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Ministry of Health and Social Welfare

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Governance

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Mid Term Review of the Health Sector Strategic Plan III 2009-2014

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Acronyms

ADDO	Accredited Drug Distribution Outlet
APHFTA	Association of Private Health Facilities in Tanzania
BFC	Basket Fund Committee
CBO	Community Based Organisation
CDC	US Government Centre for Disease Control and Prevention
CCHP	Comprehensive Council Health Plan
CFR	Case Fatality Rate
CHF	Community Health Fund
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CMO	Chief Medical Officer
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
DANIDA	Danish International Development Agency
D-by-D	Decentralisation by Devolution
DC	District Council
DED	District Executive Director
DHIS	District Health Information System
DMO	District Medical Officer
DP	Development Partner
DPG-Health	Development Partners Group Health
DPP	Director of Health Policy and Planning
FBO	Faith-Based Organization
GBS	General Budget Support
GF	Global Fund
GOT	Government of Tanzania
HBF	Health Basket Fund
HF	Health Facility
HFGC	Health Facility Governing Committee
HRH	Human Resource for Health

HRHIS	Human Resources for Health Information System
HRIS	Human resources Information System
HRM	Human Resources Management
HSSP III	Health Sector Strategic Plan III (2009 – 2015)
HSSP	Health Sector Strategic Plan
IHI	Ifakara Health Institute
JAHSR	Joint Annual Health Sector Review
JAST	Joint Assistance Strategy Tanzania
JRF	Joint Rehabilitation Fund
LGA	Local Government Authority
LCDG	Local Government Capital Development Grant
M&E	Monitoring and Evaluation
MDA	Ministries, Departments, Agencies
MDG	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MOFEA	Ministry of Finance and Economic Affairs
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
MTUHA	Mfumo wa Takwimu wa Uendeshaji wa Huduma za Afya
NatHREC	National Health Research Ethics Committee
NBS	National Bureau of Statistics
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research
NSGRP	National Programme for Economic Growth and Poverty Reduction (MKUKUTA)
P4P	Pay for Performance
PHSDP	Primary Health Services Development Plan [MMAM]
PMO-RALG	President's Office – Regional Administration & Local Government
PPP	Public-Private Partnership

PO-PSM	President's Office – Public Service Management
PSH	Population Census and Housing
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RRH	Regional Referral Hospital
RS	Regional Secretariat
SARA	Service Availability and Readiness Assessment
SASE	Selective Accelerated Salary Enhancement
SWAp	Sector-Wide Approach
SWOC	Strengths, Weaknesses, Opportunities, and Challenges
TA	Technical Assistance
TC	Technical Committee SWAp
TFDA	Tanzania Food and Drug Administration
TFNC	Tanzania Food and Nutrition Centre
TIKA	Tiba Kwa Kadi (CHF in urban areas)
TOR	Terms of Reference
TQIF	Tanzania Quality Improvement Framework
TWG	Technical Working Group
TZS	Tanzania shillings
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WDC	Ward Development Committee
WHO	World Health Organization
ZHRC	Zonal Health Resource Centre

1. Introduction

This report is part of a set of reports of the Mid Term Review (MTR) of Health Sector Strategic Plan (HSSP) III (2009 – 2015) (MOHSW 2008a). In addition to the general report, there are eight specific reports to report findings related to: General Service Delivery, Maternal Neonatal and Child Health (MNCH), Social Welfare, Human Resources for Health (HRH), Pharmaceutical Services, Monitoring and Evaluation M&E), Capital Investments and Health Financing. This report covers governance-related issues in the health sector, a crosscutting issue among all of the HSSP III's strategic areas. Governance findings are reported in each of the specific reports as well. This report discusses the specific HSSP III strategic objective of Central Support by Headquarters and Public Private Partnership (PPP). The report also discusses the governance of the SWAp process and general issues with regard to management of the health sector and the HSSP in particular.

According to the World Health Organization, governance is a political process that involves balancing competing influences and demands (Website WHO)[1]. Governance within the health sector can include:

