Report of the 6th Tanzania Joint Annual Health Sector Review

4th-6th April 2005
Kunduchi Beach Hotel, Dar es Salaam



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Acronyms

APTHA	Association of Private Hospitals in Tanzania
ARV	Anti-Retroviral
CHF	Community Health Fund
CHMT	Council Health Management Team
CMO	Chief Medical Officer
CSSC	Christian Social Services Commission
DDH	District Designated Hospital
DHR	Director Human Resources
DHS	Demographic and Health Survey
DHS	Director of Hospital Services
DP	Development Partner(s)
DPP	Director of Policy and Planning
DPS	Director Preventive Services
EPI	Expanded Programme of Immunisation
FBO	Faith-Based Organisation
FY	Financial Year
GAVI	Global Alliance for Vaccines and Immunisation
GOT	Government of Tanzania
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR(H)	Human Resources (for Health)
HSSP	Health Sector Strategic Plan
IMCI	Integrated management of childhood illness
ITN	Insecticide Treated Net
JRF	Joint Rehabilitation Fund
LGA	Local Government Authority
MMR	Maternal Mortality Ratio
MKUKUTA	Mkakati wa Kukuza Uchumi na Kuondoa Umaskini Tanzania
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
NSGRP	National Strategy for Growth and Reduction of Poverty
OPD	Outpatient Department
PMTCT	Prevention of Mother-to-Child Transmission
PO-PSM	President's Office, Public Service Management
PORALG	President's Office, Regional Administration and Local Government
PER	Public Expenditure Review
PFP	Private for-Profit
PPP	Public Private Partnership
PS	Permanent Secretary
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Team
SADC	Southern Africa Development Community
SWAp	Sector-wide Approach
VA	Voluntary Agency (Hospital)

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Executive Summary

The 6th Annual Joint Health Sector Review was concluded successfully at Kunduchi Beach hotel, between 4th and 6th April 2005. It was preceded by a Technical preparatory meeting, held at Belinda Hotel. This year's was the largest Review yet, with over 200 participants. As well as government and donor representatives, the meeting was attended by a variety of civil society and NGO representatives. The Honourable Minister of Health opened the meeting.

Judged by the milestones, performance over the last year has been mixed. The advent of the Joint Rehabilitation Fund, the successful integration of Health into MKUKUTA, the scaling up of AIDS Care and Treatment and a steep budget increase (FY2004/5) were all registered as achievements. However, little if any progress was achieved in tackling the Human Resources crisis. The meeting resolved to address the issue with renewed commitment and urgency.

A good deal of quantitative data was presented at the meeting, including the State of Health report, the updated health sector performance profile, and the ten-district study. In most respects these reports point to improvement in health service delivery between 2000 and 2003. The major areas of concern were maternal health services and child malnutrition – neither of which seem to have made any improvement over the last 2 decades. Weaknesses in the routine information system mean that data for 2004 is still patchy.

Public Private Partnership was the theme of the technical review this year. The clearest message emerging in plenary was the need to replace the current government subsidy to faith-based providers by a service agreement, linked to outputs. Another resonating theme was the need to expand the opportunity for NGOs (including FBOs) to participate in health planning and management at district level. More generally, there was a commitment by both public and private stakeholders to deepen their collaboration. The recommendations of the Technical Review extended well beyond these themes.

A good start has been made with the rehabilitation of district health infrastructure. This is expected to accelerate in the year ahead. Participants called for a holistic approach towards prioritisation and effective monitoring of implementation.

The Honourable Minister called for a new approach and renewed urgency in tackling the human resources crisis. The challenges and the priorities are clear enough. But the shared commitment of MOF, PO-PSM, PORALG and MOH will be needed in order to move forward. A cabinet paper was seen as one way to secure this joint commitment.

The financing situation for Health has improved markedly. The PER demonstrates a 33% nominal rise in health budget between 2003/4 and this budget year. FY2005/6 will witness a further steep increase. This good news is tempered by the fact that payroll expenditure is not keeping up with "other charges", and central government expenditure is expanding much faster than local government. Even these increases are not sufficient to cover the requirements of the health sector. A T. Shilling 167 billion resource gap was documented by the MOH. New financial commitments continue to come on stream, often initiated by short-term donor funding. Moreover, a substantial portion of new money coming into the sector is tightly earmarked. Flexible, discretionary resources remain highly constrained and tough choices on resource allocation will have to be made. Detailed discussion of health financing in general, and user charges / CHF in particular, was deferred to the Health Financing Workshop due in early May.

A new set of Milestones, some of them carried over from last year, was debated and concluded after the meeting. These are reproduced in Table 7.

Introduction

The sixth annual joint health sector review ("Main Review") took place on 4th-6th April at Kunduchi Beach Hotel, Dar es Salaam. It had been preceded by extensive preparatory work, including a Joint Technical Preparatory Review in mid-March at Belinda Hotel. The recorded summary of that meeting[1] identified the issues to be carried forward for discussion at the Main Review. Reports and presentations tabled at the Main Review are presented at Annex 2. Copies are obtainable from the Health Sector Reform Secretariat, MOH.

The Main Review was the biggest yet, with over 200 invitees. According to the Terms of Reference (Annex 3) the overall objective of this Review was to present for discussion all conclusions and recommendations [from the Technical Review] and to reach consensus on conclusions and priority actions for the year ahead. Specific sub-objectives included:

- Share information on developments, achievements and intentions in key areas of health sector strategy
- Receive, and deliberate on the findings of, the PPP technical review report and identify pertinent issues and actions
- Review the implications of changing SWAp environment, including MKUKUTA clusters (especially cluster 2), budget support, global funding mechanisms
- Receive progress report from Human Resources Working Group
- Receive summary findings from the Local Government Reform Programme review (October 2004), and the joint evaluation of General Budget Support
- Receive and discuss issues arising from the Technical meeting
- Formulate milestones for FY2005/06.

Opened by the Honourable Minister of Health (Annex 1), the meeting also included senior officials from Ministry of Health, Ministry of Finance, and President's Office – Regional Administration and Local Government. In addition to Donor Development Partners, a number of Regional and District Medical Officers attended, as did a range of Non-Governmental Organisations and Civil Society Organisations. The meeting hosted visiting delegations from Zanzibar, Malawi and Mozambique. The list of participants is reproduced at Annex 4.

This report provides a brief record of the proceedings. The report is organised around the topic order of the timetable (Annex 5). The summary of recommendations from the Technical Review Report (PPP) together with Government's response is reproduced at Annex 6.

[1] Entitled "Joint Technical Preparatory Meeting, Belinda Hotel, 15-17 March 2005"

Opening Session

In her opening speech, Honourable Minister Anna Abdallah pointed to tangible improvements in the health sector over recent years. This is manifest in greater public and media satisfaction with the sector, fewer parliamentary questions on shortages or corruption, as well as in health service performance indices and growing demand for public health services. Health facility committees and the Community Health Fund have provided avenues for the public to voice their needs and increase the responsiveness of service providers. The progress made is testament to the solid partnership with development partners, based on patience, mutual trust and a willingness to adopt change.

