

SECTOR-WIDE APPROACH IN TANZANIA

The Health Sector Example

OBSERVATIONS FROM A BI-LATERAL

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BFC	Basket Financing Committee
CCM	Chama Cha Mapinduzi
DAC	Development Assistance Committee
DFID	Department for International Development (UK)
EHI	National Package of Essential Health Interventions in Tanzania
GDP	Gross Domestic Product
GNP	Gross National Product
GoT	Government of the United Republic of Tanzania
HIPC	Heavily Indebted Poor Countries initiative
HIV	Human Immune-deficiency Virus
HMIS	Health Management Information System
HSR	Health Sector Reform
HSRSP	Health Sector Reform Support Programme (SDC)
IFMS	Integrated Financial Management System
IMF	International Monetary Fund
MOF	Ministry of Finance
MOH	Ministry of Health
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
NTLP	National Tuberculosis and Leprosy Programme
OECD	Organisation for Economic Co-operation and Development
OC	Other Charges, in recurrent expenditures
PE	Personnel Emoluments, in recurrent expenditures
PER	Public Expenditure Review
PHC	Primary Health Care
POA	Plan of Action
POW	Programme of Work
PRSP	Poverty Reduction Strategy Paper
PRBS	Poverty Reduction Budget Support
RALG	Regional Administration and Local Government in the President's Office
SDC	Swiss Agency for Development and Co-operation
SECO	State Secretariat for Economic Affairs
SWAP	Sector-wide Approach
USD	United States Dollars
WB	World Bank
WHO	World Health Organisation

1. INTRODUCTION

Objective

Commissioned by the Swiss Agency for Development and Co-operation (SDC), this document represents the end of assignment's report of the author, after four years passed in Tanzania. The document aims at portraying the emergence of a sector-wide approach (SWAP) for health development in Tanzania, as experienced and observed by the author. It also aims at suggesting to SDC general issues for follow-up of the sector programme, as well as internal issues for consideration at headquarter and field level.

Content

After this introduction, the second chapter presents the overall context in Tanzania with regard to economic and socio-economic situation, development framework and policy planning process, and Government reforms and governance. The third chapter presents the health sector context with a health profile and a reminder of the sector reform process, together with the main limitations to projects' aid encountered during the past.

The fourth chapter considers the sector-wide approach itself with the Government policy and strategy, as well as the programme definition together with a chronology of the elaboration process. The programme implementation is then presented and followed by issues pertaining to the financing of the sector with updated data from the last Public Expenditure Review process. A section then approaches some issues pertaining to the prioritisation of interventions in the sector programme. Suggestions are formulated for the development framework and the issue of coherence of indicators, for essential sector's inputs, and for service delivery and utilisation. Partnership in the process is then discussed, and the chapter ends with challenges lying ahead, presented as a summary of the issues raised in the previous sections.

The fifth chapter is mainly intended for SDC internal consideration. It presents SDC institutional experience during the SWAP elaboration process. The rationale for a sectoral approach as foreseen by Swiss policy is presented and followed by the experience in Tanzania. The rationale for sectoral concentration and interaction, as well as for the prioritisation of SDC support and interventions in a sector programme are then commented. A section considers then conditions for the compatibility between programme and projects approach. Under programme management, issues like field/headquarters mix, participation of Swiss institutions and programme continuity are treated, before concluding the chapter with an issue about the Poverty Reduction Strategy Paper and a summary of lessons learnt and suggestions.

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The list of people I owe the pleasure of four challenging years passed in their company and that of their experience and advice is too long to be mentioned here. To name some would be unfair to the others, and to thank them all, even if too general, is nevertheless sincere and individually meant.

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Finally and albeit commissioned by SDC, the views and suggestions expressed in this document are solely those of the author, and SDC bears neither responsibility nor commitment to it.

2. OVERALL CONTEXT

2.1. Economic situation

With the exception of a downfall in 1993-95, Tanzania has largely succeeded in the implementation of a structural adjustment process initiated in 1986 with the Bretton Wood institutions. With a significant acceleration of the reforms' implementation over the last six years, Tanzania's economy by the end-2000 is largely stabilised and market oriented. Tight monetary and fiscal policies have succeeded to contain fiscal deficit and bring inflation down to a single digit. Price controls have been lifted, imports and exports are liberalised, exchange rates are market determined, and official reserves have reached the sustainability target of four months of imports. Privatisation of parastatal entities is well under way, and foundations required for a private sector-led growth are in place, which in the last three years resulted in a constantly raising economic growth. (Table1)

Table 1. Tanzania Macroeconomic Performance, 1986 – 2000 1/						
	1986-93	1994	1996	1998	1999	2000
Growth (in %)	4.0	1.6	4.5	4.0	4.6	5.2
Inflation (annual average, in %)	28.9	33.0	21.0	12.8	7.9	5.5
Official reserves (months of imports)	1.1	1.7	2.2	3.4	4.1	4.2
Change in net domestic financing of the government (in % of GDP) 2/	4.8	3.3	-0.7	-0.2	-0.1	-0.1
Sources: Tanzanian authorities/IMF						
1/ 2000: estimates, except for 2/ 2/ Data refer to fiscal years ending in June of the indicated calendar years.						

Despite these positive achievements, and with an annual demographic growth factor estimated at 3 percent over the last few years, the average per capita growth rates have remained low. Although data on growth distribution are still missing for a segmented analysis, the absolute low per capita rates remain as a major impediment to overall social development in Tanzania. Factors to explain this situation reside in a rather sluggish implementation of the agricultural sector's reform, remaining trade and tariffs barriers, and a very limited access to micro-finance in the rural areas. Moreover, with regard to public expenditure management, while significant achievements have been made in terms of transparency and accountability, the issue of expenditure efficiency remains to be addressed. Lastly, with regard to the private sector environment, impediments remain with the existing restrictions on foreign portfolio investment in capital markets, and with the heavy transaction costs resulting from widespread corruption.

2.2. Socio-economic situation

With a GNP per capita of USD 240¹ in 1999, Tanzania is one of the poorest countries in the world. Reliable current data are scarce, but official estimates suggest that half of the 31 million's population is poor and 36 percent very poor². Poverty is largely a rural phenomenon (61 percent of the rural population is poor) with the poor concentrated in subsistence agriculture, while urban poor (39 percent of the urban population) are either concentrated in the informal sector, or unemployed³.

The youth, the old, and large households are more likely to be poor, and although female-headed households are not necessarily poorer than male-headed households, women are generally perceived to be poorer than men, owing to their vulnerability, the lack of assets (including land and livestock), and limited schooling³.

With regard to non-income poverty, the usual social development indicators have continuously declined since the 1980s and some indicators like life expectancy (mainly because of AIDS) and primary enrolment have fallen under the average rate for sub-Saharan Africa⁴.

2.3. Development framework

After independence in 1961 Tanzania's development agenda concentrated on fighting ignorance, disease and poverty. Related policies were implemented through centralised medium and long-term plans, which resulted in significantly improved social services and indicators until the late 1970s. Financial unsustainability, high inflation and a progressive collapse of the economy put an end to these efforts, and in the mid-1980s the country embarked on its structural adjustment process, with the priority objective to restore economic stability and restart growth. With this objective largely achieved, a comprehensive policy framework has been established over the recent years, to address the remaining high poverty levels in the country. (Table 2)

Table 2. Tanzania Policy Planning Process	
<i>Policy Planning Initiative</i>	<i>Objective</i>
• Vision 2025	National vision of economic and social objectives to be attained by the year 2025
• National Poverty Eradication Strategy (NPES)	National strategy and objectives for poverty eradication efforts through 2010
• Tanzania Assistance Strategy (TAS)	Medium-term national strategy of economic and social development, encompassing joint efforts of Government and the international community
• Poverty Reduction Strategy Paper (PRSP)	Medium-term strategy of poverty reduction, developed through broad consultation with national and international stakeholders, in the context of the enhanced Highly Indebted Poor Countries Initiative (HIPC) / 1
Source: PRSP 1/ Opinions differ with regard to the labelling of "broad" for the consultation process in drafting the PRSP. Although the consultation occurred, some believe that it was rushed in order to meet the HIPC completion conditions, and that Tanzania missed an opportunity to ensure coherence between the document and the main sectors' reform implementation process	

¹ World Development Report 2000

² Tanzanian authorities quoted in World Bank Tanzania CAS

³ Source: Tanzania PRSP

⁴ World Development, Human Development Reports 2000

With the Vision 2025 as an umbrella, the policy planning initiatives represent a remarkable attempt to compile development initiatives into a limited albeit comprehensive framework. The Tanzania Assistance Strategy provides the link with the international community, by covering all development areas supported by international partners, both within and outside the central Government budget.