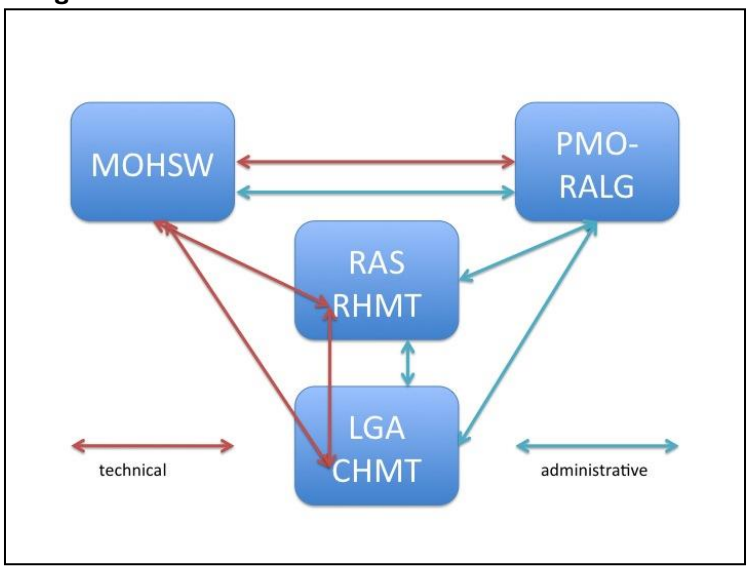
- Maintaining the strategic direction of policy development and implementation;
- Monitoring trends and developments;
- Articulating the case for health in national development;
- Regulating the behaviour of a wide range of actors - from health care financiers to health care providers; and,
- Establishing transparent and effective accountability mechanisms.

In Tanzania, Decentralisation-by-Devolution plays an important role in health sector governance (PMO-RALG 2009). Where the Ministry Of Health and Social Welfare (MOHSW) undoubtedly has the exclusive task of maintaining the space for policy development and articulating the case of health, it shares regulatory and accountability functions with other Government Ministries, Departments and Agencies (MDAs), especially with the Prime Minister's Office for Regional Administration and Local Government (PMO-RALG).

Implementation of district health is the full responsibility of the Local Government Authority and the delivery of health services in regional hospitals the responsibility of Regional authorities.

[1] http://www.who.int/healthsystems/topics/stewardship/en/

Figure 1 Relations between MOHSW-PMO-RALG-LGA



While the MOHSW maintains technical relations with the Regional Health Management Team (RHMT) and the Council Health Management Team (CHMT), these structures are part of the administrative system of the Regional Administrative Secretariat (RAS) and the Local Government Authority (LGA), respectively. Technical relations concentrate on the contents and quality of services, while administrative relations concentrate on managerial, financial and human resources management issues. The direct superior of the District Medical Officer is the District Executive Director, and of the Regional Medical Officer the Regional Administrative Secretary. RHMTs have a technical relation with CHMTs (both embedded in the PMO-RALG structure), but not an administrative relation. LGAs have an administrative wing, under leadership of the District Executive Director (DED) and a political wing in the District Council (POPSM 2011).

Important to the governance of the health sector in Tanzania is the use of a Sector Wide Approach (SWAp). The Sector Wide Approach (SWAp) provides the framework of collaboration among the stakeholders, MOHSW, PMO-RALG, Ministry of Finance and Economic Affairs (MOFEA), civil society, private sector and Development Partners (DPs) including United Nations (UN) agencies active in Health. It coordinates financing, planning, and monitoring mechanisms. Central in the SWAp is the implementation of MOHSW policies and the HSSP III (MOHSW 2007).

The SWAp Committee is the agreed overall body for dialogue among all stakeholders in health. There is one annual planning meeting and one Joint Annual Health Sector Review (JAHSR). Topics discussed are the Medium Term Expenditure Framework (MTEF), the progress of implementation of the HSSP, the Public Expenditure Review (PER) and jointly agreed topics. The SWAp technical committee serves as a joint monitoring body of the goals and activities of the health sector. There are several sub-committees of the Technical Committee, which ideally comprise a range of stakeholders, including the technical sub-committees.

The Health Basket Fund (HBF), a joint funding mechanism, was created in June 1999 and is part of the SWAp approach. The basket consists of the **central basket**, funding the MOHSW headquarters, PMO-RALG and RHMTs, as well as funds for medicines through Medical Stores Department (MSD) and the district basket, funding running costs for District and Municipal Council health services. The Basket Financing Committee (BFC), comprising representatives of the MOHSW, PMO-RALG, MOF and basket-donors, is responsible for overseeing operation of the joint funding mechanism (MOHSW 2008b).

2. HSSP III Health Objectives and Expected Results

2.1 Central Support Headquarters Objectives in HSSP III

1. Enhance decentralisation of MoHSW headquarters

2. Strengthen governance in the MoHSW

3. Strengthen the operational planning process of MoHSW headquarters, institutions and agencies under MOHSW

4. Institutionalise traditional and alternative health practice in the established health sector

The HSSP III objectives indicate that, over the life of the HSSP III strategy, MOHSW headquarters will concentrate more on stewardship functions, rather than operational issues, leaving such issues to PMO-RALG and Local Government Authorities (LGAs). This includes strengthening multi-sector coordination. MOHSW is also to promote harmonisation and alignment of sector financing, policy and planning. Where necessary, the MOHSW will develop new policies, legislation and operational guidelines, as well as revise existing policies as appropriate. Coherence between policies, legislation and plans are priorities within the HSSP III agenda. A gender sensitive and human rights-based governance system that ensures accountability, transparency and adherence to leadership ethics is another output expected during the HSSP III period.