On Public Private Partnership (PPP) the Honourable Minister noted the transition from competition to collaboration since the liberalisation of the health sector in 1991. She welcomed the focus on PPP for this year and expressed her hope that this would help to move forward the aspirations originally set out in "strategy seven". There has been notable growth in private-for-profit services, in spite of meagre profit margins. Not-for-profit providers receive government subsidy and are responsible for a substantial share of service delivery.

Financing innovations, including cost-sharing in 1993, community health funds in 1996 and national health insurance in 1999 have increased the role of private contributions to the sector. Although the revenues are small, these schemes improve quality, build popular ownership, and increase community voice, accountability and transparency. Exemptions are supposed to protect access for all. "If we feel that they are not working, let us find a system that will better protect access for the poor and vulnerable". The lobby for abolition of user fees, she felt, would reverse these gains, reduce sustainability and take us back to a dependency mentality. The Minister appealed to development partners to co-operate on the basis of openness and trust, to avoid generic policy prescriptions, and to engage in constructive, evidence-based policy debate.

In spite of the conclusions and commitments reached at last year's review, there has been little movement on the area of Human Resources. The Honourable Minister expressed her concern and urged concerted and urgent action. The bottlenecks must be tackled *now*. She noted the low proportion of births taking place at health facilities and recommended that the policy on Traditional Birth Attendants be revisited. She cautioned that global financing initiatives carry risks. They must not undermine the holistic national health system, national strategy or the SWAp. A functioning district health system is the keystone supporting service improvement: "Help us to move forward, not push us forward."

The vote of thanks, delivered by the representative of the Christian Social Services Commission (CSSC) echoed the hopes of the Honourable Minister that the focus on PPP would help us to move ahead. She noted that until now there is a gap between policy and practice and that we must move further towards collaboration rather than competition. She recommended the introduction of specific PPP mechanisms at all levels, including the adoption of a service agreement arrangement for funding non-governmental service providers. This forum must deliberate on the recommendations and move us forward.

In his opening remarks, the Chief Medical Officer reminded participants of the differences between the health and education sectors. The health sector begins from a

high base – with a widespread infrastructure network built more than 30 years ago. Tanzania's performance on services such as EPI is one of the best in Sub-Saharan Africa, in spite of severe resource shortages. Health impact would have been even better were it not for HIV.

On user fees, the CMO re-emphasised the rationale: to improve accountability, reduce drug mismanagement and leakage, to improve the availability of quality services and to create a sustainable, efficient and effective health system. He noted that cost-sharing and insurance mechanisms "level the playing field" between public and private service providers. On equity he stressed that there is one policy and one standard of service for all – not one for the rich and one for the poor. The only issue is who pays and how much. Availability of services at the time of need is the key yardstick. He conceded, however, "it is an open secret that the exemption system is not working well". He reassured participants that research was ongoing to identify the problems and propose solutions. He also noted that there is a problem with skilled assistance at delivery. Nutrition presents a chronic challenge, attributable in part to food insecurity and poverty. The Human Resources problem has worsened since last year and needs to be addressed with renewed commitment.

In reference to working with development partners, the CMO appealed to partners to work constructively with the Ministry and avoid posing endless questions – not all of which have answers! He stressed that the government welcomes technical advice – but not imposed solutions. And he emphasised the importance of strengthening the health system as a whole.

Health Sector Performance

The meeting reviewed recent performance of the sector with reference to:

- the milestones set last year
- the "state of health report"
- the updated health sector performance profile and 10 district study
- presentations on progress on priority health issues

Milestones

Progress against the milestones is described in detail in the matrix presented by government at the Review. For brevity, this is summarised in the table below, showing whether milestones were fully achieved, partially achieved, or not achieved.

Table 1: Summary of Progress against Milestones set in March 2004

No.	Milestone Description	Achievement
1.	**Human Resources**	
1.1	High level decision with MOF, PORALG PO-PSM to increase radically recruitment of frontline health workers. Specific recruitment targets agreed for next year	Not achieved
1.2	Maximum effort to fill all posts with permits in FY2003/4 and 2004/5	Not achieved
1.3	Hiring procedures clearly communicated to all levels and support provided to councils to expedite procedures	Not achieved
1.4	Strategy for equitable deployment, including incentive scheme for hardship posts agreed and applied	Not achieved
2.	**Health Sector Financing Gap**	
2.1	High level Health-MOF committee functional, including to propose revised budget ceiling for health sector for 2004/5 and intended ceilings for subsequent years	Achieved
2.2	Specific financing plans for major financing gaps in priority programmes, including HIV Care and Treatment, immunisation, reproductive health commodities, IMCI, malaria combination therapy and TB	Partially achieved
2.3	PER completed by end December 2004	Not achieved
3	**Regional Secretariat Health Team**	
3.1	Tasks and composition of RHMT confirmed	Partially achieved
3.2	All posts filled/confirmed	Not achieved
3.3	Orientation and training completed	Not achieved
4	**Sector Performance measurement and monitoring**	
4.1	High level decision on recommendations of information and monitoring task force	Achieved
4.2	At least 10 districts with complete data set for HMIS related sector performance indicators	Achieved
4.3	Analysis of trends in these key indicators in these 10 districts	Achieved
4.4	Health statistics abstract published including interpretation of results	Not achieved
4.5	State of Health in Tanzania report produced for next review	Achieved
4.6	Achievements in scaling up priority health interventions documented and reported	Achieved
5	**PRSP2**	
	New health chapter drafted, drawing on inputs from stakeholders and shared with partners in Sept. 2004	Achieved
6	**HIV and AIDS**	
6.1	Care and Treatment plan operational in at least 15 sites	Achieved
6.2	Progress on other (prevention) aspects of health sector HIV/AIDS strategy	Partially achieved
7	**District Health Infrastructure**	
7.1	Fund for infrastructure rehabilitation of primary facilities established and disbursement started	Achieved
8	**Scaling up hospital reforms**	
8.1	Hospital reforms started in regional and district hospitals	Partially Achieved
8.2	Generic service agreement concluded and agreed as a basis for funding in FY2005/06	Not achieved
9	**Improved transparency and accountability to the public**	
9.1	Information publicly available on health funds and drugs at national, district, facility level	Partially achieved
9.2	Council health basket funds audit available in good time for next review	Not achieved
9.3	All council health boards established and functioning and health facility committees in 80% of facilities	Partially achieved

As acknowledged by all in plenary, progress has fallen far short of expectations on **Human Resources**. The constraints and way forward are discussed further in the relevant section below. The milestones on **Regional Health Team** were also not met. It was explained that although conclusions had been reached on the intended number and composition of Health staff, the Attorney General's Office asked PO-RALG to complete the same exercise for all sectors before submission for the amendment of legislation. This should be complete by the time of the next Review.

