PRE-FINAL DRAFT

Report of the Tanzania Joint Annual Health Sector Review

15th – 17th March 2004
Golden Tulip Hotel, Dar es Salaam

Acronyms

APTHA	Association of Private Hospitals in Tanzania
CHF	Community Health Fund
CHMT	Council Health Management Team
DHA	District Health Accounts
DHS	Director of Hospital Services
DPP	Director of Policy and Planning
GAVI	Global Alliance for Vaccines and Immunisation
GOT	Government of Tanzania
HIB	Haemophilus Influenza B
HMIS	Health Management Information System
HR	Human Resources
HSSP	Health Sector Strategic Plan
IMCI	Integrated management of childhood illness
ITN	Insecticide Treated Net
LGA	Local Government Authority
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NHIF	National Health Insurance Fund
OPD	Outpatient Department
PO-OPSM	President's Office, Office of Public Service Management
PORALG	President's Office, Regional Administration and Local Government
PER	Public Expenditure Review
PRS	Poverty Reduction Strategy
PS	Permanent Secretary
RS	Regional Secretariat

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Executive Summary

The fifth annual joint health sector review took place 15-17 March, hosted by the Golden Tulip Hotel. It had been preceded by extensive preparatory work. The "Technical Review" provided an update of progress at district level against the recommendations agreed last year. This, and other documentation to be tabled at the main review were debated in detail at a "pre-meeting" of government and stakeholder representatives held at the Belinda Hotel in late February. Documents tabled for the meeting and presentations are listed at Annex 1. Copies are obtainable from the Health Sector Reform Secretariat, MOH.

The main review was very well attended, including senior representatives of various ministries and departments. In a welcome development from previous years, health sector representatives from Regional and District levels also participated. The meeting was characterized by open and lively discussion and debate – a sign that the constructive development relationship with partners continues to mature. The list of participants is reproduced at Annex 5.

This report provides a brief record of the proceedings. The timetable for the Review is attached at Annex 2.

The first sessions were devoted to reviewing performance over the previous year, with reference to the milestones, the technical review report, achievements and innovations of selected districts, and the health sector performance profile. The general picture which emerges is one of steady progress against objectives. However, owing to the gaps and delays in routine data, this progress has not yet been verified in objective measures of service delivery improvement.

Subsequent sessions dealt with priority programmes in more depth, including HIV, malaria, TB, EPI, reproductive health, IMCI and nutrition. In all areas significant challenges remain, in spite of progress to date. In every case there are resource gaps of varying magnitude which will need to be filled if successful scaling up and health impact are to be achieved.

Human Resources for Health provided a major focus for presentations and discussions on the second day. This was enriched by perspectives from the President's Office - Office of Public Service Management (PO-OPSM) and from the President's Office, Regional Administration and Local Government (PORALG). A clear consensus emerged that the human resource situation is in crisis. The gap between current staffing requirements and actual staffing stands at 33%. This average masks even more serious gaps in under-served areas of the country and for specific cadres. Attrition of health workers out-strips new recruitment. The health workforce is aging. Production of skilled manpower is not matched with future staffing needs. Recruitment procedures present practical obstacles to filling even those posts for which permits have been issued. Positions in hardship areas are particularly difficult to fill and additional incentives will be needed. The data which substantiates the present crisis, the worsening trend and the future requirements, is already available. The meeting agreed that urgent action and high level collaboration between the relevant parts of government would be needed to address the situation.

The second substantive area of concern is the financing of the sector. The PER update, like last year's report, describes a worrying decline in the share of discretionary public resources (*including* on-budget aid) to the health sector. This is in spite of documented resource gaps, a detailed PER, a robust bid in the current budget round, and a demonstrable commitment *within* the sector to progressively shift resources towards priority areas. The calls for increased resource allocation for the sector were supported by formal statements from Ambassadors of the Royal Netherlands Embassy and Royal Danish Embassy. Representatives from Ministry of Finance were unable to provide a firm commitment for new resources and pointed to the competing pressure on scarce government resources. However, the message was heard loud and clear and the meeting was told that there may still be room for adjustment in budgetary shares for the year ahead.