Overall, the initiatives build upon the policy reforms aimed at macroeconomic stability and market efficiency, which are supported by the IMF and the World Bank through the Poverty Reduction Growth Facility (PRGF) and the Programmatic Structural Adjustment Credit (PSAC-1). They also aim at building upon the various sector-specific reforms supported by international partners.

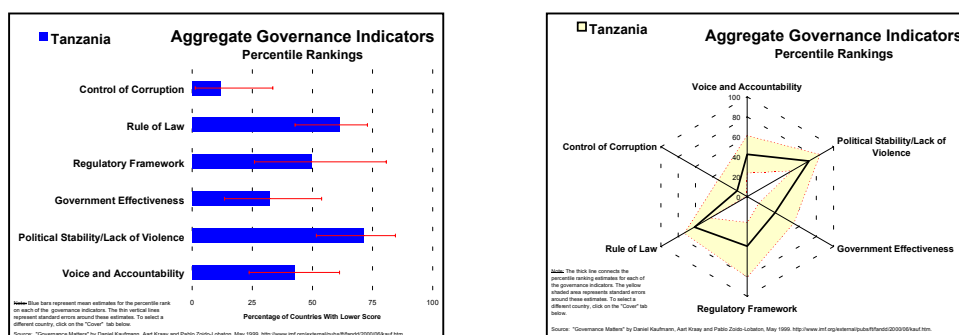
Despite the impressive output resulting from these efforts towards coherence and comprehensiveness, the current development framework raises a number of issues and concerns pertaining to its implementation. First and already mentioned in Table 2, the coherence between the sector-specific reforms and the poverty reduction strategies remains questionable, hence creating a situation that may induce negative effects in social services delivery by diluting or diverting priority interventions. Secondly, the move towards implementing simultaneously a large number of inter-linked reforms induces a very time-consuming process associated with extended requirements in terms of co-ordination, documentation and external consultants' inputs. The related increasing workload on the Government and its administration may over-stretch an already limited implementation capacity and ultimately question the leadership of the process. Thirdly, the overall development framework contains a large number of indicators aimed at monitoring both the implementation process and its outputs. Besides the above issue of coherence with indicators developed by sector-specific monitoring systems, the overall responsibility for the collection, co-ordination and compilation of information is yet to be defined. Lastly, albeit referred to as a national development framework, there is yet little to find in the planned implementation for the involvement of the Tanzanian civil society at large.

2.4. Government reforms and governance

The Public Service Reform Programme has been initiated in 1992, with a view to address the role and function of public services in the context of a liberalised and market-oriented economy. Embedded in the global restructuring of ministries, the Civil Service Reform and the Local Government Reform constitute two essential components of the programme. Overall, the aim is to re-orient central government's role towards policy making, regulation, monitoring and performance assessment, while local governments shall take over the responsibility for the implementation of services in close collaboration with civil society's agencies and the private sector. Under the Civil Service Reform, the workforce has been reduced to 254'000 people, down from 354'000 in 1993, allowing for a 75 percent pay increase in real terms. Under the Local Government Reform, devolution of powers has been extended to all district authorities and elected councils. Out of the country's 113 districts, 37 are currently benefiting from a block grants system to directly receive central government's financial resources.

Good governance is an issue in Tanzania, and the related agenda for fighting corruption remains unfinished. The graphs in Chart 1 compare Tanzania with 178 developed and developing countries, in the way a large number of surveys respondents perceive the quality of governance in these countries⁵. While Tanzania is portrayed as a politically stable country where the rule of law is fairly enforced, it appears however that the controls of corruption are perceived as almost non-existing. When compared with the numerous initiatives and reforms initiated during the recent years to address the issue of corruption⁶, this observation raises a concern. It may actually suggest that the questions of commitment and compliance with the regulatory framework as well as its enforcement remain to be further addressed, since regular interviews with the private sector and various stakeholders do not indicate a significant improvement over the last two years.

Chart 1. Tanzania: Governance Indicators



Source: Composite Governance Indicators Dataset, World Bank, data from 1998

⁵ The Bar graph indicates the percentage of countries ranked “worst” than Tanzania for the indicated dimensions, while the Diamond graph shows Tanzania’s assessment compared to an ideal of 100 percent for each of the same dimensions.

⁶ Warioba Report, Code of Ethics and Conduct for Civil Service, National Anti-Corruption Strategy and Action-Plan, National Framework on Good Governance, introduction of Integrated Financial Management System, establishment of Tanzania Revenue Authority.

3. HEALTH SECTOR CONTEXT

3.1. Health profile

Although slightly above the average for sub-Saharan Africa, the health status in Tanzania is poor (Table 3). With the increasing HIV/AIDS pandemic, HIV prevalence is said to vary between 10 and 30 %, mortality rates are high and life expectancy is fast declining. Although reliable data are scarce, the leading cause of death is reported to be malaria (22.6 %) followed by AIDS (15.5 %), and the leading cause of under-5 deaths is malaria (30.7 %)⁷. Overall, most of the health problems in Tanzania can be attributed to 10 major infectious and communicable diseases of preventable causes.

Since Independence, the government has recognised the importance of health and given it a high priority. In the 1970s and 1980s, the government adopted a Primary Health Care Approach, and expanded rapidly the number of facilities and staff under an extensive referral pyramid. As of today, with a workforce of 67'000 the government provides 60 percent of all health facilities in the country⁸. Coverage is above the sub-Saharan Africa's average with 70 percent of the population living within 5 kilometres of a state-funded facility, and a recent study⁹ shows that 70 % of sick individuals in the poorest 20 percent of households seek care first in a government facility (Table 4).

In terms of organisation, the administration of different levels of public health care services is a rather complex issue. With the decentralisation process under the Local Government Reform, certain responsibilities for health services have been devolved to the district level. Currently, regional and district hospitals are administered by the Regional Administration and Local Government in the President's Office, and the Local Governments (District Authority) are responsible for the running of health centres and dispensaries, using subventions from the central government and their own revenues. The Ministry of Health is directly responsible only for the national/referral or specialised hospitals, various medical training schools, and national health programmes, and it remains with the overall responsibility for health matters and overall policy. On the planning, management and monitoring side, the Regional/District Health Management Teams are administratively subordinated to the Ministry of Regional Administration and Local Government, and "technically" answerable to the Ministry of Health. This complex body has resulted in dual responsibilities for health services at district level.

With regard to the government's financing of the sector, health receives a fair share among the priority sectors¹⁰. By the end of the fiscal year 2000, out of US-dollars 835 million of discretionary resources¹¹, priority sectors had received 42 percent and health 20 percent of this share¹². These positive figures reflect government's efforts to protect resource allocation to priority areas over the recent years. With the substantial

⁷ Ministry of Health, Health Statistic Abstract 1998, data from 1996.

⁸ Total government, voluntary and private health facilities was 5'470 in 1998.

⁹ Tanzania Social Sector Review, World Bank 1999

¹⁰ Education, Health (incl. HIV/AIDS), Water, Roads, Judiciary, and Agriculture

¹¹ Discretionary resources are the recurrent resources left available after payment of the Consolidated Fund Services, essentially Tanzania's debt service and pension fund.

¹² Source: Tanzania PRSP

additional resources Tanzania should benefit from with the Heavily Indebted Poor Countries (HIPC) initiative, the government has expressed the commitment to further increase allocations to the health sector by 38 percent until the fiscal year 2003¹².

Table 3. Tanzania: Health Status Indicators				
	1975		1998 /1	
	Tanzania	Average for sub-Saharan Africa	Tanzania	Average for sub-Saharan Africa
Life expectancy (years at birth)	46.5	45.0	47.9	48.9
Infant mortality rate (per 1000 live birth)	129	138	91	106
Under-5 mortality rate (per 1000 live birth)	218	226	142	172
Maternal mortality ratio (per 100'000 live birth)	-	-	530	-
Population without access to safe water (percent)	-	-	34	46
Population without access to sanitation (percent)	-	-	14	52

Source: Human Development Report 2000

/1 1998 or latest available data

Table 4. Tanzania: First Source of Curative Outpatient Care by Quintile of Population (%)			
Source of Care	Lowest 20 %	Highest 20 %	All
Government Hospital	15	20	17
Voluntary Agency / Private Hospital	5	9	6
Government Health Centre or Dispensary	55	26	40
Voluntary Agency Health Centre or Dispensary	10	9	10
Private Health Centre or Dispensary	6	24	14
Other (traditional and pharmacy)	9	12	13

Source: Tanzania Human Resources Development Survey, in Social Sector Review, World Bank 1999

3.2. Health sector reform process

Given the above background, the government proposed ambitious reforms in the sector to drastically transform the roles and responsibilities in the provision and financing of the health care services, in order to ensure a cost-effective use of resources and emphasise priorities towards outcomes rather than inputs. The *Social Sector Strategy* (October 1994) seeks to increase resource allocation to the social sectors, decentralise authority to local level, promote high quality standards and higher private sector participation, and move resources closer to the households.