In addition, HSSP III indicates that the MOHSW planning process should be improved – for example, the Medium Term Expenditure Framework (MTEF) planning process will be comprehensive, and extend beyond the development of annotated budgets. Workable plans for MDAs will be formulated to enhance the health sector support system. HSSP III also calls for improved coordination, and recommends that the agencies and institutions operating under direct responsibility of MOHSW will implement their specific strategic plans.

Finally, HSSP III calls for improved assistance from the Regional Secretariat to the headquarters level in its supervisory and technical support role for LGAs. The MOHSW HQ will provide technical support to the RHMTs and, social welfare will be incorporated into the RHMT functions.

2.2 PPP strategies Objectives in HSSP III

1. Ensure conducive policy and legal environment for operationalisation of the Public Private Partnership (PPP)

2. Ensure effective operationalisation of PPP

3. Enhance PPP in the provision of health and nutrition services

One of the objectives is increased participation of the private sector in achieving access to health services at all levels, through a new policy to be developed through the PPP Steering Committee. HSSP III aims that that LGAs, non-state health providers and civil society organisations and other relevant sectors improve collaboration, working in a complementary way. The contributions of all parties have to be incorporated in CCHPs, according to HSSP III and Service Agreements will provide mutual benefit for Councils and private providers. Private providers in HSSP III will be stimulated to step up service provision to vulnerable groups and in remote areas; they will be incorporated in insurance schemes, when they meet the standards for accreditation. Private initiatives in training of health workers will continue to be promoted. Partnership with private service sector and industry related to health will be explored and strengthened.

3. Findings per HSSP III Strategic Objective

3.1 Central Support Headquarters

3.1.1 Governance in MOHSW

During the MTR, concerns were raised from many sides with regard to the long period of instability at the top management level in the MOHSW, with too many senior officials in 'acting' positions[2]. Respondents mention similar issues of "acting-acting" at Regional and District level: according to informants in the Regions visited more than half of the District Medical Officers is acting and a large proportion of the RHMT staff. This is often leading to delay of crucial decisions.

Many MTR respondents applauded the role of the Minister of Health and Social Welfare in enabling inter-ministerial high-level collaboration by calling regular meetings that include high-level management from several ministries.

In general, roles and responsibilities in the MOHSW and its departments and agencies are clear and there are well-elaborated policy and strategy documents guiding governance (MOH 2003). Also the relationship with other ministries, development partners and private sector and civil society are clearly defined. However, the MOHSW is facing challenges related to human resources. For example, at MOHSW mid-management level the knowledge among staff of policies and strategies is not always sufficient, and the capacity of some officers to translate governance concepts into practical programmes is limited. Furthermore, information is not always shared within the ministry and collaboration between departments and agencies is not always optimal. Respondents noted a tendency of mid-level managers to be inward looking within their own unit, rather than seeking collaboration across departments or the Ministry at large. The MTR team found that thinking "in silos" is still an issue in MOHSW.

In some areas, like in the area of construction, maintenance and equipment, MOHSW management is highly fragmented (please see details in Capital Investment specific report) with insufficient oversight over ongoing projects and activities, as explained in the Capital Investment report of the MTR.

Internal and external communication may be considered as part of governance. As mentioned above internal communication is not always smooth. Just as an example: the MTR team had to approach various officials personally to get access to documents, which should be publicly available. The Community Perspective study of the MTR showed that members of the general public have a limited appreciation for the MOHSW's efforts to bring health closer to the people. This is partly due to lack of understanding how the health sector is operating, and which role the MOHSW plays. MOHSW's

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2 As result of the recent appointments of the Permanent Secretary and the Chief Medical Officer this period has now come to an end, starting a new era of strengthening leadership in the MOHSW. At the same time a new Deputy Permanent Secretary position was created in PMO-RALG, concentrating on health services and the position was filled by a former CMO of MOHSW.

communication practices are not very strong, for example, the MOHSW website does not provide much up-to-date or relevant information.

3.1.2 Decentralisation in MOHSW

The HSSP III aims at decentralisation of MOHSW functions of implementation and administration to PMO-RALG and the LGAs. The MTR did not find in existence a clear plan on how this decentralisation should be operationalised. It has been more a learning-by-doing approach. There are many examples of excellent collaboration between the MOHSW Headquarters and PMO-RALG and LGAs (e.g. the system of producing the comprehensive Council Health Plans), but also many examples of duplication and unnecessary overlap (e.g. the human resources information systems), even of conflicting methods of working (e.g. closing Community Health Fund (CHF) accounts).

A common challenge in many decentralization processes is the demarcations of technical management versus administrative management.