On **health financing** the picture is mixed. On the positive side, an increase in the health sector budget ceiling was agreed following last year's review, and an even bigger budget increase has been agreed for the coming year. The PER report was not completed by December, but was availed to all participants at the review. Financing gaps persist in priority health programmes, and actual funding requirement for some has not yet been laid out in detail. But every effort has been made to prioritise within the constrained resource envelope. Government has succeeded in raising additional resources from domestic and foreign sources for Care and Treatment. Funding is secured (for the initial 2 years) for new malaria therapy.

Most of the milestones on **sector performance measurement** and monitoring were met. A pre-final updated health sector performance profile was made available to participants at the review. There was clear consensus, however, that much more needs to be done to make routine data systems fully functional. The health chapter for the National Strategy for Growth and Reduction of Poverty and the implications of the **MKUKUTA** for the health sector was completed on time. This was discussed in more detail on day 2.

The **HIV and AIDS** milestone on number of Treatment sites has been exceeded. But the number of patients on treatment falls far short of the target in the plan. Participants called for treatment targets to be more realistic, voiced concerns on funding and drug supply continuity, and called for greater emphasis on HIV prevention, particularly condom supply and availability of safe blood.

The joint **rehabilitation** fund has been set up and disbursement has commenced. Development partners are keen that lessons are learned from the first 16 councils and are applied as the programme is rolled out to 40 councils.

Regarding **hospital reforms**, guidelines, a strategic plan, and annual plans have been completed. But the status of implementation in Regions and Districts was not presented.

Finally, regarding **accountability and transparency**, government reported that information on funding and drugs is available as a matter of policy both at district and facility level. Development partners stressed that the actual availability of public information remains patchy and that more emphasis is needed on making public information readily accessible. Audit of the district basket fund has not taken place to date. It was suggested that this should be covered by the routine audit by the Auditor General rather than a separate, contracted, audit of basket funds. Council Health Boards have been established in all councils, as have health facility committees. However more than half of these have yet to be inaugurated and so are not yet functioning. It is expected that all will be functioning by this time next year.

In summary, progress against the milestones has been mixed, with Human Resources standing out as the main area where progress has fallen far short of expectations.

State of Health Report, Sector Performance Profile and 10 District Study

The "State of Health in Tanzania" the pre-final update of the "Health Sector Performance Profile" and the "10 district study" were distributed to participants. The former illustrates that underlying health determinants still pose a major challenge. The report calls for more attention to be paid to certain areas of ill health, such as disability and non-communicable disease.

The picture on health outcomes is mixed. Historic data from the DHS surveys and the census suggests little if any improvement in mortality rates. Trend data from demographic sentinel surveillance, however, paints a rosier picture for infant, under-five and maternal mortality – at least in the districts covered.

As regards health service inputs and service delivery, the report confirms that funding for the sector has increased steadily in recent years. It concludes that "*There is a wide consensus amongst directly involved stakeholders and development partners that the performance of the health system has improved, although it is still a patchy progress."* This is confirmed by a number of service delivery indices including EPI, implementation of IMCI, improvements in malaria treatment and TB treatment success rates. Client satisfaction surveys show relatively high levels of public satisfaction. On equity the authors conclude that the exemption systems are not fully functional.

However the authors conclude that Tanzania has achieved notable successes in the health sector. The principal challenge identified is the human resource crisis and the continued threat of HIV. The authors recommend full implementation of the "burden of disease" approach to health planning, continued strengthening of planning capacity, and greater attention to maternal health and to non-communicable disease. The report concludes by recommending that the timing of future reports be selected to coincide with the release of major new data sets such as the census and DHS.

The updated health sector performance profile report[2] contains a wealth of data drawn from various sources, including routine data systems, the 10 district study, census, surveys and demographic surveillance. A summary version of performance against the 22 annual indicators is presented in table 2 below. The table of 11 periodic indicators (sourced from DHS and other surveys) is not reproduced because no new data was available for 2004.

As Table 2 (below) shows, data for 2004 has only been reported for 5 out of the 22 annual indicators. "Not available" is signified in the grey shaded cells. Four indicators showed an improvement (shaded green) – 3 of them relating to health sector funding and one describing the utilisation of data for district health planning. One indicator remained stable (shaded yellow): district health funding as a proportion of total district funds. In his presentation, the Head of Health Information called for radical action to strengthen the Health Management Information System (HMIS) so as to obtain timely data on these and other indicators. Development partners echoed this point, appealing for greater commitment to strengthening the HMIS.

[2] "Health Sector Performance Profile in Tanzania for the Year 2004" Draft Version 1.2, MOH 1/5/2005

An alternative data set (for 1999-2003) is obtainable from the "10 district study".[3] This quantitative data is supplemented by qualitative data from key informants and community survey and focus groups.

On health care **financing**, total and per capita expenditure on health more than doubled in nominal terms over the period, although the increase has been faster for central MOH than for local government.

The authors confirm that the **human resource** situation remains in crisis, with only 30%-40% of staffing requirements met in key cadres. The situation is much more grave in health centres and dispensaries than in hospitals. Paradoxically, the charts in the report seem to show an increase staffing as a proportion of staffing norms over the period.

TB and Leprosy treatment completion rates improved between 1999 and 2002, but fell slightly in 2003. The proportion of women of reproductive age using **family planning** rose in 2001, but has since stagnated or fallen. **Immunisation** coverage has improved considerably for all antigens reaching the 90% mark in 2003.

There has also been a marked improvement in the proportion of health facilities judged to be in a good state of **physical repair**. The percentage of dispensaries in good repair rose from 25% to 55%; health centres from 40% to 75%, and hospitals from 70% to 81%. The trend in **drug stock-out** (using 3 tracer drugs) is more mixed, although the authors conclude that drug availability is improving.

The **proportion of births** taking place in government facilities is judged to have returned to the level in 1999 (52/53%) after falling to 47% in 2000. Skilled birth attendance was reported to have reached 80% in 2003, a finding which is not consistent with the proportion of births taking place in health facilities. Participants noted the need for clarity and consistency in the definition of "skilled attendance".

The report suggests that the proportion of children moderately or severely **underweight** (weight for age) improved from 11.1% in 1999 to 9.2% in 2003, although there are stark variations in malnutrition prevalence across districts. No significant change occurred in the leading causes of OPD attendance over the period.

The community survey (from 2003) found that two thirds of people equate **health sector reforms** with cost-sharing, while the proportion aware of health boards or health facility committees was only 3% and 6% respectively. There is a strong preference for government (rather than private) health facilities, mainly because of geographical proximity. Drug availability and physical state of facilities was judged to have improved, and levels of **satisfaction** with services were high.