In December 1994, the government further articulated its vision for the reform of the health sector in the *Proposals for Health Sector Reform*. In this document, the government redefined its role in the health care system from one of dominant provider, to facilitator. The Reform focuses on ensuring more transparent, cost-effective use of existing resources, and on improving delivery, quality and impact of

essential health care to the poor. Public health services are to be primarily channelled through a system in which authority and budgets are decentralised to the district level. The government is to focus on ensuring that an essential package of health services can be financed for all the population, with full accountability to households as consumers, beneficiaries, and active participants.

The Cabinet approved the *Proposals for Health Sector Reform* (December 1994) in March 1996. The visions in the reform proposals gained support in the donor community, and the joint Ministry of Health/Donor statement in April 1996 endorsed the visions and expressed support to its implementation process. Following a series of joint missions between government and donors, the Ministry of Health further developed its vision into strategies for reform in a revolving three years' *Programme of Work*, which in its latest version attempts to cover the sector as a whole. In response to this, and to emphasise the need for cohesive and co-ordinated inputs for the implementation of a sectoral programme, a group of partners¹³ and the Ministry agreed in March 1998 on a process to lead to a sector-wide approach (SWAP). Under this process, all partner interests were to be subsumed under a common system and programme with unified objectives. Given the limitations encountered with traditional projects' aid, the aim was hence to dilute the administrative and planning burden of multiple systems imposed through the various donor-led approaches, and to promote co-ordinated planning and resource management by government (Box 1).

Box 1. Tanzania: Limitations to Projects' Aid in the Health Sector

Public health interventions provided and co-ordinated by the Ministry of Health suffer in Tanzania the same problems met with vertical programmes in other countries. These programmes have the advantage of having clear goals and well-defined target groups, which facilitates the monitoring and the accounting within each programme. But they also have resulted in inefficiency due to their parallel implementation arrangements (separate accounting, disbursements, reporting...), the duplication of their generic functions (logistics, drug/supplies distribution, information systems), and the lack of co-ordination among the programmes (training, information, dissemination...). The final outcomes are an uneven distribution of health care services with uncoordinated activities, as well as the absence of integrated planning, monitoring and evaluation.

On the projects' side, besides the support to the above vertical programmes, a number of projects opted for district/region-based support. Integrated support has often been provided to particular districts or regions to improve the quality of services, especially at primary health care level, and to strengthen capacity at district/regional level in planning, management, and monitoring. However, inadequate information sharing and co-ordination among these initiatives has led to fragmentation, rather than replicating successful examples in other parts of the country. By nature, the initiatives have also contributed to the establishment of "islands of excellence" in the country, while entire regions and districts have been left aside donor support. The final outcomes are functional and geographic fragmented activities, resulting both in inequality and inequity, as well as the establishment of unsustainable parallel systems eventually undermining government's management capacity and ownership.

¹³ Switzerland, Denmark, Germany, Ireland, Netherlands, Norway, United Kingdom, United States, African Development Bank, UNICEF, World Bank, World Health Organisation, Christian Social Sectors Commission (CSSC), and Tanzania Association of Private Hospitals (APHTA).

4. A SECTOR WIDE APPROACH FOR HEALTH

4.1. Government policy and strategy

The overall objective of the health policy and health sector reform is *to improve the health and well-being of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people*¹⁴. From a number of specific and underlying objectives, the Ministry of Health elaborated eight strategies for the reform's implementation, which constituted the framework of the Health Sector Reform Programme of Work 1999 – 2002 (Box 2).

A number of assumptions were lying behind the strategies, pertaining to availability and efficient use of resources, clear priority-setting and monitoring, decentralised management, staff motivation, and availability of drugs and essential supplies. Together with the Plan of Action 1999 – 2000, listing the intended activities for the first year of implementation, the Programme of Work provided the basis to operationalise the government's programme in the health sector in the context of a sector-wide approach. The programme was submitted to a joint Ministry of Health / Partners appraisal in March 1999.

Box 2. Tanzania: Health Sector Reform Strategies

- 1) Provide accessible, quality, well-supported cost-effective district health services with clear priorities and essential clinical and public health packages, which are organised at the decentralised level.
- 2) Provide back-up secondary and tertiary level referral hospital services to support primary health care.
- 3) Redefine the role of the central Ministry of Health as a facilitator of health services, providing policy leadership and a normative and standard-setting role.
- 4) Address the challenges of human resource development to ensure well-trained and motivated staff are deployed at the appropriate health service level.
- 5) Ensure the required central support systems such as personnel, accounting and auditing, supplies, equipment, physical infrastructure, transportation and communication.
- 6) Ensure health care financing which is sustainable, involves both public and private funds as well as donor resources, and explores a broader mix of options such as health insurance, community-cost-sharing as well as user fees.
- 7) Address the appropriate mix of public and private health care services.
- 8) Restructure the relationship between the Ministry of health and the donors.

4.2. Programme definition

A short chronology of the essential points in the elaboration of the Tanzanian SWAP is presented in Table 5. At the time of the 1999 appraisal, while the policy environment and the framework for the implementation of the sector programme were largely considered as comprehensive and conducive, a number of issues remained however as subjects of concern.

¹⁴ Programme of Work 1999-2002, MOH

Fragmentation

By focusing on key reform areas, the Programme of Work was not covering the whole sector. As such it was not a problem, since it could be argued that a sector programme was not to be seen as a blueprint, and rather be considered as a process evolving towards more comprehensiveness. The difficulty remained however with the absence of a comprehensive resource envelope, indicating resource availability to the sector, sources of funding, as well as related activities. Without such an information, there was a risk that the sector programme would duplicate resources and activities with on-going programmes and projects.

Responsibility

Each strategy referred to a key reform area and was assigned to a Strategy Co-ordinator from the Ministry's staff. This model, not unique to Tanzania, implied that the large number of activities under each strategy was spread over several implementation bodies in the Ministry, namely the various Directorates, and even over another Ministry, the Regional Administration and Local Government, for District services. On one hand the link between the activities and the Directorates' respective budgets were hard to establish, without a fastidious micro-planning exercise. On the other hand the function and scope of the Strategy Co-ordinators remained unclear, since by status they were subordinated to the Directors, who ultimately decide on their priorities.

Performance

The practice of a management by objectives was a rather new concept in Tanzania. Managers were used to plan the use of internal resources on an incremental basis (around 10 % per year), and expectations to receive the planned amounts in full were low, which provided little incentive to proper planning. As for external resources in traditional programmes, the planning process involved substantial technical assistance and left little flexibility to the Ministry. With partners' will to support a sector programme, using government's systems, and by moving towards budget support, the Ministry was now invited to produce a plan linking substantial and unallocated resources to verifiable outputs and outcomes. With sources coming from a fragmented health database and a poorly performing management information system, the plan was fairly comprehensive, but the activities looked more like a "wish list" than structured and prioritised interventions resulting from sectoral objectives. In addition, the question of the activities' financing remained open, since no financial management system existed to cater for an earmarked budget support to the sector.

Against this background and after extended consultation among partners and the government, a strategic decision was taken, which gave Tanzania's SWAP its peculiar character:

- *Based on the estimated resources to be available, the sector programme would be revised to a limited number of key priorities and milestones to be implemented by each Directorate.*
- *Implementation would be incremental, promoting a "learning-by-doing" process, and focusing first on systemic issues like financial management system, procurement procedures, and sector performance monitoring.*

Two tacit assumptions were underlying this framework. First and given the novelty of the approach, any attempt to embark on a full-fledged sector programme was bound to fail by overloading the Ministry's capacity, and by the virtual impossibility to reach a simultaneous consensus on every issues with all stakeholders¹⁵. Second and in order to ensure sustainability, government's systems were to be used albeit customised to partners' expectations in terms of accountability and transparency.

The joint appraisal concluded with a side-agreement between the government and supporting partners, which together with a set of jointly agreed benchmarks constituted the basis for the first year of the programme's implementation.

