November 2007

JOINT EXTERNAL EVALUATION OF THE HEALTH SECTOR IN TANZANIA: 1999-2006

evaluationsummary

This is a historic evaluation. It is (probably) the first ever sector evaluation which is fully in line with the 2005 Paris Declaration on Aid Effectiveness: The evaluation was led by Tanzania's Ministry of Finance and looks into an entire sector and the role and contributions of all domestic and external stakeholders including government authorities at all levels, civil society organisations, and the private sector in Tanzania; and all development partners, bilateral and multilateral. The aim is not limited to improving the performance of individual donors, but to feed into Tanzania's Third Health Sector Strategic Plan covering 2008-15 and to give recommendations on how all stakeholders can best contribute towards the plan. The Evaluation was carried out from December 2006 to September 2007 by a consortium of COWI, Denmark; Goss Gilroy, Canada; and EPOS, Germany. Team Leader was Ted Freeman of GGI, Canada. Six development partners: Belgium, Canada, Denmark, Germany, the Netherlands and Switzerland were the major funders of the direct cost of the evaluation. The management of the evaluation was conducted by a management group comprising of Denmark, Germany and Tanzania.

Overall conclusions

The joint entry of the Government of Tanzania (GoT) and the Development Partners (DPs) into a Sector Wide Approach (SWAP) to collaborative development work in the health sector has largely been a success. It has strengthened national ownership and secured higher levels of both domestic and external financial resources for health, and it has, to some extent, replaced fragmentation and loosely or non-coordinated projects and programmes by mechanisms for co-operation and dialogue which aim at rallying all stakeholders behind national priorities.

This has delivered real improvements. For example, infant and child mortality have been reduced significantly and drug availability and services have improved at health facilities. Contributions to the Health Basket Fund in particular have contributed towards improvements of health services at the local level. But much remains to be done: maternal mortality remains at alarming levels, and reforms to improve hospital care and public private partnerships have lagged behind.

Global Health Initiatives and large multi-country bilateral programmes have injected huge and much-needed resources into diseases that are national priorities, but they remain largely outside existing health planning and management systems. This distorts local priorities and threatens sustainability. Significant positive changes have taken place during the period under review, but further improvements are needed for Tanzania to meet the Millennium Development Goals on health and to reap the potential benefits of the reforms.

Background: A health sector in poor shape

During the 1990s, the health sector in Tanzania faced a period of stagnation. Local health services suffered from severe shortages of essential drugs, equipment and supplies, and health staff lacked motivation. The sector also suffered from fragmentation: there was little cooperation between the public

A truly joint exercise.
No less than eight government agencies, more than 20 development partners, several non-government organisations, faith-based organisations, civil society organisations as well as the private sector were engaged in the joint evaluation exercise. In addition, more than 300 community members took part in focus group discussions during the evaluation which included field studies in six districts.

sector, faith-based organisations, and private health service providers. There was also little coordination of support to the sector by Development Partners. Moreover, health services were severely under-funded, with public health sector spending at USD 3.46 per capita.

A new scene was set

In reaction to this, the Government of Tanzania (GoT) and Development Partners (DPs) in the mid-90's initiated a joint process to improve the situation. By 1999, this resulted in the first major health sector strategic plan and an agreement that support to the health sector should take place within the framework of a Sector Wide Approach (SWAP). A 'Programme of Work' and a subsequent Health Sector Strategic Plan 2 (HSSP2) set the scene for comprehensive health sector reforms aimed at addressing the deficiencies in the sector and achieving the goals and targets for health as set out in the Millennium Development Goals (MDGs) and Tanzania's Poverty Reduction Strategies (PRS I and the National Strategy for Growth and Reduction of Poverty/MKUKUTA). Priority areas of strategic intervention included:

- Strengthening district health services;
- Transforming the role of the central Ministry of Health and Social Welfare into a facilita tive policy organisation;
- Improving Government and Development Partner relations to enhance harmonisation and to pool external and Tanzanian resources for health in a closer and more effective partnership.

Extra money for health, but more is needed

The new approach was followed up by extra money for health, from both domestic and external sources: From 1999 to 2006, estimated total public expenditures for health in Tanzania tripled, from USD 143.6 million to USD 427.5 million in real terms. In the same time period the domestic share of those expenditures rose from 46 to 56%.

Public spending on health per-capita rose from an estimated USD 4.1 in 2000 to USD 9.2 by 2005. This was, however, below the GoT target of USD 12.0 at that time. GoT has also yet to meet its own target of allocating 15% of total government spending to health. While these figures do not take into account significant 'off budget' funding, with escalating costs for health, due to expensive new malaria, HIV/AIDS and other drugs, it is clear that increased funding is required for Tanzania to meet the health related MDGs.