[3] "Assessing trends in the overall performance of the health sector in Tanzania. The use of sector performance indicators from 10 selected districts". Makundi E.A. et al, NIMR/MOH, January 2005.

Table 2: Summary Annual Health Sector Indicators

#	Indicator	2001 Baseline Year	2002	2003	2004
	INPUT INDICATORS				
1	Total GoT Public allocation to health per capita (in USD): Central Regional District ……National	1,245 172 848 2,265	1,529 208 1,058 2,795	1,702 242 1,334 3,278	2,799 351 1,375 4,525
2	Total GoT and donor (budget and off-budget) allocation to health per capita (in USD)	5,100	6,361	6,868	8,815
3	Recurrent expenditure broken down by level Central, Hospital Services; Preventive Services, Total (in USD)	190 1,077 894 2,161	246 1,100 1,231 2,577	423 1,270 1,397 3,090	565 1,716 1,630 3,911
4	Distribution of Medical Officers as % of the staffing norms	-	30%	-	-
5	Distribution of Assistant Medical Officer as % of the staffing norms		23%		
6	Distribution of Public Health Nurse as % of the staffing norms		23%		
7	Percentage of GoT funds available for budgeted and actual district health activities against the total overall funds available for districts	18% bud. 15% act.	17.6%	Na	17.7%
	PROCESS INDICATORS				
8	Number of districts reporting and showing use of the HMIS, NSS, Performance Monitoring data in the preparation and use of health plans	24%	35%	35%	37%
9	Proportion of public health facilities in a good state of repair	72.0% 61.7% 42.7%	80.8% 72.2% 49.0%	80.8% 75.0% 54.8%	
10	% of public health facilities without any stock outs of 4 tracer drugs and 1 vaccine				
11	Average number of days with no drug kits in public health facilities.	10 days	10 days		
	OUTPUT INDICATORS				
12	Cost-sharing fees collected by the public health facilities as proportion of targets.	0.46			
13	Number of outpatient attendance per capita.	0.71	0.72		
14	TB treatment completion rate (cure rate)	81%	80%		
15	Total number of family planning acceptors (new and old)	22%	17%	21%	
	OUTCOME INDICATORS				
16	The proportion of children who receive three doses of vaccine against diphtheria, pertussis (whooping cough), tetanus and Hepatitis B by their first birthday.	89% 65% 92% 79%	90% 80% 94% 90%	92% 90% 98% 90%	
17	% of children born to HIV-infected mothers who are HIV+				
18	HIV prevalence 15-24 age group	9.0%	7.4%	6.7%	
19	Proportion of births taking place in Government Health Facilities		68.5%		
20	Top 6 causes of morbidity among OPDs attendees and top 6 causes of mortality	The information is presented separately			
	IMPACT INDICATORS				
21	Percentage change in mortality attributable to malaria among children under-five	Dar: 11% increase Hai: 10% decrease Moro: 2% decrease	Dar: 11% increase Hai: 7% decrease Moro: 0% decrease		
22	Proportion of deaths to women of child-bearing age due to maternal causes	0.02 (Dar) 0.007 (Affluent Rural) 0.036 (Poor Rural)	0.051 (Dar) 0.011 (Hai) 0.047 (Moro)		

On the **priority health programmes**, a brief presentation was made summarising key points from the range of presentations heard at the Technical Preparatory Meeting.

Good progress has been made on malaria control and plans are in place to move towards combination therapy. The HIV care and treatment programme has also advanced, although there are concerns about financing, drug supplies, human resource constraints and the balance between treatment and prevention. In contrast, the malnutrition situation is poor

and showing little sign of improvement. Maternal care too is an area where performance has deteriorated and where concerted effort will be needed to reverse the trend. On child health, improvements have been achieved in IMCI and immunisation. Yet infant and under-five mortality remain high and the MDG is unlikely to be attained – in part because of underlying malnutrition.

In plenary, development partners, civil society organisations and non-governmental organisations all stressed the need for concerted action to tackle the slow progress in reproductive and child health, particularly maternal health. The human resource crisis must be tackled if coverage and quality is to be improved. They called for universal access to be achieved for antenatal care, post-abortion care, delivery care (including Emergency Obstetric Care), post-natal care, family planning and sexual health. These areas require additional policy attention and emphasis. It was proposed that clear strategies are needed to address maternal mortality, that this should be designated as a milestone, and that progress should be measured year on year. The parlous state of child nutrition was also a matter of concern to participants, although no consensus was reached on what should be done, how and by whom. NGOs further stressed that the inter-sectoral linkages necessary to improve food security and livelihoods need to be made a reality. Others noted that participants' appeals for faster progress come in the context of a resource gap of 167.8bn shillings that needs to be filled.

Public Private Partnership

Towards the end of Day 1, the leader of the Technical Report team presented their findings and recommendations on Public Private Partnership. These are summarised in Table 3 below. The government's initial response to these recommendations was provided to participants[4] and is reproduced at Annex 6.. The recommendations from the Technical Review on PPP have been taken forward to milestone number 1 and action will be taken accordingly.

Participants warmly welcomed the renewed attention to this area. Both government and non-governmental representatives committed to renewed collaboration and co-operation. There was broad recognition of the important role in health care played by faith-based organisations as well as by the private-for-profit sector.

Faith-based organisations called for the finalisation and implementation of a service agreement framework to form the basis of government subsidy. This should be applied to all categories of service, not only District Designated Hospitals and Voluntary Agency Hospitals. Preparatory work on a draft template is already advanced and government representatives were confident that this would be concluded soon.

Faith based organisations and NGOs also pointed to the gap between policy and district level practice with regard to information sharing and formal participation in district health planning. All agreed that greater co-operation is desirable and that both NGOs/FBOs and district health authorities should make renewed effort to work together in a spirit of trust and collaboration. It was recognised that this sort of collaboration is much more advanced in some councils than in others. FBO/NGO participants proposed that the formal "space" for collaboration be codified in national guidelines so that the opportunity for collaboration is not left to the discretion of individual council health teams. NGOs stressed

[4] Recommendations from technical review and response from MOH (8pp)

the need to complete the formation of Health Facility Committees and Council Health Boards.