Table 5. Tanzania: Chronology of SWAP Elaboration Process

<ul style="list-style-type: none"> • High level workshop on SWAP definition and experience • Joint Ministry/Partners Statement of Intent to move towards a SWAP for Health Sector Reform implementation • SDC, DFID, WB concept and commitment towards joint funding for SWAP implementation • Draft <i>Programme of Work 1999-2002</i> • Draft <i>Plan of Action 1999-2000</i> • Programme pre-appraisal • MOH/Partners Joint Appraisal, "basket partners" Side-Agreement /1 • Finalised <i>Programme of Work and Prioritised Plan of Action</i> • Basket partners sign a <i>Memorandum of Understanding</i> to agree terms and procedures • First disbursement through basket financing arrangement • First annual joint review of the Health Sector Reform programme 	<p>February 1998 March 1998</p> <p>June 1998 November 1998 November 1998 December 1998 March 1999 June 1999</p> <p>October 1999 December 1999 March 2000</p>
<p>/1 While the appraisal gathered all partners in the sector – including some actors of the private sector and civil society – SDC, Danida, DFID, Ireland Aid, Norway, and World Bank moved forward with the concept of joint financing using government's systems. Currently, Germany and the Netherlands have also joined the process.</p>	

4.3. Programme implementation

After two years of implementation, significant results have been achieved under the SWAP¹⁶. Based on the performing Integrated Financial Management System of the government¹⁷, the customisation for the health sector has been carried out and enables joint internal and external resources disbursement at both central and district level, from the Consolidated Fund with the Ministry of Finance. External funds are merged into a holding account with the Central Bank of Tanzania (commonly referred to as the basket), released to the Consolidated Fund and allocated to the spending units on a quarterly basis, following the approval by the Basket Financing Committee (Box 3). A joint audit by the Office of the Auditor General and an external audit company is performed on an annual basis, within six months of the end of Tanzanian fiscal years (June for central and December for local governments).

¹⁵ With vertical programmes for instance, a forced integration entailed the risk of both inducing strong resistances from programmes' managers and financiers outside the envisaged joint financing system, and disrupting services' delivery.

¹⁶ "Of all the five country case studies carried out (Mozambique, Uganda, Tanzania, Cambodia and Vietnam), the United Republic of Tanzania has the most advanced sector-wide approach." A. Brown, in *Current Issues in SWAP for Health Development*, WHO/GPE/2000.

¹⁷ A budgeting and accounting software called Platinum, working according to international accounting standards.

Box 3. Tanzania: Health sector management instruments

Beside government sector and cross-sectors management meetings on a quarterly, monthly and weekly basis, two main forums involving development partners focus on the SWAP:

- *The SWAP Committee*, chaired by the Permanent Secretary/MOH, with members from the Ministries of Health (MOH), Regional Administration and Local Government (RALG), and Finance (MOF), as well as donors active in the sector, the private sector, non-governmental agencies, and voluntary (religious) agencies.
- *The Basket Financing Committee (BFC)*, co-chaired by the Permanent Secretaries MOH and RALG, with members from MOH, RALG, and MOF (including Deputy-Permanent Secretary), as well as all donors contributing to the basket.

The BFC is a sub-committee of the SWAP committee, as are various specific working groups e.g. for performance monitoring, procurement, audit, and hospital reform.

The SWAP committee meets on a biannual basis to review the overall Health Sector Reform process.

The BFC meets on a quarterly basis to review budget execution, receive annual audit and quarterly financial/activity reports, and approve quarterly disbursements from the holding account with the Central Bank.

With regard to the sector performance, despite the weaknesses of the Health Management Information System (HMIS) as data provider, an overall monitoring system is progressively emerging. An interim set of input, output, outcome, and process indicators based on existing information and measuring six key sectoral areas and six priority dimensions has been selected (Table 6). With this information, a first sector profile is being developed for the second annual review in March 2001, which should serve as a priority-setting framework for the planning of resources allocation for the fiscal year 2002. Embedded in the production of the annually revolving Medium Term Expenditure Framework, this process should in the medium term offer a practical example of the performance budgeting concept recently introduced by the Ministry of Finance. It should also provide donors with the output and outcome-oriented plans requested for an effective budget support to the sector.

Table 6. Tanzania: Interim Health Sector Performance Monitoring Matrix																								
Priority	Network				Human Resources				Drugs				Financing				Utilisation of Services				Health Outcomes			
	Indicators				Indicators				Indicators				Indicators				Indicators				Indicators			
	I	o	u	p	i	o	u	p	i	O	u	p	i	o	u	p	i	o	u	p	I	o	u	p
Access																								
Effectiveness																								
Efficiency																								
Equity																								
Quality																								
Sustainability																								
Input: i Output: o Outcome: u Process: p																								
Stand by March 2001. The current database allows monitoring of some priority dimensions in each key area, with some type of indicators. The highlighted zones show the type of indicator and the priority dimension. The matrix will develop with the improvement of the database, government's priorities, and the development of the ministry's system and technical capacity.																								

With this focus on systemic issues and the necessary administrative adjustments resulting from the interaction between three ministries¹⁸ to address a new paradigm of joint government/donors collaboration, disbursements to the programme have been rather slow. With most public health interventions still supported on a bilateral basis¹⁹, transaction costs for the Ministry have remained high and may even have increased with the SWAP process²⁰. Given the pragmatic and sound strategic orientation chosen for the Tanzanian model, this however comes as no surprise and should not lead to premature conclusions. A national system evolves only with time and perseverance, and transaction costs will reduce proportionally to the progressive mainstreaming of projects and programmes into the sector programme.

4.4. Financing of the sector

The recent update of the Public Expenditure Review for the health sector²¹ has evidenced the good execution of the government's budget over the recent years, save for the development budget which remains a residual item due to the prevailing cash budget system²² (Table 7). Apart from a surprising peak in 1998/99 for recurrent expenditure, associated to referral abroad, the budget shows an increasing trend in line with government's commitment towards priority sectors, notably during the current fiscal year with the extra resources expected from the HIPC initiative.

Tsh. Billion	1997/98		1998/99		1999/00		2000/01
	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Recurrent	46.89	46.82	62.21	62.18	60.73	57.99	75.79
Development	2.88	2.56	2.16	0.92	3.86	1.94	4.18
Total	49.77	49.38	64.37	63.10	64.59	59.93	79.97

The further breakdown of the recurrent expenditure between Personnel Emoluments (PE) and Other Charges (OC) over the three last years confirms the weight of the 67'000 workers' wage bill, which absorbs two third of the total recurrent expenditures. While considering the expenditures by level of expenses, a similar proportion of two third is allocated to hospital services. This proportion stands clearly against the stated government's emphasis towards primary health care. Strategically however, it can be argued that with the traditional strong donor support to this level, the government demonstrates a judicious use of fungibility, by allocating resources to ensure proper functioning of the hospitals²³.

¹⁸ Health, Regional Administration and Local Government, and Finance

¹⁹ See rationale in note 15 above

²⁰ The ultimate paradox, since a founding principle of a SWAP aims precisely at the contrary.

²¹ Public Expenditure Review Health Sector in Tanzania, E. Jefferys/J. Mahon for SDC, February 2001

²² To avoid over-expenditure, monthly releases from the Consolidated Fund are based on the average revenue collected during the quarter preceding the release. Recurrent expenditures are protected, first in the priority sectors, and development expenditures are treated as residual in case of overall revenue shortage.

²³ Primary Health Care is a must and a priority, yet one would not expect people to die from a broken leg or appendicitis.

Finally, the allocation to drugs and medical supplies²⁴ further absorbs a rough twenty percent of the total government recurrent budget, which in addition to the wage bill's share leaves a rather low percentage available for utilities, maintenance, cleaning etc. (Table 8)

Table 8. Tanzania: Health Government Expenditure Breakdown												
Tsh. Billion	1997/98				1998/99				1999/2000			
	PE	OC	Total	%	PE	OC	Total	%	PE	OC	Total	%
MOH	1.96	1.06	3.02	7	1.97	1.74	3.71	6	2.61	1.25	3.86	7
Hospitals	19.45	8.74	28.19	60	21.68	17.12	38.80	62	23.93	10.69	34.62	60
PHC 1/	9.90	5.71	15.61	33	11.79	7.88	19.67	32	11.89	7.62	19.51	33
Total recurrent	31.31	15.51	46.82	100	35.44	26.74	62.18	100	38.43	19.56	57.99	100
o/w Drugs	(8.34)				(8.43)				(9.96)			
%	67	33	100		57	43	100		66	34	100	
		(18)				(14)				(17)		

1/ Primary Health Care
Data extracted from PER, February 2001

Despite demonstrated efforts to increase allocations to health as part of the priority sectors, government's financing of the health system remains far from the sector's needs. External resources remain in order, as well as the need to further consider alternative sources of funding. While currently user fees remain marginal, donor support to the health sector equals government's own efforts. Despite fragmented data, the table below attempts to portray the retrospective sector's resources envelope derived from data collected during the recent PER study²⁵ (Table 9, page 21).