These two major concerns (Human Resources and Health Sector Financing) are reflected in the first two milestones agreed on the final day of the meeting. Other milestones relate to the strengthening of health sector performance monitoring; getting in place the capacity at Regional Level to provide adequate support and supervision; scaling up action on HIV/AIDS (including care and treatment); accelerating hospital reforms at regional and district levels; making tangible progress on district health infrastructure rehabilitation; and improving transparency, responsiveness and accountability of health providers to clients, communities and the public as a whole.

Introduction

The tone of the meeting was set by the Honorable Minister's speech, delivered by PS-Ministry of Health. This set out both achievements during the year (on establishment of health service boards and facility committees, on the cabinet's resolution of the structure of the Regional Secretariats and on community health financing). The speech also highlighted challenges, most particularly in the crisis of health sector human resources where urgent action is needed to staff the sector adequately, with the right skills in the right place. The continued shortfall in health sector financing was also cited as a major impediment, which will constrain the country's ability to move ahead with the HIV/AIDS Care and Treatment Plan. Non-governmental health providers were challenged to engage constructively with government by bringing forward proposals for improved collaboration.

In his vote of thanks the chair of the Association of Private Hospitals in Tanzania (APHTA) acknowledged assistance received from Ireland and MSH and described how APHTA was developing a new, more focused strategy, including additional emphasis on HIV. Information gathering on private sector infrastructure, personnel, equipment, capacity and constraints will continue, as will negotiations to strengthen relationships with the National Health Insurance Fund. In closing APHTA called for improved co-ordination at the district level.

The Chief Medical Officer echoed the opening speech, comparing the chronic shortage of financing for the sector with the situation in industrialized countries. But he also called for efficiency improvements and reduction in transaction costs, citing the proliferation of task forces and working groups. He proposed a further streamlining of the review process, with a major review every second year and "mini reviews" in intervening years. In subsequent discussion the principal of a "light" review every other year was endorsed. The need to ensure that task forces, sub-committees and working groups did not become an end in themselves was also endorsed, although participants felt that a selective approach was needed, recognizing the utility of some of the groups.

Milestones 2003-2004

Progress against the milestones set at the last review is described in detail in a separate milestones report, which had already been discussed with development partners at the Belinda workshop. While the milestones were grouped into 10 "headings" it was noted that there were 64 separate actions specified. Comments and discussion were welcomed from the floor on each milestone area in turn. On balance, progress against milestones was judged to be fair – but some way short of aspirations. It was agreed that new milestones should be fewer, more focused and achievable in a one-year time horizon.

On **HIV** considerable progress has been made in taking forward the sector HIV strategy although the pace has been limited by the significant gap between resources required and those actually secured. A great deal of detailed planning has been done on introduction of care and treatment. The meeting noted that the speed with which the care and treatment plan can be rolled out will be determined by the availability of *human* as well as financial resources. On the **human resources** situation in general,

there has been no material change in the situation described at the last Review, although considerable data gathering and analysis has now been undertaken to substantiate the widespread perception that human resources for health is in crisis. All agreed that the priority now is to use available information to reach agreement across different branches of government (MOF, OPSM, PORALG, Councils) on the need to radically scale-up recruitment of health workers and improve their distribution. Similarly, concern was voiced that the incompleteness of **HMIS data** means that it is still not possible to "take the pulse" of the health sector year-on-year. However, progress has been made in the reconciliation of various indicator sets and there has been an incremental improvement in reporting rates. On infrastructure **rehabilitation** there was clear consensus on the need to move ahead as rapidly as possible with district level facilities and to extend basket financing to cover rehabilitation. **Public-private partnership** has been enhanced through the increase in the bed-grant subvention and a draft "service agreement" for contracting with non-government providers has been drawn up. GOT called for proposals from non-government providers to finalise this as a new basis for funding. Progress has also been made on most aspects of the **public information and participation** milestone, although more needs to be done to assure compliance with sharing information. The clients' charter represents an important instrument in meeting patients' rights, enforcing service standards and improving accountability. MOH/PORALG were commended for the introduction of the new formula for inter-council resource allocation, but the overall **financing** situation for the sector was a serious concern which recurred throughout the meeting (see proceedings of day 3). On the remaining three milestones steady progress has been made. The new **health sector strategic plan** has been completed and disseminated. This is more closely aligned with PRS objectives and now forms the basis of annual and action planning in the health sector. Cabinet has resolved the long-standing uncertainty over the composition of **Regional Secretariats**. Discussion focused on the need to ensure that this capacity is in place and functioning. Fair progress has also been made against most recommendations set out in last year's **Technical Review**, as described in further detail in the follow-up study this year.