A clear example is that the Open Performance Review and Appraisal System (OPRAS) is difficult to implement because it is handled through the administrative system of human resources management, while performance is mainly based on technical criteria. As mentioned in the HRH specific report, health service related targets couldn't be easily translated into personal performance indicators.

Coordination between MSD, MOHSW and LGAs with regard to pharmaceutical supplies is work in progress on defining roles, as elaborated in the specific report on Pharmaceutical Services.

A complicating factor is how to set priorities within the health sector: whether priorities should reflect national level targets, or should be defined locally. Some respondents argued that CCHP guidelines are too prescriptive, and changing too often, confusing the CHMTs. Indeed, some CHMTs met during the MTR do not feel empowered to set priorities according to local needs, nor to take management decisions. According to the LGAs the MTR team met with, in the context of limited resources, when CCHPs cannot be implemented as planned, it is difficult to make decisions on which activities to drop. There is always somebody in MOHSW Headquarters disagreeing with decisions.

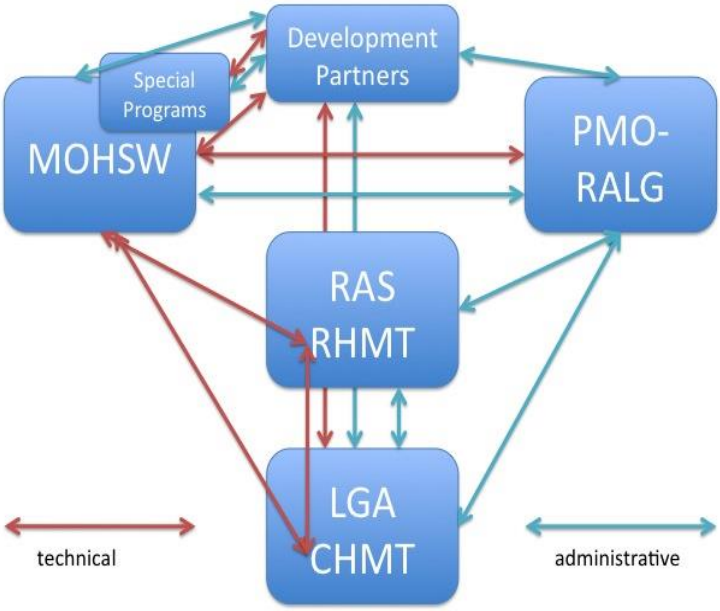
In regards to information generation and use, there seems to be limited integration between the data and reporting systems of the LGAs and health facilities through HMIS and other channels. Further, the use of PMO-RALG processed information (such as PlanRep) within the MOHSW Headquarters is very limited. MOHSW managers sometimes don't know which information can be obtained through administrative channels.

Table 1 Technical and administrative lines of communication

Technical (MOHSW-RHMT-CHMT)	Administrative (PMO-RALG-RAS-LGA)
• Policies, strategies in health	• Integrated rural/urban development
• TQIF, guidelines, standards	• Management manuals, instructions
• Supervision, coaching	• Follow-up, financial control
• HMIS	• Implementation reports
• Human Resources Development	• Human Resources Management
• Performance management	• OPRAS
• Technical reports	• Political accountability

For every technical relation between MOHSW and RHMT or CHMT a matching administrative relation can be identified between PMO-RALG, RAS and LGA, which might challenge each other (and actually do at times), as the table above shows.

Figure 2 Complex interactions within health sector



The MTR team found that, especially in disease control programmes and reproductive health projects, the separation between technical and administrative relations is difficult. Reporting and accounting obligations to donors (funding these specific types of programmes) interfere in government relations, as the figure above shows. Sometime the relations do not follow government structure. Issues of insufficient donor harmonisation and alignment do have a bearing on the system, down to grass root level.

In principle there is a cascade system of supervision and support: the central level MOHSW supports the regional level technically and RHMTs support the CHMTs. The new establishment of the RHMTs enables broader support, but still many RHMTs face human resources problems. The essence of technical support is not clear to all stakeholders, despite efforts to produce guidelines and tools. Many health workers see the supervision they receive mainly as administrative ("ticking the boxes"). All staff in health facilities visited during the MTR appeared to be generally clear about who they were accountable to. However, some HFGCs and CHSBs and members from the communities hold the MOHSW responsible for implementation of all services. The D-by-D seems not to be fully understood by the general public.

The plan to give the Zonal Health Resources Centres (ZHRCs) a place in capacity building, technical support and supervision has not been implemented (Koot and Kilima 2009). These institutions are not functional in these roles. The ZHRCs do not have a legal basis and are not embedded in a structure. (Even the term "zonal" is not uniform within the ministry, e.g. in relation to the catchment areas of maintenance workshops, or in relation to Demographic Health Surveys.)