The interpretation of data leads to a number of broad observations. First and with the exception of the basket funding and a few programmes, the bulk of donor assistance to the health sector remains outside the government's budget, and considered fully as development expenditures in absence of more precise information. This situation unfortunately maintains the difficulties encountered with projects' aid (see box 1 above), and comes a bit as a surprise given the 1998 broad commitment to move towards a unified system. Assuming that the confidence in the system will grow over time with the development of the SWAP, the sector-wide strategic allocation of resources shall however remain difficult in the medium term, given the usual rigid framework provided by projects' cycles, objectives and activities.

Secondly and despite a sharp increase in donor support²⁶, the sector's financing gap remains significant by mid 2000. By including figures from the voluntary sector, and if prospects for HIPC relief materialise, the gap will though reduce substantially and get closer to the US-Dollars 9.0 per capita for public health and essential clinical services delivery²⁷. This observation is quite encouraging and the trend shall hopefully be maintained long enough to address two main concerns. On one hand, with the remaining system's distortions and the constraints imposed by off budget

²⁴ Drugs: 85 %; supplies: 15 %

²⁵ Public Expenditure Review Health Sector in Tanzania, E. Jefferys/J. Mahon for SDC, February 2001

²⁶ 50 % increase between 1998 and 2000. With the volume off budget, an increase simply due to enhanced donor reporting can not be excluded.

²⁷ World Development Report 1993 / PER 1998, target of USD 12.0 per capita minus USD 3.0 for health-related interventions.

expenditures, the resources available in the medium term will not immediately transform in efficiency gains in service delivery. Improvements will only materialise with sustained management efforts to correct the system's inefficiencies and with donors' willingness to channel their resources through the system, in support of the sector programme. On the other hand, the government's efforts to increase allocation to the sector are probably reaching their upper limit with the further increase projected under HIPC, and current measures to increase tax revenue can only be expected to significantly impact on the health budget in the rather long term. While the trend observed in donor support should cater for the needs in the medium term, the related heavy dependency suggests that user fees are to become an increasing concern in the near future. Initiatives to deepen the process of introduction of harmonised schemes and address the current bottlenecks should hence be supported, and the issue of exemptions further addressed in regards of both financial needs and financing perspectives.

Overall, despite large progress and achievements over the recent years, the sector is unlikely to benefit from major flexibility in resources allocation in the medium term. Over time and with the incremental process of implementation of the sector programme, more issues and actors will be incorporated in the scope of interventions. Meanwhile, it can be reasonably assumed that the basket with its budget support's function will remain the most flexible instrument to support the government in the further implementation of the reform. Related issues and costs are many, and despite an increasing trend in resources made available through this instrument, prioritisation of interventions shall remain in order. In view of the past experience and the relatively slow and low disbursements observed from the basket, the issue of impact of the interventions may however require further analysis. In this regard, it may be debated whether prioritisation should imply small scale priorities spread over each sector's strategies, or rather comprehensive interventions targeted towards correcting the remaining major structural imbalances in the sector.

Table 9. Tanzania: Health Sector Resource Envelope /1								
Tsh. Billion	1997/98		1998/99		1999/2000		2000/01	
	%		%		%		Estimates	
Planned Resources	<i>100</i>	100.25	<i>100</i>	124.15	<i>100</i>	139.08	<i>100</i>	180.02
Government budget	<i>50</i>	49.77	<i>52</i>	64.37	<i>46</i>	64.59	<i>45</i>	79.97
Donors on budget	<i>27</i>	26.92	<i>20</i>	24.23	<i>16</i>	22.17	<i>21</i>	37.68
Donors off budget	<i>23</i>	23.56	<i>28</i>	35.55	<i>38</i>	52.32	<i>32</i>	59.41
User fees /2		-		-		-	<i>2</i>	2.96
Actual Expenditures	<i>100</i>	100.71	<i>100</i>	123.99	<i>100</i>	133.59	<i>100</i>	180.02
o/w Recurrent	<i>51</i>	51.45	<i>55</i>	68.87	<i>51</i>	68.10	<i>56</i>	100.15
Salaries	<i>31</i>	31.31	<i>29</i>	35.44	<i>29</i>	38.43	<i>25</i>	44.58
Drugs and Supplies /3	<i>13</i>	12.97	<i>12</i>	15.12	<i>12</i>	16.72	<i>13</i>	22.15
Other Charges	<i>7</i>	7.17	<i>14</i>	18.31	<i>10</i>	12.95	<i>18</i>	33.42
o/w Development	<i>49</i>	49.26	<i>45</i>	55.12	<i>49</i>	65.49	<i>44</i>	79.87
On budget	<i>6</i>	6.37	<i>14</i>	17.07	<i>7</i>	9.51	<i>14</i>	25.02
Off Budget	<i>43</i>	42.89	<i>31</i>	38.05	<i>42</i>	55.98	<i>30</i>	54.85
Sector Needs /4		173.16		195.11		220.78		235.74
Financing Gap		72.44		71.12		87.19		55.72
<i>In US-Dollars million</i>		<i>113.5</i>		<i>101.7</i>		<i>113.2</i>		<i>69.7</i>

1/ Currently without data on private and voluntary sectors

2/ Cost sharing and Community Health Fund (CHF)

3/ Includes user fees recorded but not planned for the period 97-2000 (0.86; 1.11; 1.23). Given the limited amount, assumes it is all allocated for drugs. Includes also data from MSD concerning donors direct support to MSD, an annual average of 4 billion Tsh, which would normally be treated as off budget, plus 1.4 billion from WB normally as Development on budget. Estimation from MSD is 85 % for drugs and 15 % for other supplies.

4/ Needs based on USD 9.0 per capita for a 30.1 million population in 1997/98, growing at 2.8 % for subsequent years, at average exchange rate for the fiscal year considered

Data extracted from PER, February 2001

4.5. Prioritisation of interventions

4.5.1. Development framework and indicators

Tanzania is undergoing major reforms with the attempt to also implement a significant number of initiatives simultaneously. The impact of this general trend on the Ministry of Health has been noticeable, and the related administrative load has likely been a major factor in the difficulties observed for the prioritisation and coherence of interventions and objectives for the sector programme. Health targets and indicators are encountered in many policy documents or guidelines²⁸, which are spread over various ministries. The performance monitoring system has been able to incorporate, retroactively, a fair number of these targets, but the overall issue of cross-sector co-ordination and policy formulation remains to be addressed in future,

²⁸ Benchmarks under the MOH/RALG/Donors Side-Agreement; several targets under the Logical Frame of the PRSP; National Minimum Standards for health from RALG; objectives for health in the TAS

together with the questions of final responsibility, initiative and leadership in terms of health matters. In this regard, the dual responsibility mentioned in section 3.1 between the Ministry of Health and the Regional Administration and Local Government remains a subject of uncertainty, reinforced by the delays in the implementation of the Local Government Reform. While the overall question is unlikely to be clarified in the near future, short-term actions should however be envisaged to ensure the proper functioning of the districts' funding arrangement. In so doing, the issue of harmonisation and linkage between both ministries' Medium Term Expenditure Frameworks and appropriation accounts²⁹, as well as the issue of capacity building and technical support to Local Authorities seem to deserve urgent attention.

4.5.2. Sector's inputs

Although already identified in 1998³⁰, essential sector's inputs have not yet received sufficient attention. With a *public network* of 3'282 facilities, the issues of their severe disrepair and overall functionality remain modestly addressed³¹. With construction unit costs produced by the Ministry, the rehabilitation needs were estimated at US-dollars 338 millions in 1998³⁰. While the affordability of such rehabilitation is questionable, the issue has to be considered in parallel with the network's functionality, since it is unlikely that all the facilities deliver the package of care expected from their category³². A prioritised rehabilitation plan is hence required, which needs government's courageous decision and funding possibly based on a comparative advantage, among partners, for support to investment versus recurrent costs.

Human resources and drugs also remain a matter of concern. With a 67'000 work force, out of which 50 percent is unskilled and only 3 percent made of graduates³⁰, correcting this distortion is of paramount importance to enhance the quality of health care delivered and ensure a successful implementation of the reform. A study recently commissioned by the Ministry³³ provides a basis to address the financial incentive and retribution for the work effort expected from key personnel. The proposed phased introduction of the scheme, together with the simultaneous introduction of a personnel performance assessment system, offers interesting perspectives albeit to be considered on an equity point of view. In addition however, government's current efforts should also simultaneously address the above distortion, by further considering the existing work force against the needs and expectations for each function, and propose solutions to correct the prevailing rural/urban bias in staff deployment.