District Health Services

The recommendations from last year's technical review were welcomed by government and formed the basis for concerted effort during the year under review. A follow-up "technical review" this year assessed progress in implementation, although the sample of districts studied[1] was necessarily limited. The study grouped recommendations into five broad areas:

- Service delivery and quality
- Planning and budgeting
- Accounting and auditing
- Regional support and,
- Stakeholder involvement and advocacy of reforms.

Overall the report describes an improvement over last year, including increases in service utilization and satisfaction. The review team welcomed the extra emphasis placed on service delivery in the new HSSP. The team found "that the availability of drugs, medical supplies and basic equipment has improved significantly". In

[1] Kinondoni, Hai, Babati, Muheza

discussion it became clear that there remains serious discontent on the lack of transparency on drug budget allocations to councils. Severe staffing shortages were found in all districts visited. The report highlights the fact that recruitment procedures are proving problematic in practice: 47% of LGA health posts, for which permits had been issued, had not been filled. In discussion all agreed the need to ensure that councils are fully conversant and capable of following recruitment guidelines – including the facility for extending permit validity where necessary. The team found that non-traditional financing sources (such as NHIF and project grants) are not adequately reflected in comprehensive council health plans. Although the sample districts are not yet operating the CHF, the technical review team cited evidence that the user charge exemption system is not operating as intended. The review team noted no progress at service delivery level in the proliferation of guidelines and recommended a "mechanism to develop and update guidelines to form a coherent set for each level".

In contrast, joint disbursement system, procedures manual, budget and planning guidelines have been harmonised and simplified - although there is sometimes confusion at district level as to which version of guidelines is the current and valid one. The recommendation of last year to relax rigidities in the guidelines on use of basket funds has been fully implemented. The Review Team endorsed the recommendations on information and performance management made at the 3-5th February meeting, but noted that the priority for HMIS is to put in place mechanisms to support CHMTs in making the health information system operational.

With regard to financial releases, the situation in 2003/4 has greatly improved with a major reduction of delays in disbursement of basket funds and production/scrutiny of periodic reports. This positive outlook is not the case with audit. Confusion persists on the proper terms of reference and approach to external audit of council basket funds. Most councils' basket accounts receive a qualified or adverse opinion. The team also reported inadequate action by management to address audit recommendations or to take sanctions in case of proven irregularities.

Following cabinet decision on the proper composition of the Regional Secretariat, the review team highlighted the importance of making this pivotal level in the health system function as intended. They recommend a clear mandate, a more proactive attitude and concerted investment in the capacity of the RS.

Stakeholder participation at the district level continues to lag some way behind policy aspirations, particularly with respect to voluntary and private health providers. The formation of health service boards and health facility committees was welcomed, and is expected to accelerate over the coming year. Communication from the center on reforms and desired actions at the council level is still wanting.

The technical review was supplemented by presentations from selected districts on diverse local initiatives and achievements. The participation of the districts at the review and the contribution of their perspectives was warmly welcomed by all participants.