3.1.3 Operational planning in the MOHSW

The Government has a well-established system of MTEF planning, reporting and accounting, which is applied in the Ministry. Most of the agencies under MOHSW (e.g. MSD, Tanzania Food and Drugs Agency (TFDA), Tanzania Food and Nutrition Commission (TFNC)) also have specific work plans. The MTEF plans remain to be mostly annotated budgets, as mentioned in the situation analysis in HSSP III in 2008, with no clear links between the MTEF plans and the HSSP III priorities and timeframes. Furthermore, the Strategic Plan for the MOHSW Headquarters 2012 - 2016, which should be guiding annual planning is still in a preliminary draft within the Department of Policy and Planning. Disease control programmes and other health programmes have specific work plans (often reflecting collaboration with partners, e.g. the One Plan, HIV/AIDS or malaria control programme). Broader harmonisation as envisaged in the HSSP III has not yet been realised. There is no evidence of a functional OPRAS system in the Ministry where performance is measured against plans.

The Annual Performance Profiles give excellent information on the performance of the health sector as a whole, and programme managers know performance of their particular projects well. However, there is no monitoring at all of process indicators of HSSP III (HSSP III Chapter 6) and no overall assessment of progress of the HSSP III as a comprehensive plan (MOHSW 2012).

3.2 Public Private Partnerships

3.2.1 Policy and legal environment

According to the HSSP III Public Private Partnership (PPP) can take a variety of forms with differing degrees of public and private sector responsibilities and risks. The Tanzania Health Sector Assessment Study conducted in 2011 identified five themes for strengthening PPP, including: policy and enabling environment, service delivery in the private health sector, private sector HRH, access to essential pharmaceuticals and medical commodities, and the private sector in health financing (USAID 2011).

A number of key policy and guiding documents for the operationalization of Public Private Partnership have been completed since 2009 including the National PPP Policy (2009), the PPP Act (2010), PPP Regulations (2011), PPP Strategic Plan (2010-2015), Health Sector PPP Policy Guideline (2011) and PPP Comprehensive Annual Operational Plan (2013/2014) (MOHSW 2011).

Some MTR respondents commented that the laws and regulations are more suitable for "hard" PPP, e.g. joint ventures for oil drilling, than for collaboration in the health sector. Unfortunately, the documents listed above are not easily accessible, not even on the MOHSW's website.

The PPP Technical Workgroup offers the platform for joint action, in which private (for profit) providers and Faith Based Organisations (FBOs) collaborate with government ministries and DPs. The TWG has produced guidelines for the CHMTs to develop Service Agreements (SAs), as well as guidelines for inclusion of PPP in CCHPs. The PPP TWG advocates for implementation of SAs, mobilizing additional funds to support SAs for service delivery, developing a PPP databank at MOHSW (for 2 zones initially), and supporting establishment of a regular Public Private Health Forum at national level, as well as in 50% of all regions (MOHSW 2013a).

3.2.2 Effective operationalisation PPP

The MOHSW has started advocacy meetings, e.g. using Regional Health Forum meetings to inform RHMTs and CHMTs about the concepts and practices of PPP. In addition, training tools and advocacy materials have been developed.

There are 53 Service Agreements in the country with FBOs, often replacing previous working arrangements between CHMTs and church health facilities (of the 99 FBO health institutions). In general, HBF funding is used for payment, but due to limited budgets, it is difficult to honour the SAs. Often, districts do not budget enough funds for honouring those agreements. This is partly an issue of priority setting, partly an issue of lacking capacity to cost services properly, and partly an issue of not putting a ceiling on services offered (leading to high bills). A few districts have begun to address related issues, and already have plans and budget for PPP activities in their CCHPs, as envisaged in the HSSP III.

There are no SAs with private (for-profit) providers, and – according to the PPP coordinator in the ministry – this is only possible when government is convinced that such contracts offer value for money. The MTR team concludes that there is still a high level of mistrust between government and private for profit sector in health.

Although MMAM envisaged that the private health sector would be stimulated to open new facilities in rural areas, it is clear that the private sector is not expanding significantly, and certainly not in rural areas. The number of private facilities is hardly growing in Tanzania. Private-for-profit facilities are still concentrated in urban areas. The FBOs are not expanding in view of reducing support from overseas.

3.2.3 Enhance PPP in the provision of health and nutrition services

The National Health Insurance Fund and National Social Security Fund contract accredited private health facilities, which constitute the majority of contracted facilities. Private facilities are not routinely involved in CHF.

Some respondents in the MTR only consider Service Agreements aiming at health service delivery as PPP, but in the review several activities were identified, which can be labelled as PPP. There are examples of informal public private collaboration "under the radar", e.g. vaccination activities, where the CHMT provides vaccines and needles, while private facilities provide labour. Collaboration also occurs in disease control programmes, such as through the ITN voucher scheme or ARV treatment (Axis 2012). Contracts for maintenance of vehicles or equipment or for cleaning of hospitals can be considered PPP. The Capital Investment report provides examples of PPP in maintenance, as implemented in Dodoma (with support from the Swiss Development Cooperation project Health Systems Strengthening. The Pharmaceutical Services report elaborates on the experiences with ADDOs in the country and with private pharmaceutical laboratories.

