation of poverty reduction strategies – while SBS supports sector-specific reforms and dialogue).

Other donors view SWAps and the associated SBS as merely an intermediate step between project-based cooperation and general budget support, and believe the latter is the ultimate, ideal aid financing modality. The World Bank, for instance, plans to switch to GBS for supporting the health and education sectors in Africa – while recognising that "strong sectoral programmes", which build up confidence and develop sectoral capacities, "are a precedent to using this approach". [100]

[97] In the form of "structural adjustment" and "macroeconomic support" credits and grants.
[98] This argument can be contested: government hardly ever starts a budget with a "clean sheet" – and fungibility can help "rebalance" the budget towards government's own priorities.
[99] In Tanzania, the Commission is not involved in the health sector, but it is a significant contributor the education sector.
[100] The strategic framework for the World Bank's assistance to Africa plans to ultimately move to PRSCs, i.e. general budget support, to support health and education (WB 2003:8).

Annex 5: Risks and opportunities associated with international vertical initiatives

Main risks and issues

1) Budgetary distortions:

In the annual MTEF/budgetary process, the massive resources promised by vertical programmes constitute a disincentive for the MoF to maintain or increase the contribution government makes to the health sector: it is tempting to consider that some resources can be freed up and allocated elsewhere, since donors seem willing to increase their contribution to specific health sector activities (see notably WB 2003:57).

Counting on temporarily high vertical programme resources to finance the health sector would of course be a serious mistake – both because vertical programme funding to the scale currently announced is likely to have a short half-life, and because it is earmarked for very specific activities that constitute, at least to some extent, an extra burden on the public health system, that could not be sustained as external funds shrink. Also, the new vertical programmes can potentially bring a lot of resources to the health sector, but the predictability of these funds is considered lower than that of other external resources (both because funds are slow to flown in even when money has been pledged, and because the renewal of commitments to the expected scale cannot be taken for granted).

Another aspect of budgetary distortion is the fact that even if vertical programme funding was truly additional, resources would be allocated disproportionately to some diseases or interventions, without any regard for overall sector priorities and the actual burden of disease. The case of ARV therapy is extreme since, if the current plan is to be implemented, as much should be spent on this intervention only as on all other health sector interventions taken together (It has been estimated that 250 million USD/year are required, which is roughly the amount of the 2004/05 health budget.) Even if external donors were willing to spend this money on a long-term basis, this is completely unreasonable in view of all other pressing and unmet needs.

2) Loss of government leadership and ownership, and undermining of coordination mechanisms:

There is a real concern among some DPG Health members that the new international vertical programmes may undermine the past years' achievements in terms of government leadership and ownership, as well as the overall donor coordination process and the transparency of the sector policy dialogue. The danger stems from:

- the lack of enthusiasm shown by many of the new programmes for joining and integrating with existing coordination mechanisms, and their marked preference for bilateral negotiation – maybe out of fear that joining multilateral forums will slow down disbursement;
- the huge amounts of money potentially at stake, which make it very difficult for government to refuse to implement activities that do not necessarily coincide with its defined policies and priorities;

- the disregard shown by some vertical programme managers for existing policies and strategies, as they try to push forward their own approaches.

GAVI, for instance, has very much pushed Tanzania to adopt large-scale hepatitis B vaccination (through the adoption of expensive combined vaccines). HB vaccination is hardly a national priority, and cheaper vaccines are available for priority diseases. The problem is, GAVI finances the expensive polyvaccines in full for a few years, but then it gradually withdraws the money… and expects government (or other donors) to take over, whatever national priorities may be!

Among AIDS-related initiatives, President Bush's PEPFAR is considered to be the most disruptive in terms of policy ownership, as it:

- tries to impose the use of branded drugs, when government policy is clearly to use generics (the compromise solution is that PEPFAR will provide branded drugs for second-line medication, in cases of resistance or intolerance to first-line generic drugs);
- by-passes government's policy of (roughly) "condoms for all those who might need them", and tries to impose its much more conservative prevention policy (promotion of abstinence, condoms only for high-risk groups) through the choice of a technical agent/implementing agency (this move was blocked by other bilateral donors, which secured the funds to ensure government could continue working with the NGO that has so far supported it in the development of its prevention policy).

3) Establishment of parallel implementation structures:

The temptation to establish parallel implementation structures (for management, care, training, drug supply, …) is usually high, as the promoters of vertical programmes fear that integration with existing structures may be lengthy and thus slow down disbursement rates. Ideally, all priority areas of the health sector programme should be developed simultaneously and reasonably "proportionally" – but this is a slow process with a weak absorption capacity, which makes the promoters of international initiatives impatient. They may also feel that implementation would be managed more competently and accountably by structures they directly control (this would be typical, for instance, of US initiatives).