Table 3: Summary recommendations of PPP Technical Report

Specify Roles and Responsibilities
Define more clearly present and future roles of regulator, purchaser/fund-holder and provider
Use public/private providers to deliver the essential health package
Decentralise drugs budgets to council level
Address human resource constraints for public and FBO providers
Contractual Agreements
Finalise and implement contractual agreement between councils and FBO providers
Service agreements for private AND public providers to promote performance
Review and update health legislation as required
Review/improve efficiency of registration & accreditation process
Adopt national standards, applicable equally to public and private, for accreditation and quality assurance
Facilitate private providers to attain quality standards/accreditation
Set, through negotiation, prices for essential drugs and services
Define PPP concepts separately for private-for-profit, FBO and NGOs
Institutional Set-up and mechanisms for co-ordination
Pro-active promotion of PPP by MOH and PORALG
Create formal, permanent forum for public-private dialogue and information sharing
Separate PPP desk in MOH from hospital registration desk
Formal, funded, steering committee as broker between government and private sector representatives
Include NGOs in policy debate, planning and implementation
Encourage National Policy Forum
House Medical Council independently of MOH
Different private sector segments to organise themselves into representative bodies / umbrella organisations
Medical Association of Tanzania (MAT) should become umbrella for professional associations
APHTA should become umbrella for PFP actors
CSSC to build up the inter-faith forum to be representative of all FBOs
Other Recommendations
Disseminate examples of PPP best practice
Donors support/facilitate capacity on both public and private sides for PPP
Periodic monitoring and evaluation of PPP implementation
Capacity and Service Utilisation
Comprehensive study into capacity and utilisation of private providers (profit and non-profit)
Comprehensive study into source of capital and recurrent financing for private providers (non-profit and maybe profit)

They also called for "simple and easily understood systems for public scrutiny of budgets, disbursements and uses of health funds need to be instituted in every village, ward and district." This last point was endorsed by the Director for Local Government, PO-RALG. PO-RALG re-emphasised that NGOs should be welcomed by CHMTs as long as they have made themselves known and made their case. By law all interested parties are already entitled to request observer status at meetings of the Council.

FBOs raised the difficulty they have in accessing district/basket funding and the short-comings of the existing guidelines. There is broad consensus on the need to move beyond the existing system of grant subventions and substitute it with a service agreement arrangement which relates subvention to levels of service output. It was also clarified that FBOs are supposed to be able to access the Joint Rehabilitation Fund.

The private-for-profit (PFP) representative also commended government for the growing collaboration with PFP providers. He noted that user fees were essential to the sustainability of private providers. He called for equal treatment of PFP and FBO sub-sectors, specifically in access to wholesale drugs from MSD. He stressed that information could be obtained (on activity levels) from private providers and suggested that this be linked to regular registration/accreditation. The private for profit sector is attempting to build and consolidate its representation through APTHA. This is in the process of building its capacity, developing a new constitution, and a national secretariat. Liaison offices might also be established in 6 zones.

Local Innovations

This presentation summarised key points and policy implications from a series of presentations made at Belinda by regions, districts and FBOs. From faith-based providers, the clearest messages coming through were:

- The paucity of government subsidy in relation to actual service delivery costs
- Poor access to this funding, particularly for facilities not designated as DDH or VA
- The gap between policy and practice in the involvement of non-governmental providers in health sector planning and management; the need for greater mutual transparency and trust.
- The need to move towards a service agreement model of subsidy for non-profit providers

Also included in this presentation were experiences of contracting out ancillary services (Morogoro Regional Hospital), solar electrification of rural facilities in Songea Region, the medical equipment maintenance service being provided by FBOs, and the need for vehicle replacement.

More than half (57.4%) of the primary health care vehicle fleet exceeds the economical age of 5 years. The current procurement rate is totally inadequate to renew the vehicle stock. Although a "vehicle replacement fund" (depreciation account) has been proposed, consensus was not reached on the best modality for setting funding aside for vehicle replacement or on procurement modalities.

Umasida

This presentation show-cased the mutual health scheme catering for informal sector / self-employed people in urban areas. Participants were impressed by the scheme. It has succeeded in expanding its subscriber base through group premium payment and other flexible arrangements. By spreading financial risk across people and over time it reduces the impact of health payments. The scheme has used its "buying power" to secure improvements in prescribing habits, driving cost down and quality up. It success to date illustrates the feasibility of such a mutual / pre-payment scheme and the willingness to pay of subscribers. Participants cautioned that Umasida subscribers – while evidently low income – are nonetheless better-off than the rural poor. The MOH proposed extending this model as an urban model of the CHF, to be known as "tiba kwa kadi" – though some participants felt that successful mutual schemes can only grow through bottom-up participation.

Infrastructure Rehabilitation

The presentations focused on the new Joint Rehabilitation Fund. This has allocated T.Shs. 5.2 billion for rehabilitation in FY2004/5, of which 1.8bn had so far been disbursed in 16 councils. The funds available fall far short of the funding needed for comprehensive rehabilitation, so councils are prioritising (using multiple criteria) the top 25% of basic facilities in need of rehabilitation. Presenters noted that the functionality of rehabilitated facilities would remain sub-standard until adequate human resources are put in place to staff them. For the coming year, the scheme is expected to expand to 40 councils, with a total outlay of T.Shs 16.5 billion. Development partners stressed that they are keen for infrastructure rehabilitation to expand as quickly as possible. However, it will be important to institute spot checks on project completion and financial management. DPs

also called for a comprehensive, harmonised approach towards rehabilitation using a single set of criteria for the JRF and the domestically-funded local government capital grants. They stressed that lessons from this first phase must be incorporated into the roll-out to 40 councils. Participants also noted the importance of health facility committees and the ownership of health infrastructure by communities as essential elements in assuring ongoing maintenance. A further point raised was the need to assure that standard designs are updated to reflect the functions expected of facilities, including VCT and PMTCT.

Human Resources

The range of problems on Human Resources for Health is well known: foremost among them the chronic shortage of skilled staff, particularly in remote areas. The Director Human Resources stressed the need to move "from talk to action", noting that solving this crisis requires the joint commitment of MOF, PO-PSM, PORALG and MOH. He laid out the immediate priorities as:

1. To fill the 674 vacancies for clinical officers in 116 councils
2. To obtain permission to recruit other critical cadres
3. To steadily reduce the staffing gap through phased recruitment of 20,000 staff over five years, at a total additional payroll cost of T.Shs 26.3 billion
4. To upgrade the skills of existing cadres through in-service training; continue the upgrading of clinical assistants and MCH Aides; and strengthen the capacity of the Zonal Training Centres to achieve this. Greater use should be made of the Regional Hospitals for health worker training. Reciprocal internship arrangements between public and private training schools and facilities should be encouraged.
5. To strengthen the capacity of the HRH department at MOH in order to take this ambitious agenda forward.

Over the medium term, he set out the need to:

1. Revisit HR policies, including renegotiation of health worker remuneration scales and incentive packages for hardship posts
2. Refine the staffing norms
3. Define a medium and long-term HR plan, including the supply side (training outputs)
4. Introduce bonding ("national service") for new graduates as one measure to fill unpopular postings

All of these steps will require a strategic and longer term improvement of the basic and continuing education training capacity, greater use of private training capacity, and the concomitant improvement of health infrastructure. Also noted were the international dimensions of the HR crisis (brain drain). In plenary, participants suggested a collective approach on the brain drain problem by SADC countries.