As for drugs, little of the recommendations made in 1998³⁰ seem to have been followed up, and despite fragmented data and little information about procurement outside the Medical Stores Department, it appears that the sub-sector remains significantly under-financed³⁴. With resolute interventions needed to reduce wastage

²⁹ Sector budget and expenditures need to be more easily traceable in RALG reporting formats. A model adopted for health could likely be rolled-over to other sectors.

³⁰ Recurrent Costs in the Tanzanian Health Sector, E. Pavignani for SDC, in the Public Expenditure Review (PER) process FY99, November 1998.

³¹ Rehabilitation assessment plans foreseen since 1999, but still pending.

³² Tertiary referral hospitals, Regional referral hospital, District hospitals, Health Centres, and Dispensaries

³³ A Pilot Scheme for Operationalising Selective Accelerated Enhancement for the Health Sector, MOH/HSPS, May 2000.

³⁴ Based on Table 9, average amount per year for drugs was around USD 16 million over the period 1997/2000, a small USD 0.5 per capita, against estimated needs of USD 1.75 all drugs and vaccines inclusive (PER 1998). Assuming 50 % of under-reporting, the gap remains yet significant.

by improving the overall management and kits systems, warehousing, transport, training, and distribution, the joint funding mechanism in place is under-utilised to address these issues together with the need for additional procurement³⁵. Drugs availability is a major incentive for people to use health services, and with 60 percent of the population assessing availability as poor³⁶, essentially in the peripheral units, there is urgent need to address efficiency and imbalances in the sub-sector.

4.5.3. Service delivery and utilisation

Lastly, with the growing concern for effective poverty reduction and impact of health activities, the issue of service delivery and utilisation is expected to attract increasing attention in the near future. While on-going activities and programmes have registered noticeable success³⁷, the related issues are surprisingly absent from most of the sector policy dialogue. If more partners are expected to join the sector programme's implementation process and increasingly channel their resources on rather than off budget, a renewed and broaden dialogue needs to be established. Issues, priorities and activities need to be openly and widely debated, with the view to actively increase sector co-ordination. In this regard, a significant step would be realised by increasingly mainstreaming aggregate data from the major programmes' information and reporting systems into the overall sector performance monitoring system. The expected Sector Annual Profile³⁸ would hence develop accordingly, and increasingly serve its expected function of sources document for informed and strategic discussion in the framework of the sector annual review.

In addition, refinement of the Essential Health Interventions (EHI) package could also represent a major contributing factor. The latest version³⁹ offers a comprehensive set of priorities, together with detailed interventions for implementation. The package however suffers the two essential shortcomings of not being costed, and not addressing the organisation and functionality of the major inputs necessary for its implementation. Although due decentralisation for implementation is foreseen, the overall assessment of the resources available to the sector rests at central level, together with the capacity to adjust the inputs' definition, scope and standards accordingly. Costing the package together with its functional, organisation and management component hence appears as a further step needed for implementation, as well as the containment of the exercise in the upper-limit of the above mentioned US-Dollars 9.0 per capita.

4.6. Partnership in the process

After three years of implementation of the sector programme, the expectations created in 1998 with the Joint Statement of Intent to move towards a sector-wide approach have only been partly met. All of the fifteen DAC members active in the sector⁴⁰ and some representatives of the voluntary and private sectors meet in the SWAP

³⁵ To address the general shortage and the expected increasing impact of HIV/AIDS

³⁶ Tanzania Social Sector Review, World Bank 1999

³⁷ e.g. NTLIP, Impregnated Treated Nets, or Immunisation Programme

³⁸ First edition scheduled for March 2001 review

³⁹ National Package of Essential Health Interventions in Tanzania, MOH, January 2000.

⁴⁰ Donor matrix on sources and distribution of assistance to Tanzania, EU, February 2001

Committee and participate to the annual sector review. However⁴¹, many non-basket-funding members consider that the effective health sector policy and dialogue process only occurs with the eight members of the Basket Funding Committee¹³. Possible rifts and animosity among donors are reported⁴¹, which if non-addressed may jeopardise the consultation and co-ordination needed for the success of the sector programme implementation process.

Albeit worrying this situation is not surprising. Given the rather short span of the programme's implementation it has likely to do with the priorities addressed so far, which aimed at the concrete application of a fundamental principle of the SWAP concept, the harmonisation of procedures and the use of national systems. Over time this essential issue has disappeared from the dialogue's agenda, to be replaced quite unfortunately by a polarised debate about the programme's funding modalities, hereby creating two apparent blocks with basket-funding partners on one side and non-basket-funding partners on the other. Yet in reviewing DAC members' regulations⁴¹, it appears that out of the twenty-three members in Tanzania only three⁴² declare that their regulations preclude them to enter into basket-funding arrangements. The paradox installs itself and can only get cleared by further considering additional rules and pre-conditions. At this point, issues like earmarking, attribution and visibility, together with tied aid and technical assistance appear as the essential constraints, as well as more subjective reasons like trust in government's systems and capacity, attachment to projects' relationships, and relative size of some donors' contribution to the sector.

Against this background, the need for a renewed dialogue takes quite an urgent character. A first step could be to remind partners that none of the above reasons are basically incompatible with the implementation of a SWAP, and that albeit highly desirable, budget support is not the only alternative for the financing of a sector programme. The second step should definitely address the better inclusion of partners and on-going activities into the sector programme. In this regard, extensive work on the resources envelope should be pursued in the short term, in order to capture activities and their cost into a comprehensive framework⁴³. A reporting format in line with the government's budget cycle should be developed and circulated annually to all partners, in order to identify planned expenditures and disbursements as per the IFMS expenditures' coding structure. In addition, the mainstreaming of aggregated data from on-going programmes' information and reporting systems into the overall sector performance monitoring system would also represent a major step ahead. Overall, the combination of these initiatives together with the willingness to revamp dialogue with all stakeholders should provide a sound basis to concretely accelerate the integration process.

4.7. Challenges ahead

Derived from the previous sections, the following box provides a summary of the issues raised. (Box 4)

⁴¹ The Health SWAP and Health Sector Basket Fund, G. Hobbs, Economic and Social Research Foundation, February 2001

⁴² Belgium, Italy and the World Health Organisation. Italy is not active in the health sector.

⁴³ The on-going National Health Accounts reconciliation shall provide determinant inputs

Box 4. Tanzania: Summary of challenges lying ahead

- 1) The reference framework for the development of the health sector is spread over several implementing bodies. Coherence of initiatives, targets and indicators is not always ensured. Orientations taken by the sector reform should better inform the overall government reforms' implementation process, to ensure that all expectations and resources converge towards the same priorities established under the leadership of the Ministry of Health.
- 2) The harmonisation of the Health Sector and Local Government reforms is a factual condition for effective and efficient health services delivery. Delays in the LGR implementation may jeopardise the harmonisation process in the short to medium term. Short term priorities could however address the issues of harmonisation of the Medium Term Expenditure Frameworks – for the health part – as well as output-oriented capacity building and technical support to Local and Regional Authorities.
- 3) The largest share of donor assistance to the health sector occurs outside the government's budget and the majority of on-going activities are not captured in the sector programme. Based on the National Health Accounts consolidation exercise, a comprehensive sector's resource envelope needs to be established. To enhance the integration process and to serve its planning function in the MTEF, the envelope needs to be updated on an annual basis. A reporting format in line with the government's budget cycle should be developed and circulated annually to all partners, in order to identify planned expenditures and disbursements as per the IFMS expenditures' coding structure.
- 4) The sector's aggregate information database remains too fragmented to support the decision-making and planning process. The on-going definition of an overall sector performance monitoring system should be strongly supported. In the short to medium term, aggregate data from the major programmes' information and reporting systems should increasingly be mainstreamed into the overall monitoring system. Additional indicators and targets could also be added in a progressive way, albeit giving due attention to the availability of source information and capacity to collect it routinely.
- 5) Essential sector's inputs like facilities network, human resources and drugs require urgent re-addressing and priority interventions. A prioritised rehabilitation plan needs to be established, based on available resources to finance it, and taking into consideration the network's functionality in delivering the expected Essential Health Interventions (EHI) package. Distortions in the work force structure and functionality also need to be corrected in the perspective of delivering the EHI package, and addressing the prevailing rural/urban bias in staff deployment. As for drugs a prioritised albeit holistic programme should be developed, in order to correct the severe under-funding of the sub-sector, and simultaneously address the remaining gaps in the system's management and logistics.
- 6) With the growing concern for effective poverty reduction and increased impact of health activities, it appears that service delivery and utilisation receive little treatment in policy dialogue, despite noticeable achievements. Developments of the overall performance monitoring system shall provide one input to address this issue, and refinement of the EHI package should constitute another determinant input. In this regard, the costing of the package together with its functional, organisation, and management component appears as a prerequisite for its implementation, as well as the containment of the exercise in the upper-limit of the targeted US-Dollars 9.0 per capita to cater for essential sector's needs.