Kigoma district council received particular accolade for having demonstrated the feasibility of establishing safe blood transfusion at health center level in spite of

chronic staff shortages and very poor communications. It is notable that since the improvements at Nguruka health center, total OPD attendance has risen by almost 50% in a single year and the fatality rate was only 3 out of 165 transfusions performed. **Rufiji District** demonstrated the value of the district health accounts tool in shifting resource allocation to align more closely with burden of disease priorities. They recommended rolling out the DHA methodology country-wide. **Bukoba Town Council** illustrated measures to improve adolescent sexual health including a youth center, post abortion care and related sexual health counseling. **Songea district** encouraged others to adopt the community health fund and user fees, showing how resources mobilized had been used for electrification of health centers, rehabilitation, supplies and contracting with private health providers. Similarly, **Tabora municipal** council described improvements in infrastructure, supplies and patient satisfaction achieved through introduction of user fees in September 1999. Finally **Mbinga district** council demonstrated how 80 health staff were recruited, initially using the CHF and later put on the council payroll. The CHF was also used to fund rehabilitation works and supplementary supplies. The council health board and health facility committees were formed to strengthen local governance. The main question here was on the fall-off in CHF membership following the advent of the NHIF and the increase of the CHF premium, although the meeting heard that those with more than one spouse and/or more than four children can supplement their NHIF coverage by continuing to subscribe to the CHF.

Health Sector Performance and Priority Programmes

The Health Sector Performance Indicators provide an objective measure of various aspects, including inputs, process, service delivery and outputs. Most data comes from *2002* and is compared to the 2001 baseline. Some input measures (skilled staff, finances) improved over this period, while drug stock-outs had yet to show any improvement. The picture on service delivery is much more mixed with very little change in indicators such as OPD attendance per capita, vaccination coverage, TB treatment completion and family planning uptake. The share of morbidity attributable to the top 6 causes also shows little if any discernable change between 1998 and 2002.

While the health sector performance profile seems to show little change in outputs, other documentary evidence does suggest an improvement. The latest EPI coverage data indicate 87% coverage (DPT3), the IMCI evaluation has found a 12% mortality reduction, and other demographic surveillance sites also point towards a decline in mortality across all age cohorts. Updated population-based estimates of infant and under-five mortality (from census and from forthcoming Demographic and Health Survey) are therefore eagerly awaited.

Interpretation of indicators data for decision-making has not been done, mainly because of time and staff constraints at the center. Problems remain with the completeness and timeliness of HMIS data, attributable largely to bottlenecks in the smooth flow of information from facility upwards. Various measures have been taken to strengthen HMIS, but a “clear way forward” has not been mapped out as envisaged in last year’s milestone. Participants stressed the need to address this so as to obtain objective information by which to “take the pulse” of the health sector.

Good progress was made on reconciling objectives and approaches between the various stakeholders involved in monitoring (poverty monitoring, local government M&E, sector performance indicators) and a number of recommendations have been made. However, these recommendations[2] await decision-making by senior management in the respective ministries/departments – a fact that the PS-Health promised to follow up.

From this "macro" view of health system performance, the meeting proceeded to examine progress on priority health challenges:

- Malaria
- HIV/AIDS/TB
- EPI
- Reproductive Health
- IMCI
- Nutrition

On **malaria**, concerns were raised on the rapidly increasing resistance to SP. In discussion it was agreed that policy change on first line treatment must be based on evidence. Combination therapy (current estimates) will cost an order of magnitude more than SP – requiring about $35m per year – equivalent to the entire drugs budget at present. No immediate prospects present themselves for financing this additional requirement.

On **HIV** government is committed to taking forward a comprehensive programme, including care and treatment. Various approaches and commitments need to be harmonised under a single, integrated operational and financial plan. The commitment of development partners to harmonizing their contributions and could be enhanced by adoption of a code of conduct. The US Global AIDS programme emphasized their commitment to working in close partnership with MOH and other development partners within agreed policies and strategies. All recognized the very considerable logistical, organizational, human resources and financial constraints to scaling up action on HIV in general, and care and treatment in particular. This implies building the capacity not only in the central NACP (in line with the health sector mandate under the national HIV policy) but also at council level.

HIV is fuelling the spread of TB, where further improvement in case finding (from 55% to over 65%) and treatment completion rates (from 77% to 82%) is essential. Multiple drug resistant TB needs to be tackled early since second line treatment costs up to 100 times first line treatment and is more difficult to administer. The recently completed review of the TB programme should be shared widely including debate and adoption of relevant recommendations by senior management.