PPP in training of human resources for health already exists, with private schools and universities contributing to training of health workers. Clear regulations, e.g. by NACTE guide that sector and contribute to a level playing field between providers.

An area of concern mentioned in the MTR was the registration and inspection of private health facilities and other service providers. For example ADDOs are inspected by the District Committee for Food and Drugs under chairmanship of the DED and the secretariat of the DMO. Private dispensaries are inspected by the CHMTs on behalf of the MOHSW. Private providers felt that this does not contribute to creating a level playing field for service delivery, because the criteria applied in inspection of private

facilities are not applied in public facilities. Furthermore, some health workers in public facilities also work in private facilities, and may have competing interests. A fully independent accreditation system for all providers would end this inequity between providers, in the view of private providers. This accreditation body should not be part of an insurance company.

There is underreporting by private providers in HMIS, who fear that this health information will be used for tax purposes. This underreporting leads to incorrect health sector performance figures for the city of Dar es Salaam (MTR-AR 2013).

Dar es Salaam is one of the fastest growing cities in Africa, with 4.3 million people (NBS census 2012), where 70% of the health facilities is private. About 50% of the Tanzanian population now lives in urban areas, with a steep increase due to economic growth. The contribution of the private sector to health service delivery will be more and more important in the HSSP IV period. PPP therefore is not a "nice-to-have" issue, but critical for the future of the health of the population in Tanzania

3.3 SWAp

The SWAp governance mechanisms are clearly lined out and agreed by all stakeholders (MOHSW 2007), with Technical Working Groups (TWGs) for each of the strategic areas, the TC-SWAp meetings and the Joint Annual Health Sector Review (with a technical arm and policy arm). The Health Basket Fund is steered by a Basket Finance Committee with representatives of Government Ministries and Development Partners. The mechanisms are accepted by all stakeholders and seen as an example for other sectors in the country or even for other countries in the Sub-Saharan region, according to the WHO.

3.3.1 TWGs

For each of the strategic areas of the HSSP III and for some other important areas of work (e.g. pharmacy, health promotion) a TWG has been instituted after the initiation of the HSSP, based on the working groups that prepared the plan. Some TWGs (e.g. MNCH) have sub-TWGs for more specific areas of concern. The TWGs are chaired by a senior MOHSW official, sometime a Deputy Director or programme coordinator, while the Health Resources Secretariat is supposed to provide support to the TWGs. In general TWGs have clear Terms of Reference. Some TWGs overlap with specific task groups, like the Steering Committee for the One Plan, or the Monitoring and Evaluation Strengthening Initiative.

Health sector stakeholders vary widely in their assessment of performance of TWGs. During the MTR, some respondents reported that select TWGs perform very well, while others offer limited contribution to coordination and collaboration between partners. Some TWGs seem to function as drivers for innovation, while others simply exchange information. It appears that leadership of the TWGs and secretarial support can make a difference in TWG's effectiveness and contributions.

Participation in the TWGs is open to representatives from ministries, from private sector and civil society, national and international NGOs and from development partners. In general, there are no restrictions to participation. In practice, participation fluctuates: some TWGs have a consistently high level of participation, while others may see at times only few members showing up (particularly MOHSW members). The participation of members from other ministries in general is low across TWGs. MTR respondents feel that improved participation by PMO-RALG is necessary to link to LGAs, although the location of PMO-RALGs in Dodoma creates a physical barrier for active participation. There may also be an element of technical-administrative differences in approaches as explained above. The new appointment of the Deputy PS Health in PMO-RALG opens new perspectives for

collaboration. Another observation among MTR respondents was that sometimes TWGs could serve as for members to advocate for their own agendas.

TWGs are supposed to meet monthly, but in practice the frequency of meetings is dependent on the leadership and effectiveness of the Chair. Members of well-functioning TWGs feel that they are able to push coordination and make a change in the system. They express satisfaction with the arrangements.

The TWGs are supposed to keep an oversight over the implementation of the HSSP III strategies. In practice, this does not appear to be the case. As an illustration, none of the TWGs was aware of the process indicators in HSSP III (chapter 6) and none of them was monitoring progress against targets.