- 7) In view of the above, the objectives, targets and indicators to be developed accordingly should increasingly serve as the basis for the enhancement of the recently introduced performance budgeting system for the health sector. In so doing, the adopted move towards considering the Ministry's Directorates as implementing bodies and cost centres should be vigorously pursued, taking advantage of the coding possibilities of the IFMS. Where possible, at least at regional level and in some districts, a similar approach could be envisaged with regional and local health administrations, as well as health facilities, as additional cost centres.
- 8) The significant increase of internal and external resources' allocation to the health sector, over the recent years, suggests that traditional sources of funding may soon reach their upper-limit. Given the remaining financing gap, and even by assuming that all possible efficiency gains materialise, alternative sources of funding will increasingly become necessary to address shortages in the medium term. User fees' current schemes and exemptions mechanisms will require re-addressing in view of a new financing paradigm. A further analysis of the comparative advantages between district authorities and communities themselves for the management and accountability of collected funds, may also be required.

As a conclusion, a number of issues require careful attention and treatment in the near future. Ad hoc studies will be needed to highlight and detail the related critical areas and consequences for the implementation of the sector programme. Partners will be expected to support the government in fulfilling these studies, with the view to identify new objectives, targets and indicators for the programme. Over the recent years, the Public Expenditure Review process has become a traditional forum and instrument for conducting some studies of this kind in the public expenditure field. While it is expected to continue doing so, a similar approach could be envisaged for other sector analysis. Under the leadership of the Ministry, the annual sector review could serve as the forum to identify needed studies, as well as to agree upon related logistic issues such as scope, timing and financier for the studies.

Overall, with few spectacular steps but persistent efforts to realise fundamental pre-conditions, a long way has been covered since the inception of a sector-wide approach for health development in Tanzania. All partners in this endeavour have demonstrated the flexibility, commitment and mutual trust necessary to establish a unified and joint system for the implementation of the sector programme. With essential systemic functions well under way, and significant resources available, there is now scope for deepening the reform's implementation process. While acknowledging that the initiated process entails long term commitment and consistency, further progress will require to adjust the programme to a changing environment. With the improvement of the information basis, partners will have to review the programme's orientation and priorities in regards of the resources available and the remaining imbalances in the sector. At this point, courageous if not popular decisions will be needed, which may trigger the definition of new priorities for the programme and the further improvement of the health and well-being of all Tanzanians.

5. SDC AND THE REFORM PROCESS

5.1. Swiss policy and the sector approach

Switzerland's development and co-operation policy provides a conducive framework for the participation to the development of sector-wide approaches. Both the 1994 and 1998 *Messages to the Parliament concerning Technical Co-operation and Financial Assistance*, recommend sectors and resources concentration, enhanced specialisation, and active participation to aid's co-ordination, as a way to further ensure the efficiency of Swiss assistance to low-income countries. Switzerland's full support to the *20/20 Initiative* also represents a favourable opportunity, since experiences made so far tend to confirm that sector-wide approaches have better chances of success in social sectors.

In practice the participation to the development of this new approach develops slowly, with currently two cases in the health sector in Tanzania and Mozambique. Factors to explain this situation relate on one hand to legitimate concerns pertaining to the existence, or not, of necessary pre-conditions for the emergence of a SWAP in other sectors and countries where SDC is active. On the other hand, uncertainties with regard to image and visibility, partner administrations' capacity, and public/private mix are not uncommon within the institution. In addition, Swiss NGO as traditional partners in projects' implementation seem to observe the development of this new partnership's paradigm with some scepticism, most likely due to remaining concerns with regard to their possible role in such approaches.

Overall, the concept of sector-wide approach appears to offer a concrete and effective answer to Swiss policy principles and guidelines for activity in low-income countries. Replication of pioneering experiences may develop with a better understanding of the SWAP concept, both within and outside SDC, as well as with the lessons learnt from these experiences. In the resulting dialogue it will be essential to avoid a polarisation of the debate and to rather consider, provided the basic assumption of support to a national sector reform and unified programme through national systems is fulfilled, that both the implementation and support modalities of a SWAP remain flexible and contextual. Ultimately however, while countries' analysis on a case by case basis will remain in order, SDC move towards further sectors concentration and SWAP implementation will likely depend on high level strategic decisions and operational guidelines.

5.2. Experience in Tanzania

Based on the previously described context and conducive environment for the emergence of a SWAP in Tanzania, as well as the perceived challenge represented by this approach to foster health development in the country, a preparatory phase for SDC involvement was conducted between January 1998 and June 1999. In collaboration with DFID and the World Bank, the phase supported the elaboration of the Government's programme with various studies and analysis, which together constituted the basis for the elaboration of the first phase of the SDC Health Sector Reform Support Programme (HSRSP) July 1999 – June 2002.

In a SDC institutional perspective, lessons learnt during the preparatory phase provided a sound input in the definition of the strategic and conceptual framework of the Tanzania – Swiss Country Programme 1999-2003. Together with experiences made so far during the programme's first phase, these lessons are commented in the following sections.

5.2.1. Sectors concentration and interaction

With limited financial and human resources available for the implementation of a country programme, the efficiency in the mobilisation of these resources was a permanent concern, reinforced by the expectation to bring a relevant contribution to aid's co-ordination and policy dialogue. SDC decision to concentrate her activities in two main sectors and two cross-cutting programmes⁴⁴ with a supportive function, constituted a first step to address this concern. The search for further synergy with the other Swiss government actor in low-income countries, the State Secretariat for Economic Affairs (SECO), constituted another step specifically intended to address the issue of efficiency in resources use and allocation.

In the perspective of sector-wide approaches and general or earmarked budget support, the synergy area proved to be fiscal policy and management, with a mutually needed active participation to the Public Expenditure Review process. This determined the selection of the third "Economic" sector of the Swiss programme in Tanzania. Such a limitation and concentration, as a result of an extended consultation process with the Tanzanian government and partners, allowed Switzerland to gain a selected and clear profile, easily identifiable by all partners. Together with the constitution of related teams in the Co-ordination Office, it also significantly facilitated time, priorities, and resources management.

5.2.2. Prioritisation and visibility

For the Co-ordination Office's health team, given the number of projects on-going at that time and the number and scope of sector issues at stake, further concentration was deemed necessary. Based on a consultation process with all partners concerning sector priorities prevailing at the SWAP inception, as well as the expertise available in the team, SDC concentrated on sector financing and sector information and performance monitoring⁴⁵. Together with other donors addressing other sector dimensions, this arrangement offered a flexible and participatory instrument to support the Ministry of Health in defining and reaching jointly agreed targets and objectives for the sector programme. It also constituted the basis for the current working groups under the Basket Financing, respectively SWAP Committees, and enabled the implementation of the sector programme without the need for a leading-partner in donor co-ordination.

⁴⁴ Respectively Health, Infrastructure and Transport, Gender-balanced development, and Decentralisation and Democratisation

⁴⁵ For the latter, experiences made in Mozambique also provided an incentive, and exchange between the two programmes started in late 1998.

Under the leadership of the Ministry, SDC support to the elaboration of the joint financing and performance monitoring systems, as well as to the PER process for the health sector, disseminated a positive image of Switzerland's co-operation and willingness to actively participate in joint partnership. However, given the reserves expressed by the Ministry towards long term technical assistance⁴⁶, the active participation to the working groups and sector co-ordination's meetings imposed a heavy workload on the Co-ordination Office's health team. To keep up with SDC commitment towards effective partnership, a Health Adviser was hence recruited to enlarge the team until the end of the current HSRSP phase.

Overall, the prioritisation in SDC scope of support to the sector programme brought positive results. Most notably, the de facto specialisation of the team increased the effectiveness and efficiency of the interventions and contributed to further shape SDC profile in the sector. However, the observation of the limited institution's experience in this new approach also revealed questioning implications in terms of capacity, institutional memory, backstopping and health networking needs. As an important issue, these implications are taken up again and elaborated in section 5.3 under.

5.2.3. Projects and sector programme

In the foreseen perspective of mainstreaming SDC-supported projects into the sector-wide approach, the comprehensive interventions in Dar es Salaam and in the Kilombero district offered positive prospects, since they were pursuing the same objectives as those of the sector reform. Following the development of the financing scheme for recurrent budget support at district level and its introduction in Dar es Salaam, the region's funding through SDC (respectively the Swiss Tropical Institute) was hence interrupted by the end of the year 2000 and the allocated amount transferred to the basket account. At the time of the reform's implementation in the Kilombero district, a similar process will be adopted. As for the support to the National Tuberculosis and Leprosy Programme, albeit already on-budget the programme's further integration into the sector programme will follow the steps described in section 4.5.3 above.