The **EPI** programme has already achieved a significant reduction in vaccine wastage rates, although this could be improved further. National coverage rates are good, but marred by selected areas and population groups with unacceptably low coverage rates. The meeting shared MOH's concerns on the financial sustainability of new vaccines,

[2] Contained in "Health Information for Decision-Making: Reconciling Systems and Approaches. Report from workshop in Morogoro 3-5 February 2004."

particularly Haemophilus Influenza B (HIB). MOH is still studying the prospects on if/when to introduce HIB.

The inter-relationship of **malnutrition** and many other priority health problems was emphasized repeatedly during the day, with calls for stepping up action to reduce malnutrition rates, for a higher profile in the update of the Poverty Reduction Strategy, and for multi-sectoral action at the council level. Vitamin A supplementation, a key measure to boost immune response should become fully integrated and financed as a routine measure.

The **reproductive and child health** section laid bare the grim reality that maternal mortality ratios – a key PRS and health sector goal – would not show any improvement in the absence of radical action. MMR remains unacceptably high, and yet the proportion of births receiving skilled assistance is in decline. In particular, improving access to obstetric emergency services and reduction of the 3 delays in accessing such care should receive additional emphasis. But such achievements will only be possible if reproductive health moves beyond "project mode" to be a shared, integrated, costed and prioritized programme, fully reflected in sectoral plans and budgets at central and local levels. This also applies to commodity security, where repeated shortfalls in funding and procurement threaten supply of these essential commodities.

The **IMCI** approach received warm support, having demonstrated impressive results in improving facility-based management of childhood illness. These proven benefits can be achieved at no marginal increase in the recurrent cost of service delivery since IMCI has also been shown to deliver measurable efficiency gains. What is needed now to is to complete the scaling up exercise and to assure that IMCI, including the community component, is implemented in all councils in Tanzania.

In addition to the "headline" priority services, calls were heard to ensure that other diseases afflicting the poor, such as trachoma[3], leprosy and lymphatic filariasis, are not neglected. Although the achievements to date on both are encouraging, these *disabling* diseases still require additional effort to scale up the successes demonstrated so far. More generally, the meeting heard a call for improving access, and responsiveness, of health services to the needs of disabled people.

Human Resources

Most discussion and debate on day two focused on the Human Resources crisis in the health sector which was highlighted by the Honourable Minister's opening speech. The central challenge is to close the widening gap between availability of skilled front line health workers and the staffing requirement for service delivery. The meeting heard both from MOH and from PO-OPSM how the current procedures work for human resource planning, recruitment and management. Yet local government authorities have failed to employ adequate qualified staff and 33% of positions defined by the official staffing norms remain vacant. In part this is due to inadequate resources and the lack of funded posts. But, as the technical review demonstrated, it is

[3] The meeting benefited from a presentation of progress made in Tanzania to eliminate Trachoma under the International Trachoma Initiative, ITI.

also due to procedural obstacles in the recruitment process. Local government authorities and health management teams are not fully conversant with the procedures, and even funded posts may go unfilled. The procedures need to be disseminated more effectively and councils assisted to follow them.

The "open market" recruitment system also presents special challenges for filling posts in remote areas where living conditions are harsh, communications poor, and the opportunity for private practice more limited. While councils do, in principle, have the powers to provide additional incentives to fill posts in hardship areas it is not apparent that this is being achieved in any systematic fashion. The need to develop incentive packages to fill hardship posts was mentioned repeatedly. It was suggested that at the very least medical internship should be extended to cover more referral (regional) hospitals, but this would need adequate professional supervision in those hospitals. The question of "bonding" new health trainees to serve in designated areas was also cited repeatedly. Some felt that the old central posting process performed better in achieving equitable staff distribution, but it is difficult to see how the clock can be turned back in the new policy and economic environment.