Assessment of Tanzania's health sector 2007

District health services strengthened

What has really worked and made a difference in the health sector in Tanzania has been the devolution of responsibilities for health facilities and health planning to Local Government Authorities. A key factor was the establishment of the Health Basket Fund and Block Grants. Not only did they provide extra financial resources. Perhaps more importantly, they secured stable and predictable funding, which made local planning and budgeting possible and contributed towards improvements in service quality at health facility level. Interviews with focus groups confirm the overall impression that services at local health facilities have indeed improved.

Problems at hospitals remain unsolved

Hospital reform has been slower than other aspects of health sector reform. While budgets for regional hospitals have increased, they remain underfunded and lack qualified staff and the full requirement of essential drugs. They also continue to suffer from serious overcrowding, as the referral system is not working effectively. This also increases costs, as many people are treated at a high er level than necessary.

Better infrastructure, but more needs to be done

The proportion of health facilities in a good state of repair increased over the period as a result of major construction and renovation activities. Still, many health facilities, including even some hospitals, lack running water, electricity and communication equipment. While steps have been taken to address the 2004 findings, where more than half of the health facilities in rural areas were reported to be at the point of collapse, this should be a continued focus before new facilities are built. In contrast, new facilities for HIV/AIDS are mushrooming financed by sharply increased funding earmarked for HIV/AIDS.

Competition could improve drug supply

The supply of drugs, equipment and other medical supplies provided by the Medical Stores Department (MSD) has improved over the evaluation period, but shortages and delays in delivery are still common. More competition should increase efficiency and ensure better availability of drugs at facilities. The supply of new and expensive anti-malaria and anti-retroviral drugs (ARV), by contrast, is excellent thanks to well-funded vertical programmes. However, unfortunately this has been at the expense of the essential drug supply and these programmes should increase efforts to assist the MSD system as a whole.

Still not equal access to health services

Equal access to health services in Tanzania remains a problem, and the benefits of improved health services – and HIV/AIDS Programmes in particular – are thus not shared equitably. Some of the constraints to equitable access are outside the direct control of the health sector as they are based on geographic isolation and high transport costs.

Nevertheless, the sector has not responded effectively to address these constraints.

Make better use of trained health staff
Tanzania has faced a severe shortage of skilled health sector workers throughout the evaluation period and continues to do so, despite some improvements in quantity (small) and quality (more significant) of the health staff. The challenge is not only to train more health staff, but to make better use of the health staff Tanzania actually produces. From 1994 to 2004 Tanzania produced more than 23,000 health graduates. Of these, the government employed less than 4,000 (16%). More effective management of human resources to raise productivity is required. In addition, ensuring that health facilities in remote rural areas are staffed is critical, as this is where the greatest unmet health needs exist.

HIV/AIDS effort struggles to meet targets
HIV/AIDS was included as a special strategy in the Health Sector Strategy Plan 2. This has contributed towards a more effective national response to the disease, but important challenges remain like limited rural coverage and lower participation by males.

External funding for HIV/AIDS has seen a huge increase and was budgeted to reach almost USD 350 million in 2006/07. This has boosted HIV/AIDS treatment and care, and made new and expensive anti-retroviral drugs (ARV) available for free. Still, achievements fall far short of set targets – in 2006, 60,000 Tanzanians received ARV drugs, while the target was at least 150,000 people – and coverage of HIV/AIDS services like Prevention of Mother to Child Transmission are still low compared to needs.

Involve Faith Based Organisations
40% of the health facilities in Tanzania are operated outside government, mainly by Faith Based Organisations (FBO), which have a long tradition in Tanzania, but also by other private health service providers. They attracted many public health workers in the 1990's, but this trend has been reversed in recent years due to increases in salaries for public health workers. The improved formal and informal dialogue between the GoT and DPs has tended to marginalise FBO's and other private health service providers and efforts should be made to involve all stakeholders in dialogue and planning. Overall progress in public private partnership has been weak in comparison to the other reforms.

Assessment of the Development Partnership in health

Improved, but cumbersome partnership
The development of formal structures for dialogue in the health sector has helped to maintain a common sense of direction among stakeholders and foster harmonisation, but the structures are cumbersome and should be streamlined. Improved alignment and harmonisation have relieved GoT of some of the burdens of dealing with a multitude of individual Development Partners. Some DP's adhering to agreed procedures, though, feel that they have lost access to GoT, which concentrate on stand-alone projects and the new Global Health Initiatives. The SWAP arrangement set up in 1999 committed all health stakeholders, including Global Health Initiatives, to put all activities in the health sector under one common sector-wide program. Despite improvements, this target is still far from being met.