This, in turn, involves a *clear risk of undermining years of efforts dedicated to the building of integrated primary healthcare and other services*. While it is nearly certain that the newly created structures would be unsustainable in the medium and long run, their establishment could destroy an already fragile public health system, in particular if scarce medical and managerial staff are "poached" to operate the new structures, possibly with the attraction of higher wages.

Tanzania's "Round 5" proposal for getting GFATM funding for ARV therapy illustrates this risk. The initial proposal, written by freshly disembarked US consultants financed by USAID, considered hiring project-specific human resources, topping up salaries and setting up specific structures to deliver ARV therapy. The proposal was altered *in extremis*, after some MoH officials and DPG Health members spent a few hectic days, just before the deadline, making the proposal more compatible with existing structures and policies and ensuring it would be taken up in the MTEF.

4) Establishment of parallel planning, monitoring and evaluation structures:

As the managers of global vertical programmes feel the need to be accountable to their own donors, they may be tempted to set up their own, programme-specific M&E structures and processes, rather than integrating with existing ones and contributing to their overall reinforcement. This is another way of undermining the SWAp. It may ultimately lead to reduced transparency and general accountability, as specific accountability mechanisms are again preferred to general ones.

The same remark applies to planning systems: a significant degree of verticalisation is inherent in the participation in global initiatives, since their application procedures and planning processes have to be respected. This could be avoided if global initiatives would limit themselves to raising funds, and remain just like pools of funds from which countries can draw resources. Unfortunately, they all tend to turn themselves into international organisations, with the procedural rigidities this involves.

Potential benefits and opportunities

1) Injection of funds in support of pre-existing national priorities:

In Tanzania, the GFATM is supporting the national deployment of a pilot project that promotes the use of insecticide-treated bednets for malaria prevention by providing pregnant women with vouchers to buy these bednets – which are otherwise unaffordable for poor households. This is a good example of how the funds made available by international vertical programmes can be used to support national public health priorities, without distorting them, and without creating any parallel structures.

Generally speaking, unlike the HIV/AIDS component, the malaria- and TB-related components of the GFATM do not seem to give rise to any controversies. Rather, they seem to have been well integrated with the National Malaria Control Programme and the TB-Leprosy Control Programme – and therefore to provide many more benefits than disadvantages. (Admittedly, the malaria, TB and leprosy programmes already operate as vertical programmes, which may facilitate integration; yet these programmes are themselves well integrated in the national health system.)

2) Incentive to tackling the HR crisis:

Among possible positive effects of the Global Fund: thanks to its importance to the delivery of ARV therapy, the long-standing issue of the HR crisis is now finally being taken up on the agenda.

Annex 6A: Pros and cons of wide-scale ARV therapy

Arguments *in favour* of wide-scale ARV therapy

1) From a social and humanitarian point of view, even a few life years gained can make a tremendous difference to the concerned individuals (notably for those who have young children); denying treatment now because the funds may become insufficient to continue the therapy in a few years' time is not ethically acceptable – the people concerned prefer to incur this risk than to remain untreated and die earlier.
2) Wide-scale treatment can become an instrument of transmission prevention, and thus help control the epidemic, as: (i) the viral load decreases so much in many treated people that they are likely to become much less contagious (see counter-argument a bit further); (ii) it encourages people to go for counselling and testing, and thus raises both disease awareness and knowledge of transmission modes.
3) Wide-scale treatment is likely to bring the cost of treatment further down (it has already significantly decreased), and opens the prospect of (public or private) health insurance schemes one day accepting to cover HIV-positive people (this is already happening in South Africa, on the basis of government's commitment to take up the cost of ARV therapy itself).