The plenary discussion on HR issues[5] emphasised the chronic shortage and maldistribution of staff as **the number one problem faced by the health sector**. This was clearly stated by the Honourable Minister, and was echoed in formal statements by Development Partners and NGOs. The Minister, like the DPs, called for a new and more urgent approach to the problem. A Cabinet Paper on the subject was proposed as the best mechanism to secure consensus and action across the relevant arms of government – and this was subsequently adopted as one of the "milestones" for the coming year. The Director HR proposed in his presentation that the fast track recruitment and deployment

[5] Including comments on Day 1

may need to be re-centralised in MOH, at least over the short term, to make significant progress in filling vacant posts.

Other points raised in plenary included:

- Recruitment needs can be reduced if more attention is paid to retention and motivation existing staff, thus raising their productivity
- Upgrading the skills of existing staff will help to address shortages, improve capability, improve retention and staff morale.
- The brain-drain contributes to high attrition rates. Tanzania should address this problem together with other countries in the SADC region.
- Government's investment in training health workers is wasted if they do not go on to use the skills
- To take this agenda forward, the HRH Task Force should be reconvened, develop detailed action plan with clear allocation of responsibilities and adequate resources to follow through.
- Shortage of the most scarce skills could be addressed by requiring hospitals to provide outreach clinics and supervisory support
- Difficulty in attracting staff to unpopular areas is linked to "environmental" considerations, including employment for spouse, education for children, living conditions and amenities.
- Health worker pay and "hardship posting" incentives need to be tackled in the context of overall public sector pay reform (going on now)
- MOF pointed out the need to consider the supply side for human resources. Are trained staff really available to fill 20,000 posts over 5 years?
- The cost of additional health workers is small in relation to the total resource envelope, small in relation to annual budget increment, and would be money well spent in terms of health system productivity

In subsequent plenary it became clear that Ministry of Finance is not fully aware of the gravity or urgency of the problem. The Commissioner of Budget wondered whether the problem lay in cumbersome recruitment procedures rather than financial provision. He stated that if MOH and PORALG come up with the analysis of needs, cost implications and availability of unemployed skilled staff, the Ministry of Finance would be happy to look at it. The PS Ministry of Health stated that she would follow this up with MOF.

It was also proposed that, in view of the gravity of the situation, Human Resources should be selected as the focal topic for next year's Review.

Health Sector Financing

This session comprised the presentation of the MKUKUTA, key findings from the Public Expenditure Review, the outline MTEFs of Central MOH as well as PORALG and Local Government (Health), and a presentation on the coming year's budget process and ceilings.

In his presentation on the National Strategy for Growth and Reduction of Poverty (NSGRP or MKUKUTA), the Head of the Health Sector Reform Secretariat described how this links to the health sector strategy, Vision 2025, and the Millenium Development Goals. He explained the three "clusters" and the relevance of Health, particularly in Cluster 2. The MKUKUTA is a living document, which can be updated. All health sector stakeholders should be familiar with it and understand its contents. He reassured participants that the

document is fully consistent with the Health Sector Strategy and that all the major programmes and initiatives are reflected in it. However, these aspirations have major implications for human and financial resources. The health sector will not be able to attain its goals if the resource gap cannot be narrowed.

The PER shows that the current financial year (2004/5) has witnessed a sharp increase in funding for the health sector. In nominal terms there was a 33% increase (compared to 17%) the previous year. As a share of the total GOT budget, health reached 10.1% in 2004/5. This is a small increase compared to the previous year, but still falls short of the 11% achieved in 2001/2 and even further short of the 15% Abuja target. Per capita expenditure in current dollars has reached $7.42, compared to $5.41 in 2003/4.

As can be seen in Table 4 below, around 50 billion of the total increase is attributable to foreign aid not passing through the exchequer. A much bigger absolute increase (93 billion) is evident in total "on-budget" health spending, of which 52 billion is an increase in MOH Recurrent budget, and 18.5 billion for Local Government recurrent. Total on-budget development spending is up 25 billion, 15bn of the increase being at MOH and 10 for PORALG, Regions and LGAs.

At the level of the LGAs, total recurrent subvention (excluding basket funds and development) increased from 40.7 bn in 2002/3 to 46.5bn in 2003/4 and 63.6bn for the 2004/5 budget. The latter represents a nominal increase of 37%. However, the increase is much greater for the OC element (up 56%) compared to PE (up 29%).

Table 4: Change in Health Sector Spending by Composition (T.Shs. Billions)

	2002/3 actual	2003/4 actual	% change year-on-year	2004/5 budget	% change year-on-year
Recurrent					
Acc Gen's Office	5.5	10.6	93%	10.1	-5%
MOH	72.3	87.1	20%	139	60%
Regions	7.8	11.9	53%	9.7	-18%
LGAs	57.5	63.8	11%	82.3	29%
Sub-Total Recurrent	***143.1***	***173.3***	***21%***	***241***	***39%***
Developmentt					
MOH	29	41.4	43%	56.7	37%
PORALG		0.3		0.7	133%
Regions	2.5	2.7	8%	9.4	248%
LGAs	1.7	2.3	35%	5	117%
Sub-Total Development	***33.2***	***46.8***	***41%***	***71.8***	***53%***
Total on-budget	***176.4***	***220.1***	***25%***	***312.8***	***42%***
Cost-sharing	1.7	7.5	341%	7.5	0%
Other foreign	59.1	82.8	40%	132.9	61%
Total off-budget	***60.8***	***90.3***	***49%***	***140.3***	***55%***
Grand Total	**237.1**	**310.4**	**31%**	**453.2**	**46%**

Finally, the PER found that spend on "priority items"[6] within the sector has increased in nominal terms. But expressed as a share of total sector spending/budget it has slipped from 36% in FY ending 2003 and 2004 to 30% in FY2004/5 budget.

[6] This comprises the total subventions to LGAs, the preventive sub-vote of Regions, drugs for LGAs within the MOH budget, and the MOH Preventive Services sub-vote.

The subsequent presentations on preliminary budget ceilings / MTEFs for the coming year show that a further steep increase is anticipated, particularly for the central government element.

The Ministry of Health budget ceiling for next year (2005/6) is up 54% (T.Shs 105 billion) compared to the current budget year. Less than half (45 bn) of this increase is attributable to more foreign development assistance. An increase of 58 bn (up 56% compared to 2004/5) is anticipated on the GOT recurrent budget, almost all of it on "other charges". While these increases are very considerable, it should be borne in mind that MOH documented a total resource gap of 167 billion (between ceiling allocated and the resource requirements for priority activities).

Within the MOH Recurrent budget, the biggest increases are for the sub-votes of Department of Hospital Services (up 23bn to 76.5bn), Chief Medical Officer (up 18bn to 25 billion) and Department of Preventive Services (up 47 billion to 60 billion).