With the appropriate design of the project, in line with the sector reform's content and objectives, the mainstreaming process of Dar es salaam Urban Health Project proceeded smoothly. The main issue encountered related to a component of the sector reform treated by the project, but not yet addressed in the incremental implementation process of the sector programme, namely the Community Based Health Care (CBHC). After consultation with the concerned parties, the pragmatic decision to pursue with a direct limited support to CBHC was taken, together with the commitment to support the regional/local health authorities in implementing and managing the systems designed under the SWAP for financial, information and performance management and monitoring.

⁴⁶ The Ministry insists on ensuring Tanzanian leadership and ownership of the process, which is hence considered as incompatible with long term TA. Partnership is understood as a direct relationship between the Ministry and partners.

A similar situation being expected in Kilombero led to the further decision to keep a limited portfolio of projects in the medium term⁴⁷. Such a portfolio shall ensure a smooth transition to the sector approach for the projects' partners, and it will also address SDC need to keep a field experience to inform the sector reform process. In the longer term such a portfolio could also be considered. However, in order to avoid past experiences with projects as previously described⁴⁸, the activities should be commonly agreed with the sector programme's partners, with the view to accumulate in a given time relevant information for the overall reform's implementation process.

5.3. Programme management

The broad SDC decentralisation process coupled with a tradition of flexibility and limited administrative procedures provided a conducive framework for the implementation and the management of the programme in Tanzania. Based on the experience made, some issues concerning the inter-action with Switzerland may however require further consideration.

5.3.1. Field / Headquarters mix

With SDC intention to further promote, where possible, the implementation of SWAP as an answer to sectoral concentration and increased efficiency in resources allocation, the question of the field/headquarters mix for reaching such an objective requires clarification. While in-country programmes can be conceived as implementation fields and think tanks, it has been shown that prioritisation of interventions in selected sector's dimensions is a necessity conditioned by the relative size of SDC. If case by case analysis will remain in order to address programmes' context and history, it nevertheless seems that the choice of dimensions should result from SDC sectors' policy, experience and comparative advantages. A regular inter-action process between the field and headquarters would then occur, in order to establish a mutually profitable demand/offer loop.

At the time being, health experience in Tanzania shows that such a process remains fragmented, with limited prospects for mutual exchange and benefit. In a field perspective this may not represent an issue, since the institution's flexibility allows the Co-ordination Office to directly address external support and backstopping. However in terms of institutional memory and capacity, this situation may induce unfortunate losses and missed opportunities in terms of international development policy dialogue, partnership and visibility⁴⁹, as well as contribution to SDC institutional profile and sector policy enhancement, and networking with Swiss institutions. A further dialogue based on field experiences should hence occur, with the view to specifying the scope, limits and modalities of interventions envisaged by the whole institution, together with her network, in supporting the implementation of sector programmes.

⁴⁷ Although still under discussion, the current thinking is to allocate 2/3 of the resources envelope to the sector programme, and the remaining 1/3 to projects.

⁴⁸ Box 1, page 13.

⁴⁹ E.g. UN/OECD International Development Targets, Inter-agency Group on SWAP, Roll Back Malaria Initiative.

5.3.2. Participation of Swiss institutions

Swiss academic institutions have so far not been very involved in the SWAP process, save for the participation of the Swiss Tropical Institute to the sector review in 2000. With the Co-ordination Office's intention to further address and learn from the issue of diseases control and services delivery and utilisation in the context of the sector programme, discussions are on-going to identify the type of support which could be provided by the Institute in this area. If prospects for an extension of sector-wide approaches to other countries and sectors materialise, this trivial situation represents nevertheless an example of the need for active networking between the field and Swiss academic institutions to be expected.

With the limited man/days resources of SDC technical departments and the complexity of sectors issues at stake, such a networking will constitute a key milestone to address questions like institutional memory and programmes' continuity, as well as technical support and capacity building. To remain manageable such a network should however be primarily articulated around sectors transversal issues and co-ordinated at headquarters level, which sends back to the issue of prioritisation mentioned in 5.3.1 above.

5.3.3. Programme continuity

Although the initial health-team in the Co-ordination Office had no previous experience in participating to the elaboration of a sector programme, the issue of technical expertise did not represent an impediment to active participation, since the team experience developed in parallel with the programme's elaboration process. Over time however, with the further technical⁵⁰ development of the programme, it may be expected that the question of specialisation versus generalisation in the expatriate staff deployment becomes an increasing concern. The issue will likely be addressed in the broader perspective of the development, or not, of similar approaches in other SDC priority countries. In the interim specialists can be recruited as advisors like in Tanzania or Mozambique, albeit acknowledging that the operational experience develops and stays with them. The debate on institutional memory is hence tabled again to address alternatives to such an arrangement. Without anticipating a conclusion to this debate, the practicality of a recourse to the above mentioned Swiss academic institutions may be worth analysing.

⁵⁰ By opposition or in addition to the initial systemic focus

5.4. Conclusion and summary

The participation to the elaboration of the SWAP for health development in Tanzania has been a challenging experience and opportunity to actively associate SDC to a major donor co-ordination endeavour. It is hoped that the narrative of this experience shall give rise to desires for embarking on similar approaches elsewhere. Before concluding with a summary of the suggestions made in this chapter for this purpose, another issue pertaining to the Poverty Reduction Strategy Paper (PRSP) requires a short elaboration, due to its possible impact on the implementation of the health sector programme in Tanzania.

With the growing concern for effective poverty reduction, the implementation of the PRSP is increasingly becoming the focus of policy and strategic dialogue, together with the issue of implementation's financing and modalities. In this regard, the Poverty Reduction Budget Support (PRBS) facility currently set up receives growing recognition as the likely lead-financing instrument. With the on-going initiatives aiming at enhancing the coherence between the PRSP and the sector reforms, the prospects for a health sector programme becoming part or totality of the PRSP health programme should eventually materialise. At this point and given the principles of resources' fungibility, the question of SDC earmarked budget support to the sector will inevitably overlap with the rationale for general budget support through the PRBS. With the current demarcation between SECO and SDC on this subject, an early consideration of this question shall serve as an appropriate anticipation.

The box in next page provides a summary of this chapter. (Box 5)

Box 5. Tanzania: SWAP and SDC, lessons learnt and suggestions

- I. Provided the basic assumption of support to a national sector reform and unified programme through national systems is fulfilled, both the elaboration, implementation and support modalities of a SWAP are flexible and contextual.
- II. With SDC limited financial and human resources available for the implementation of a sector programme, the efficiency in the mobilisation of these resources calls for a concentration on few sectors in a Country Programme, with a maximum possible inter-action between the activities and interventions.
- III. In the perspective of sector-wide approaches and earmarked budget support, the issue of fiscal policy and management deserves paramount attention and requires SDC active participation to a dynamic Public Expenditure Review process.
- IV. SDC simultaneous involvement in both a SWAP and on-going projects is basically not incompatible. However, the resulting increased workload on the Co-ordination Office calls for further concentration in the sector, with a prioritisation of the sector dimensions envisaged for SDC support and interventions in a sector programme.
- V. The choice of the dimensions for SDC involvement should result from a concerted and balanced analysis between the country's context, the programme's priorities and SDC comparative advantages. In this regard, SDC headquarters objectives in terms of international development's policy dialogue, partnership, image, as well as sector policy should be considered, together with prospects for active networking and support by Swiss academic institutions.
- VI. When on-going projects are in line with the sector reform's content and objectives, a process for mainstreaming them into the sector programme can safely be considered. The projects' recurrent funding through SDC or a supporting agency should be the first component for a transfer of resources to the sector programme.
- VII. In order to keep a field experience to inform the sector reform process, maintaining a limited portfolio of projects could be envisaged. Activities should however be agreed with the sector programme's partners, with the view to accumulate relevant information for the overall reform's implementation process.
- VIII. Over time, the technical development of a sector programme challenges the expertise available within SDC as well as the continuity of the institution's involvement. Interim specialist advisors can be recruited to address this trade-off, albeit at the expenses of SDC institutional memory. To address this risk, the practicality of an increased recourse to Swiss academic institutions should be considered.
- IX. The eventual implementation of a sector programme in the context of the Poverty Reduction Strategy Paper could ultimately lead to the programme's financing through the Poverty Reduction Budget Support instrument. The implicit solution for addressing the fungibility of resources between earmarked and general budget support would imply an overlap between SDC and SECO. This issue requires consultation between the two offices at an early stage of the implementation of the PRSP.

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