Arguments *against* wide-scale ARV therapy

1) Health structures, already over-stretched, cannot cope with the massive requirements (notably in terms of staff availability) called for by the supervision of a large number of ARV-treated patients; if too much focus is put on ARV therapy, whether in existing or in parallel health structures, medical staff will simply be distracted from its other tasks – which will quickly result in a worsening of the provision of general health services; this, in turn, may quickly result in a worsening of overall mortality figures.
2) ARV treatment is acknowledged to be a very cost-ineffective procedure, in general and especially in conditions in which compliance and treatment continuity cannot be guaranteed (which is definitely the case in Tanzania: risk of interruption in the supply of drugs, black market for drugs, insufficient health infrastructure for controlling compliance by a large number of patients, …); if the government of Tanzania would ask for considerable funds to be spent on, say, heart surgery, no donor would accept to fund this; but the massive international pressure surrounding ARV therapy (coming notably but not exclusively from the WHO) makes it impossible to use common sense arguments, that would dictate to limit its use to a small number of patients, for whom compliance and continuity of treatment can be reasonably guaranteed without exhausting the capacities of health structures.
3) Discontinuity in the provision of funds for ARV therapy is a serious risk, the consequences of which should not be under-estimated. The budget to be spent on it, if the current plan is implemented, might be larger than the overall health sector budget – yet, treatment cannot be interrupted or the virus quickly multiplies again. Not only would this make previous "investment" useless in a very short time; it may also re-ignite the spread of the disease on a massive scale, as both infected and uninfected people have relaxed their prevention efforts.

4) "There is a risk (…) that if drug-delivery programmes are rolled out willy-nilly without accompanying transmission-prevention programmes, they will eventually make the situation worse. This risk is the object of furious debate, not least because there are very few data. But it is plausible enough to worry about, and it comes in two parts. The first is that sloppy adherence to drug-taking regimes will cause drug-resistant viruses to emerge. The second is that those on drugs, feeling themselves to be better—and even, possibly, immune to further infection—will engage in the sorts of risky behaviour that infected them in the first place" (The Economist 30/07/2005, Science & Technology section).

Annex 6B: Staffing requirements in relation to ARV therapy

(Source: interview)

The huge staffing requirements arise from the fact that HIV/AIDS is a chronic disease, and people need to undergo regular checkups: the national programme advocates a blood test every 6 months, to control the CD4 count as well as the liver and kidney functions (viral load testing will be reserved to a few selected hospitals, as it is too expensive); drug distribution is done on a monthly basis and therefore requires at least a monthly visit to a health facility – or a monthly visit to the concerned households, in the context of home-based care projects.

Whether public or private, each C&T team (there may be several teams per facility) should consist of six people with the following skills: one clinician (MD or assistant MD); one nurse; one pharmacist; one laboratory technician; one counsellor; and one home-based care provider. These teams have to be trained (they currently receive one week of training, they will get two as from next year). How much they get paid depends on the policy of their employer, as well as the policy of the donor specifically financing the facility (if any). Some donors top up salaries, some don't. The "poaching" of staff from those institutions that pay less in favour of those that pay more is seen as unavoidable. Public health facilities are likely to be the greatest victim.

Annex 6C: Public-private partnership in AIDS-related home-based care

Tanzania: Family Health International's project

Under a large home-based care project managed by the US NGO Family Health International, 23 NGOs/FBOs/CBOs train people selected in local communities to become voluntary community workers, who then follow up and counsel ARV-treated patients in their communities, under the supervision of district medical staff.

This "community workers" structure is seen as vital for the prevention of dropout and therefore for making ARV therapy work; district and hospital medical staff are indeed too busy to provide any form of home-based follow up (or any follow up at all, as a matter of fact, outside periodic but infrequent medical checks). As for the remuneration of the community workers, some NGOs do not pay fees as they believe this is not sustainable; others do as they believe this is necessary to maintain motivation.

An example of good practice: TASO in Uganda

(Source: interview in UNAIDS. More information on TASO's activities is available on www.who.int.)

In Uganda, where 40,000 people are currently under ARV therapy, a large NGO called TASO ("The AIDS Support Organisation") follows and supports 5,000 patients. The TASO model is innovative in various ways:

- it rests on community-based follow-up of patients in villages; community assistants equipped with motorbikes visit patients at home, follow the evolution of their health, send medical help if needed, and bring them drug supplies at home (which makes treatment possible for people who would otherwise not have the money to travel to a clinic to renew their drug supplies); these community workers, all graduates, follow one month of intensive training into all aspects of the disease and treatment before going in the field; they get a salary (paid by donor money); unpaid community volunteers provide further assistance;
- the entire family of each patient is tested and counselled – so that all those who need treatment get it; from a compliance point of view, this reduces the risk that patients share their drugs with other family members – and therefore do not take the prescribed doses; from a prevention point of view, testing a whole family (with their consent) and identifying the infected people raises awareness of the disease and its transmission mode and encourages those who are seronegative to avoid catching the disease.

Community-based initiatives make the follow-up of patients easier, and tremendously improves outreach in poor, remote communities. The use of people without formal medical education (but with formal education in other areas) avoids the excessive "poaching" of scarce medical staff for the purpose of ARV therapy.