For ease of interpretation and to provide a preliminary "sector-wide" view, the figures presented for MOH, PORALG and Local Government are set against those of FY2004/5 budget in Table 5 below. Comparator figures for 2004/5 Local Government have been extracted from the PER.

Table 5: Preliminary Allocations for FY2005/6 vs Budget FY2004/5

	Budget 2004/5	Indicative 2005/6	Nominal increase	% change
Ministry of Health				
Personal Emoluments	5.9	6	0.1	1%
Other Charges	98.5	156.7	58.2	59%
Total GOT Recurrent	104.5	162.7	58.3	56%
Domestic Dev't	3.6	5	1.4	41%
Foreign Dev't	87.7	133[7]	45.4	52%
Total Development	91.2	138	46.8	51%
Total MOH	***195.7***	***300.8***	***105.1***	***54%***
PORALG & Local Govt				
LGA Recurrent (GOT)	*63.6*	70.5	6.9	10%
Council Basket Recurrent	*18.7*	19.6	0.9	5%
Basket Rehabilitation	*5.2*	18.6	13.4	72%
PO-RALG Basket	n/a	0.1	n/a	n/a
RHMT Basket	n/a	0.4	n/a	n/a
Total PORALG, Regions, LGAs[8]	***87.5***	***109.2***	***21.2***	***19%***

As the table shows, the increases anticipated in health sector spending next year are much bigger for Central MOH than for the Local Government level. Domestically-funded recurrent budget for MOH is expected to increase by 56%, while the GOT recurrent subventions to councils will increase by 10% and the council basket by 5%

The major change for the local government component is the significant increase in funds allocated for rehabilitation under the Basket. In another new departure, basket funds have

[7] Note: This 133bn Central Foreign-Development includes 46 billion Basket fund, of which 35+ billion is actually going to the councils. Adjusting for this, the foreign development component in the MOH ceiling would come down from 133 to around 98bn.

[8] NB: excludes Regions GOT budget for health and LGA GOT budget for development

been allocated to PORALG and to the Regions to help monitor comprehensive council health planning and to facilitate and monitor the joint rehabilitation fund.

The Commissioner of Budget, Ministry of Finance put all of this in wider perspective, describing the key changes in the budget process with the introduction of the MKUKUTA. Unlike previous years, when priority *sectors* received preference, the new emphasis is on MKUKUTA priority *outcomes.* This is illustrated by the preference allocated by MOF to MKUKUTA priorities in the MOH's resource bid.

Table 6: MOH Resource Bid vs Ceiling Allocated (T.Shs. Millions)

	Resource Bid	Ceiling Allocated	Ceiling as % Bid
NSGRP items	344,945	262,762	76%
Non-NSGRP items	10,832	3,274	30%
Total	**344,945**	**266,036**	**77%**

The new "Strategic Budget Allocation System" (SBAS) is expected to:

- enhance outcome-orientation
- ensure consistency between policy and budget
- standardise inputs for the budget guidelines
- improve transparency to stakeholders (matching allocations vs priorities)
- track NSGRP goals, targets and MDA allocations

In plenary a number of comments were made on the impact of ARV funding on the sector. The increase in funding for ARVs was welcomed. But the key concern was whether this was displacing funding for other health priorities. Participants wanted to know how much of the increase in the new budget is attributable to care and treatment, and whether the drugs budget for non-ARVs has increased. DPs suggested that funding for ARVs be considered separately from MOH's budget ceiling for other health priorities in order to assure additionality. But MOF made clear that it makes no difference where – in the overall resource envelope – ARVs are budgeted. The Commissioner of Budget emphasised that the new budget system allocates resources to MKUKUTA priorities, not simply to sectors. The resource gap is not peculiar to Health. Indeed Health has done well this year in relation to other sectors. He stressed the need for sectors to prioritise the allocation of scarce resources within the sector.

These concerns were mirrored in a wider discussion on the growing commitments associated with scaling up essential health interventions. Noting the massive future funding requirements of AIDS care and treatment, combination therapy for malaria and new vaccines, the CMO posed the question, "What should I do?" He noted that in many cases, new activities are supported by donors for only two or three years, after which government was expected to carry an "impossible" burden of costs. A growing proportion of new money coming into the sector is tightly earmarked, meaning that there is a much smaller increase in discretionary, flexible resources.

Turning to the allocation of resources within the sector, it was noted that the steep increases in non-personnel budgets are not being matched by the personal emoluments budget. The result is more money for the health system, but not the staff to run it. The sentiment was also expressed that health expenditure is still too centralised – and the central component is growing faster than local government health resources (domestic and basket). The stronger financial management environment at council level means that more of the centrally held money, including drugs budgets, could be devolved. Linked to this

was the need to have more transparent criteria for the allocation of the drugs budget. The meeting concluded, though, that the drugs budget will need to remain with MOH for the time being.

The session on financing wound up noting that in spite of the major funding increases this year and next, a major resource gap exists. MOH appealed to both MOF and DPs to increase further the funding for the sector.

Milestones

The final day was devoted to a discussion on milestones. The PS MOH opened the session saying that these must be specific "deliverables" which the MOH (and other health sector stakeholders) must be committed to achieving since performance will be judged on them next year.

This was a difficult session to chair, since only a very preliminary list of topic areas was presented for debate. A variety of suggestions were made to elaborate on this and to arrive at specific milestones for the year ahead. Written submissions to the Secretariat were made by various stakeholders to propose milestones.

While consensus began to emerge on some of the topics, it was recognised that the milestones need to be kept to a manageable number. The Technical Committee was tasked with further refining the milestones based on the priorities which emerged from discussion. The final outcome of these deliberations is reproduced below in Table 7.

Closing

In her closing remarks, the spokesperson for the Development Partners thanked all parties for making the sixth annual health sector review a success. She congratulated government on the progress that has been made over the past 5 years, emphasising the importance of a solid partnership and strong government leadership. Noting the trend towards direct budget support, she noted the implications for securing an increasing share of GOT budgetary resources and reiterated the need to maintain strong sector dialogue.

For their part, the NGOs assured the meeting of their renewed passion and commitment, thanking the government for making the space for active NGO participation. The spokesman assured the meeting of a commitment by NGOs to work in partnership, and their commitment to promoting equity.

The PS from Ministry of Health Zanzibar thanked the organisers for their invitation, saying that the delegation had learned a lot. Similar reforms, albeit at an earlier stage, are ongoing in Zanzibar and Development Partners were welcomed to play their part.

The PS MOH formally closed the meeting, thanking all for their active participation and looking forward to a further year of work in partnership.