More predictable funding
The share of DPs health funding that is on-budget has risen significantly. This has several advantages: While off-budget funding from various sources makes it impossible to predict what resources are actually available for health, on-budget spending facilitates planning and improves predictability and transparency. Also on-budget funding has been found to be more likely to be released on time and according to pledges and can be used much more effectively.

What aid modalities work best?
A mix of all available project and programme aid modalities are in use in the health sector in Tanzania. Though an assessment of the different aid modalities is desirable to enhance aid effectiveness, it is not possible to make a definitive assessment, but some observations can be made.
Projects: are valued for their timeliness and flexibility; in short, their ability to 'get things done.' On the other hand, government authorities are sometimes unaware of projects within their area and it is not possible to predict what comes where and when. Projects also tend to be supply-driven with limited local ownership. Contrary to expectations, the SWAP has neither led to a decline in the number of externally funded projects nor in project funding for health, but despite the rise in the number and value of projects, more external funding is now subject to the budgetary process of the GoT.

Sector support programmes: are mostly project aid using government systems. The biggest advantage of these programmes is their predictability. The dilemma of DPs is that their influence diminishes as 'their' funding is processed through the governmental mechanisms.

The Health Basket Fund stands out among aid modalities
The Health Basket Fund has played a particularly important role in strengthening district level health services. In 2005, when the health basket was increased significantly, it led to a notable 28% increase in health finances to councils. The biggest advantage of this aid modality is the predictability. The

Health spending key figures FY 2006	
Total public spending on health	USD 560 million (incl. on- and off-budget)
Domestic share	56% (incl. General Budget Support)
External share	44%

planning of the use of basket funds has been largely in the hands of the councils and they know precisely how much funding is coming. The Health Basket is jointly funded by eight donors and provides flexible funds which use government's own procedures.

A disputed newcomer: The Global Health Initiatives

The new global health funds are not an aid modality, but rather a mixture of projects using government and parallel systems. Because of the vast amounts of funding involved they have profound ramifications, as the continuing rapid and significant increase in resources for HIV/AIDS in Tanzania shows. This has been relevant to addressing a critical problem and a national health priority, but given the sheer volume of HIV/AIDS funding, almost USD 350 million expected for 2006/07 – as compared to total public spending on health of USD 561 million in 2005/06 (in current prices) – it is hardly surprising that HIV/AIDS funding also tends to distort priorities and draw staff away from, for example, maternal and child health services. The increasing number of and funding by Global Health Initiatives and large bilateral programmes threaten to destabilise health sector planning and prioritising as they remain largely outside established coordination and alignment mechanisms. Of the almost USD 350 million budgeted for 2006/07 for HIV/AIDS, it was expected that almost USD 300 million would remain outside government accounts.

General Budget Support: The increase in GBS overall has resulted in more money for the health sector and greater amounts of funding which is GoT owned and managed. Given that GBS is flexible money which the MoF can allocate according to country priorities, there is concern that health will lose out in relation to other needs. This was illustrated by DfID's decision to move its funding from the Health Basket Fund to General Budget Support. This resulted in a net loss to the health sector which, in relation to the overall share of the government budget, has only just been regained after four years.

Recommendations

- The GoT and DPs should maintain the SWAP and make every effort to increase funding for health and to align and harmonise existing and potentially new off budget funding as much as possible.
- A target should be set for the per centage of public health expendi tures to be allocated to Local Gov ernment Authorities.
- Already agreed reforms in the health sector should be consoli dated before focus turns to new reforms.
- Concrete steps should be taken to accelerate progress in hospital reform and public private partner ship.
- Effective action to reduce maternal mortality and improve health services for deliveries should be taken.
- Improving equity of access to health services should be a cross-cutting theme of the next Health Sector Strategic Plan.

Key health indicators and targets

Indicator	1999	2004/05	MDG Goals (2015)
Infant Mortality Rate	99	68	40
Under Five Mortality Rate	147	112	47
Maternal Mortality Rate	N/A	578	133
Percentage of births attended by trained personnel	36	46	90
% HIV/AIDS Prevalence among Adults	9.4	7	‹5.5
Number of People Living With HIV/AIDS and Receiving Anti-Retro-Viral Drugs (ARV)	N/A	125,312 in AIDS Care and Treatment and 60,341 on ARVs	100,000 by Dec 2006 (Tanzania's National Strategy for Growth and Reduction of Poverty)
Public health sector spending per capita	USD 4.1 (2000)	USD 9.2	USD 43

The figures suggest that indicators, which can be addressed through large-scale vertical program interventions, have shown positive change. For example, immunisation, malaria treatment, and other focused interventions can reduce child mortality, while reducing maternal mortality requires much broader interventions.