The PO-OPSM outlined the policies, procedures and institutions which govern the management of human resources for health under the Public Service Act and associated regulations. PO-OPSM called upon the health sector to finalise its human resources plan and to work closely with PORALG on strategies to recruit and retain staff in rural areas. It was further noted that pre-service training capacity needs to be adjusted to match more closely the medium term HR requirements of the health sector. In-service training and continuous professional development can also be strengthened through a systematic approach to building up the capacity and curricula of zonal training institutions.

In discussion the full extent of the HR crisis was widely recognized. The MOH suggested following the MOEC example of fast-track central recruitment to resolve the crisis in the short-run. But it was also noted that the new funding formula for local government health grants provides councils with the option and flexibility to "trade-off" between PE and OC and thus shift the balance to address HR shortages where this is the binding constraint on productivity.

It was also recognized that much, if not all, the information required to document and analyse the shortage and maldistribution of staff already exists. In conclusion the Permanent Secretary MOH reiterated her personal commitment to addressing the HR issue as a matter of priority, in close collaboration with PORALG, OPSM and the Ministry of Finance. She called for maximum effort in all councils to fill – this financial year – all of the vacancies for which permits have been issued. She emphasized the need for concrete action to address the HR gap and wished this to be prioritised, while other aspects of the complex HR management agenda are taken forward over the medium term. These commitments were echoed in milestone #1, adopted in the closing session, which sets out focused actions to be achieved over the coming 12 months.

While it touched on HR issues, the presentation on local government reform placed greater emphasis on improving participatory planning and management, strengthening fiscal decentralization and financial management, restructuring institutions at council

and regional levels, and achieving legal and managerial harmonization of reform programmes.

Health and the new Poverty Reduction Strategy

The process of updating the PRS has been set out with a clear timeline and is already underway. Civil society representatives requested greater opportunity to feed in ideas. The NGO group had already made a formal submission[4]. Health sector stakeholders were welcomed to participate through written submission of suggestions and proposals by the end of March, to be taken forward by the drafting team. A closer synergy has already been achieved between the health reforms and the over-arching Poverty Reduction Strategy through the finalisation of the Health Sector Strategic Plan. The thinking which went into this should be reflected in the new Health chapter of the PRS. Similarly, convergence of indicators has already been achieved, with the PRS targets and indicators being a sub-set of those used to measure health sector performance.

In the context of the new PRS, reducing health inequalities is a concern. The meeting witnessed several calls, from a variety of different stakeholders, for greater attention to be paid to equity. On the one hand, last year's Poverty and Human Development Report, issued by Vice President's Office, describes various barriers affecting access of the poor to health services. These findings are reinforced by the literature review "poor people's experiences in relation to use of health services", copies of which were circulated at the meeting.

The fact that inequalities in health persist in Tanzania is not in dispute. Where there is division of opinion is on whether reduction of inequalities should be a principal focus of policy, or whether universal provision of well-financed, high quality services should be the over-riding concern. In this respect, different views emerged on whether cost-sharing is part of the problem, or part of the solution. Although this question was an under-current to various discussions at the Review (including the Technical Review), no consensus was reached at the meeting.

Various recent policy measures should improve equity in health – including the introduction of the new block grant formula (weighted in favour of poor populations, sparsely populated areas and higher burden of disease). The indent system should make drug supply more responsive to service requirements. Commitments to address human resource and infrastructure constraints at the district level will also help. On the demand side it is hoped that health service boards, facility committees and the clients' charter will improve accountability to consumers and communities. The MTEFs of recent years have also achieved a progressive resource shift in favour of basic and preventive services meeting the needs of vulnerable groups, rather than the urban-based referral hospitals. But the question remains as to how to address persistent inequities within population groups in their ability to access the services which are available. The equity issue will be discussed further in the Technical Committee. If agreeable to all parties, it may be taken as one of the focal areas for next year's review.

[4] NGO Comments for the 2004 Joint Health Sector Review and Poverty Reduction Strategy Review.

Health Sector Financing

The final day of the Review was devoted to financial issues. The draft Public Expenditure Review update provided delegates with information on the trends in financial allocations to the health sector, budget execution performance, and the allocation of resources within the sector. The draft MTEF sets out objectives and intended (MOH) resource allocation for the year ahead.