There are two mechanisms designed for coordination between the various streams of work. First, TWG Chairs should report on TWG discussions to their respective Directors, who would take up relevant issues with MOHSW senior management. In practice, it is difficult for the Chairs to brief their Directors regularly due to time constraints, and there is little coordination between the TWGs. Senior management in the MOHSW is not sufficiently kept up-to-date on the work of TWGs. The second mechanism is through the SWAp Technical Committee, which meets twice yearly. In practice, that forum is too large and meetings too infrequent to have in-depth discussion of issues. (The TORs clearly define the limited number of people who should attend, but that is not followed.) With exceptions, most TWGs work on their own and have limited contributions to decision-making at top levels in the Ministry.

In the view of the MOHSW officials, there are still too many parallel programmes and projects – all with their own reporting requirements, accounting systems and steering committees. Harmonisation and alignment has not yet resulted in reduction of the MOHSW workload related to support by Development Partners. If more work could be done through TWGs and TC-SWAp it would smoothen work processes, according to MOHSW officials.

3.3.2 TC-SWAp and JAHSR

The system of Technical Committee SWAp and Joint Annual Health Sector Reviews (JAHSR) Technical and Policy Meetings, is an excellent method for joint planning and monitoring the HSSP III, according to all stakeholders interviewed. The reports and minutes show a very open and transparent process of critical analysis and frank discussions. In fact, most of the critical issues raised in this review can be found in the meeting reports of previous years.

The process of formulating milestones and assessing progress against the formulated indicators gives a clear guidance. However, the follow up of performance of milestones is not subject to agreed procedures. Certain urgent issues (e.g. defining an essential health care package, or formulating a health financing strategy) are pushed forward from year to year. The linkage of the milestones to the indicators of the HSSP III strategies is not very clear. TC-SWAP and JAHSR for example never discussed the process indicators for the strategies. The timing of JAHSR does not coincide with the MTEF planning process; sometime planned activities cannot be included in the budgets.

3.3.3 Health Basket Fund

The Health Basket Fund (HBF) in the health sector in Tanzania is well established with clear procedures and working arrangements. Over recent years three Development Partners have withdrawn, due to internal policy decisions on development aid. For the first time, contributions to the basket reduced, and are now lower (in USD terms) than 2009, when HSSP III started. Non-basket donor funding over the

last two years is more than two times the basket funding. Still, basket funding is crucial for districts in particular, as it provides important resources for health programmes, while the major share of the government funds is tied to personal emoluments, amenities, etc. Unfortunately, disbursement of HBF funds can face delays at times, which can ultimately affect service delivery. According to MTR informants, the reporting and accounting requirements and deadlines are the basis for delays. MOHSW and PMO-RALG officials and Development Partners often discuss these issues at length in the meetings.

3.3.4 DPG Health

The Development Partners Group for Health (DPG Health) is a collection of 17 bi-lateral and multi-lateral agencies supporting the health sector in Tanzania. DPG Health is organised based on TORs and the Code of Conduct and has a troika chairing structure (an incoming, present and outgoing chairing arrangement). This coordination mechanism reduces transaction costs for the MOHSW, although according to the MOHSW there are still many parallel processes of planning and reporting, which could be streamlined further.

In general, DPs are satisfied with this mode of operation. The TWG structure allows DPs to interact with each other and the officials of ministry on many occasions and therefore enhances interaction and coordination.

4. Crosscutting issues

Quality

With regard to technical quality in the MOHSW, major steps have been made in systems development with the introduction of TQIF, the framework, the tools, the approach, etc. However, the positive effects are not sufficiently trickling down to the facility level. The striking dichotomy between poorly performing general health services (including maternal health) on the one hand and well- performing disease control programmes on the other hand needs further study. In the view of the MTR team the key issue for advancing the health services in general is development of a culture of quality. Leadership and commitment are important factors in this regard.

The quality of many policy and strategy documents and work plans of departments, programmes and agencies of MOHSW Headquarters is good.

The long period of uncertainty in the MOHSW with regard to top management has affected the quality of management and has affected the quality of partnerships. Priority in the health sector is now establishing a quality culture, where good management performance is the standard.

Equity

The overall assessment of the MTR is that equity has somehow progressed in physical accessibility, but not in financial accessibility. Despite the efforts to reduce the rural – urban divide (e.g. MMAM, resource allocation formulas), differences in service delivery are still striking.

In governance the resource allocation formula aim at more equitable distribution of resources. In practice when it comes to actual disbursement, the formula is not always applied. Resources are now often spread to thinly to make an impact on the health status of the most vulnerable people in the country. The MTR team advocates a tailor-made approach, where hot spots of serious health problems are identified by using the M&E tools, and tackled by priority. This requires proactive governance, not using routine measures or procedures.

Gender

In general terms, gender in the health sector is understood as reproductive health for women, which is a very narrow approach. Involvement of men in reproductive health is limited. The Reproductive Health Services are poorly performing and not well accepted by clients. Issues of privacy and confidentiality are not properly addressed in most health facilities.