The trends revealed by the PER update were the cause of grave concern since they demonstrate a continued decline in the share of government resources allocated to the health sector.[5] This is *after* taking into account all on-budget resources, including the basket funds. Development partners made formal statements on the issue, delivered respectively by the Ambassadors of the Royal Netherlands Embassy and the Royal Danish Embassy. In short, they noted that this is the second year running when health has taken a reduction in budget share, in spite of it being a PRS priority sector. It looks as if Health has been penalized for following MOF policy to move a greater share of aid to the sector "on budget" in the form of basket funding and direct budget support. Without additional resources, the very considerable financing requirement for care and treatment will further squeeze funding for priority areas within the health budget. Development partners called for tangible financial commitment and requested a high level meeting on the issue with Ministry of Finance. The Ambassador of the Royal Danish Embassy went further to say that the declining share sent the wrong signal to partners, made it difficult to justify additional basket support to the sector – at a time when Denmark is developing proposals for its largest ever health sector support in Tanzania. Again, it was emphasized that Care and Treatment must be funded from additional resources – and not by encroaching on the funding of other priority services. The draft budget guidelines for the coming year (2004/5) appear to show an increase for the health sector – but this is attributable entirely to an anticipated sharp increase in "off-budget" aid. Delegates questioned the basis for this estimate and wondered whether these project resources had, in fact, been pledged. It was also re-iterated that all aid resources, including project funds, should be fully reflected in the MTEF.

In discussion delegates continually re-emphasised the unfavourable trend in health sector financing. They wondered why this was, given the well-justified resource bid from the health sector and the detailed annual analysis in the Public Expenditure Reviews.

In response, the Commissioner of Budget noted the multiple demands on scarce government resources. He hinted that the budget guidelines were not yet final and further fine-tuning in sectoral allocations was likely. He accepted the need to convene the health sector financing committee which had not met during the previous year, in order to get to the bottom of the figures and trends.

[5] Various measures were used in the report to compare health to total government expenditure. No matter which variation is taken on nominator and denominator, the trend reveals a decline of approximately 1.5 percentage points between 2002/3 and 2003/4.

Within the sector, the public expenditure review and the draft MTEF for 2004/5 illustrate continued positive trends. Budget execution rate has fallen slightly for GOT funds, but improved considerably for basket resources. The proportion of sectoral resources devoted to local government level has increased by around 20%. The share of sectoral resources devoted to drugs and medical supplies and priority programmes has increased. In spite of this, there are very substantial new demands on the health budget; most notably malaria control (move to combination therapy, scaling up of ITNs), EPI (sustaining GAVI-financed new and combination vaccines). The Care and Treatment programme is of a different order of magnitude – requiring an estimated $500+M over five years, plateauing at an annual funding requirement of around $200M per annum – roughly equivalent to total health sector spending at present. MOH and other stakeholders also recognized the need to scale up other highly cost-effective health interventions, including routine immunization, voluntary counseling and testing, ITNs, filariasis control, IMCI, etc.

All present at the meeting recognized that with a constrained resource base and multiple demands, difficult choices are unavoidable. The consensus was clear, though, that there is a robust case for additional resource allocation to the sector. Stakeholders anticipated follow-up dialogue with MOF after the Review to make this case.

More generally, the Tanzania Health SWAp received high praise. Partners commended government on the health sector reform process and the SWAp vision which has now matured into one of the best in the world. Partners also praised the standard of detailed documentation and preparation for the Review. They thanked the Secretariat for the preparation of the meeting, including a daily recap of points from the preceding day.

Milestones for 2004/5

The final session of the meeting was devoted to agreeing upon milestones for the year ahead. Thanks to a high level of consensus generated in the course of the deliberations, the secretariat was able to provide a draft set of milestones. This draft was further elaborated by various stakeholders before being tabled for open discussion.