Gender balance in CHSBs and HFGCs is often not observed, with men dominating the committees representing the population and little attention being given to women's issues and concerns as shown in the Community Perspective study.

Changes in gender approach do not come from policy documents but from champions in management positions, who persevere putting it on the agenda, and who can translate theoretical concepts into practical measures.

Efficiency

Efficiency is a major problem in the health services in Tanzania, in the view of the MTR team.

In general, in health facilities, health workers' productivity is mixed: in some situations productivity is low (in terms of numbers of patients attended or services provided), while in other situations, health workers are overburdened. Distribution of health workers is not equitable and is usually not based on health system needs. Issues of service readiness can negatively influence staff efficiency as well. Another major efficiency problem exists with medical supplies, where many medicines expire in the health facilities, are not prescribed rationally, or are stolen. Efficiency problems also exist when the health infrastructure is expanded while no staff is available for those facilities.

Efficiency losses occur through duplication of work, e.g. parallel information systems between MOHSW and PMO-RALG, or NGOs or Development Partners engaging in similar types of activities without coordination (a feature seen in Maternal Health programmes). Not using the decentralised system and continuing central operations is highly inefficient.

In health financing the delays in disbursement, with long periods of non-availability of funds, constitute a major issue of inefficiency, with consequences directly impacting the availability of services at the district and facility levels.

The production of strategy documents, policies, guidelines and tools could be a waste of resources, if they are not distributed and not used in practice.

In fact, all issues of efficiency boil down to good or insufficient management. The MTR team recognises that human resources problems at mid-level management play a role in inefficiencies, but sees improved communication and supervision with the MOHSW as one of the ways forward.

Sustainability

Tanzania, like many other countries in Sub-Sahara Africa, is heavily dependent on donor support to run the health sector. Where many countries show a positive trend of increasing relative government contribution to the health sector, Tanzania experiences an opposite development. Year-by-year the percentage is declining (now below 60%). There is increasing donor dependency, whereby non-basket funding has become the major source of donor funding (now 27% of the total funding). The reality is that the resource envelope for health will not increase in the coming years. The expectations in HSSP III with regard to growing funding for health could be considered unrealistic, in hindsight. This requires strong leadership in the MOHSW, to set clear priorities and make choices. Many planned activities of HSSP III may not be feasible under the present conditions and therefore need phased in a proper way.

5. SWOC analysis

Strengths	Weaknesses
• Well established policies and overall strategies with regard to D-by-D and with regard to PPP • Clear systems within PMO-RALG to serve MOHSW regarding planning, reporting, accounting • Well established systems in SWAp with TWGs, TC-SWAp, JAHSR, BFC • Recent clarity on management positions and leadership • Successful PPP activities "under the radar" •	• Link between operations and strategies not always clear (e.g. follow-up on HSSP III) • Mid-level management in MOHSW not always able to translate general government policies into practical measures (e.g. equity, gender) • Working in silos, also by TWGs, sub-optimal internal communication • Under-utilisation of systems run by LGAs and PMO-RALG • Performance management not operationalised • External communication insufficient to inform general public • PPP not yet fully operationalised at regional and district levels
Opportunities	**Challenges**
• Political commitment to health issues • Further commitments of PMO-RALG to health department	• Financial constraints becoming structural, without short-term perspective of growth • Public dissatisfaction with performance of health services resulting in low utilisation

6. MTR Recommendations

- Strengthen the relation between strategic planning and operational planning; finalise the draft MOHSW-HQ strategic plan 2012 – 2016 and enhance comprehensive annual planning.
- Strengthen management capacities of MOHSW mid-level management and junior staff, with better information on governance policies, coaching and guidance, applying performance-based management.
- Better utilise decentralised systems, which are part of the PMO-RALG management system; cut out duplication of work in information and reporting systems; maintain strict work planning between MOHSW and PMO-RALG to meet deadlines jointly.
- Focus on efficiency measures to improve value-for-money, learning from good practices and examples in programmes and regions.
- Improve the MOHSW supervision on technical aspects in a cascade approach; bring the ZHRCs back into operation, as planned in 2009, capacitate the RHMTs in supervision, focusing on empowering the CHMTs.
- Strengthen relations between senior management in MOHSW and TWGs, as well as improve coordination and interaction among TWGs; establish working group of TWG chairs to enhance implementation of priorities for the remaining period of the HSSP III; ensure regular reporting; enhance joint meetings and work to avoid overlap or duplication.
- Enhance monitoring of HSSP III process indicators, and enable flexibility in indicator targets to reflect reality (such as lower budget allotments than planned, etc.).
- Make "under the radar" PPP in districts more visible and use such efforts as stepping stones for trust building and increased investments of the private sector in health, especially in rural areas.
- Improve MOHSW communication, internally and externally, with a vibrant website and public campaigns on the achievements of the health sector to build trust of the general population.

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