It was agreed that the milestones should be fewer and more focused than in previous years. They should also be phrased as deliverables, which are achievable and measurable in a one-year time horizon. The open and constructive discussion, which had characterized the meeting thus far, continued during the closing session. The one milestone suggested where consensus could not be reached concerned addressing health equity. Although this does not appear in the final milestone list, the MOH has welcomed evidence-based commentary and proposals from partners. The final milestone list is reproduced below.

No.	Milestone & Objectively Verifiable Indicator	Responsible
1	**HUMAN RESOURCES CRISIS: Meet agreed health sector recruitment target for FY2004/5**	PS MOH
1.1	High level decision with MOF, PORALG, OPSM to increase radically recruitment of front line health workers. Specific recruitment targets agreed for next 5 years	
1.2	Maximum effort to fill permits issued FY2003/4. 90% of posts with permits issued filled in FY2004/5.	

1.3	Hiring procedures clearly communicated to all levels and councils supported to expedite procedures	
1.4	Strategy for equitable deployment including an incentive scheme for "hardship" posts agreed and applied	
2	**HEALTH SECTOR FINANCING GAP: Increase health sector budget share (on-budget resources) FY2005/6**	PS MOF
2.1.	High level Joint Health-MOF Committee to be functional, including to propose revised budget ceiling for health sector for coming year and intended ceilings for subsequent years	
2.2	Specific financing plans for major financing gaps in priority programmes, including HIV care and treatment, immunization, RH commodities, IMCI, malaria combination treatment, TB (multi-drug resistant).	
2.3	PER completed by end December 2004	
3.	**REGIONAL SECRETARIAT HEALTH TEAM CAPABILITY: Health Secretariat capacity in place and functioning by January 2005**	PS PORALG
3.1	Tasks and composition of RHMT confirmed	
3.2	All posts filled/confirmed	
3.3	Orientation/training completed	
4.	**SECTOR PERFORMANCE MEASUREMENT AND MONITORING: Health sector performance indicators updated, findings interpreted and taken as focal point for next Review**	DPP
4.1	High level decision on recommendations of information and monitoring task force	
4.2	At least 10 districts with complete data set for HMIS-related sector performance indicators	
4.3	Analysis of trends in these key indicators in these 10 districts	
4.4	Health Statistics Abstract published including interpretation of results	
4.5	State of Health in Tanzania report produced for next Review	
4.6	Achievements in scaling up of priority health interventions (malaria, RH, EPI, IMCI, Nutrition, TB) documented and reported.	
5.	**QUALITY HEALTH CHAPTER FOR PRSP(2): New health chapter drafted, drawing on inputs from stakeholders, and shared with partners in September 2004**	PRS health sector focal person
6.	**SCALING UP ACTION ON HIV/AIDS: Health sector strategy on HIV/AIDS implemented according to plan, subject to additional funding**	NACP
6.1	Care and Treatment programme operational in at least 15 sites	
6.2	Progress on other aspects of Health Sector HIV/AIDS Strategy documented and reported	
7.	**District Health Infrastructure Rehabilitation:**	PS-PORALG
7.1	Fund for infrastructure rehabilitation of primary facilities and district hospitals established and disbursement started	
8.	**Scaling up Hospital Reforms**	DHS
8.1	Hospital reforms started in Regional Hospitals and District Hospitals	
8.2	Generic service agreement concluded and agreed as basis for funding in FY2005/6	
9.	**Improved transparency and accountability to the public**	PORALG, Councils
9.1	Information publicly available on allocation and utilization of health funds *including drugs* at national level, district level, facility level	
9.2	Council health basket funds in a/c no.6 audit available in good time for next review	
9.3	All council health service boards established and functioning and health facility committees established in 80% of facilities	

Closing

In closing the Chair thanked all present for their participation and for the warm and open spirit in which discussions had been conducted. This evidences a true partnership in the sector, characterized by trust, constructive debate and strong collaboration.

Annexes

1. Resource Documents and Presentations for the Review
2. Timetable
3. Summary of day's proceedings: Day 1,2,3
4. Terms of Reference for the 2004 Joint Health Sector Review
5. List of Participants
6. Side Agreement with Basket Partners (to be completed)