Table 7: Milestones 2005-2006

S.No.	Milestones	Responsible
1	**Public Private Partnership**	
1.1	Service Agreement governing subsidy to non-profit providers concluded by Sept 2005, process of implementation started and included in MTEF FY 2006/7	MOH, PORALG, CSSC
1.2	Technical Working group on PPP established by June 2005; develop and implement work plan to take forward recommendations of PPP Technical Report	MOH
2	**Health Sector Financing**	
2.1	High level meeting of MOH and MOF to review PER and Health MTEF, and agree a medium term funding strategy for the health sector in the context of MKUKUTA	PS-MOH
3	**Human Resources**	
3.1	To secure top-level commitment, submit Cabinet Paper setting out the urgency and severity of the problem, the proposed solutions, the financial implications and the obstacles to be overcome	PS-MOH
3.2	Plan of action for "quick wins" developed and implementation started by June 2005	DHR-MOH
3.3	Approved health care worker vacancies in all councils are filled through a fast-track approach, with assistance from PORALG and MOH	Director Local Govt.-PORALG
4	**Maternal and Child Health**	
4.1	Finalise by August 2005 roadmap for reducing maternal mortality with defined indicators that are measured and monitored annually. Priority actions are fully integrated into MOH MTEF and council comprehensive health plans FY2006/7	DPS
4.2	Revision of TBA policy finalised and disseminated by March 2006.	DPS
4.3	Strategy for rapidly accelerating progress in reducing under-five mortality is agreed following June and October meetings of the MCH partnership	DPS
5	**HIV and AIDS**	
5.1	Full implementation of Health Sector HIV/AIDS Strategy, with particular emphasis on prevention aspects, including a secure condom supply. Progress on this reported at next Review	CMO
5.2	Monitoring system including ARV logistics and security developed and put in place	CMO
6	**Sector Performance Monitoring**	
6.1	Update and interpret health sector performance profile matrix to include all 2004 and 2005 data by March 2006 and present at next Review.	Ag. DPP
6.2	Publish and disseminate health statistics abstract 2003 by July 2005 and HAS 2004 by March 2006	Ag. DPP
7	**Regional Health Teams**	
7.1	Comprehensive restructuring of Regional Secretariat, including Regional Health Team, agreed FY2005/6, outcome presented at next Review, and implemented in FY2006/7	Director LG, PORALG

Annexes

ANNEX 1:

Opening Address By Hon. Anna M. Abdallah (MP) Minister Of Health

The Permanent Secretary, Ministry of Health,
Permanent Secretary, President's Office, *Regional Administration and Local Government,*
Distinguished Representatives of Development Partner Agencies,
Representative of the Union the Government Ministries,
Representatives of the Government of Zanzibar,
Representatives of Private Partner Agencies,
National Consultants and International Consultants,
Invited guests,
Ladies and gentlemen,

On behalf of the Government and people of Tanzania I would like to take this opportunity to formally welcome you all distinguished participants to this important forum. To those coming from outside Tanzania, I wish to extend to you a warm *KARIBU SANA* and to all others known to us I say *KARIBUNI TENA.*

As we embark into this very important exercise of looking back after another similar joint and very transparent review conducted last year, we need to congratulate ourselves on the progress made in implementing health sector strategic plan in the context of Sector Wide Approaches.

Ladies and gentlemen,
If we had the ability to play back the "reform tape" depicting what the situation was five years ago, I do not think there would be anyone in this room who will deny the fact that a substantial change, for the better, has been achieved by the health sector in Tanzania. In that context I feel most honored and privileged to be the Minister for Health and therefore I am pleased to be associated with this progress.

My colleagues in the region, whom I have had contacts with, often ask me how, we have managed to continually improve health care service coverage and accessibility despite the immense obstacles we face. I am also frequently asked how we have managed to have such cordial working relationships with our development partners in our sector. How are we managing to strengthen ownership of the services to communities through initiatives that include health financing options?

My very frank responses to all these questions and comments has been PATIENCE, OPENESS IN OUR PARTNER RELATIONSHIPS, TAKING RISKS, AND THE WILLINGNESS TO CHANGE BY ALL THE HEALTH SECTOR STAKEHOLDERS. WE HAVE BEEN TRUSTED AND WE ALSO MUST TRUST OTHERS. THESE ARE IMPORTANT PRE REQUISITES IF ANY REFORMS ARE TO SUCCEED OR BE SUSTAINED.

I do not know how many of us in this room know the health reforms that have given yield to these positive results and how we access our consumers' appreciation. To mention a few simples methods to measure our successes are:

(i) through appreciation messages receive from the public.

(ii) the declining number of complaints in the media regarding health services in this country and;

(iii) in my position, as Minister of Health for the last four years I answer fewer questions in Parliament regarding drug shortages, corruption and other problems of the sector, than before.

(iv) Latest figures from the Prevention of Corruption Beaurau (PCB) from various regions also indicate complaints of corruption being directed to the health sector have gone down, and;

(v) People's voice concerning the performance of the health sector is being articulated through their committees.

Interestingly for the first time there is a trend by the people to prefer public to private and NGO health facilities for their health care probably indicating more satisfaction due to improving quality of services signaled by more reliable drug supplies and more competent and skilled health workers. This also goes for the movement of staff from private to public facilities.

This trend was noticed way back in 1996 when CHF was being pre tested in Igunga District, and later piloted in 10 other districts. This shows that the complementary financing options introduced are working and serving consumers the way they perceive, and the quality of the services being provided by public facilities.

However, the experience has not been all along smooth. We have encountered short falls and pot holes along the way but a lot of water has flowed under the bridge. Based on our vast experience, we can confidently advise others on THE DO's and DON'T's of partnerships for reforming health sectors or other sectors for that matter.

I am proud to inform this gathering that because of the experience we have gained, various officials from my ministry are engaged in providing guidance and other forms of support to the Ministries of Education and Agriculture on the mainland and Ministry of Health in Zanzibar on their own reforms. We are frequently visited by officers from other Ministries and Zanzibar, and from as far as Nigeria, Malawi and Kenya.

With regards to the progress achieved, there are available reports and studies indicating, among many other things, the following achievements. These include but not limited to:

- High immunization coverage
- High antenatal care coverage
- Dropping Total Fertility Rate
- Sharp reduction in child mortality in some districts and regions
- High TB detection and treatment completion rates,
- Good geographical access to basic health services
- Progressive upward trend in health care financing
- Progressive improvements in quality of health infrastructure network
- Overall improvements in availability of drug and other medical supplies

Nevertheless, there are still some challenges we are facing; the health human resource situation remains a crisis. This is made worse by the HIV/AIDS epidemic. Also despite the existence of an extensive health infrastructure network, our success in improving functional accessibility of health services is being constrained by staffing levels in the health facilities.

Births taking place at public health facilities still remain lower compared to those taking place at homes. However the Traditional Birth Attendants (TBA) policy guidelines encourage safe pregnancies, to be supported by TBAs to deliver at home. We may need to revisit this approach.

Ladies and gentlemen,
Looking back at the commendable achievements in the health arena in Tanzania that I had made reference to earlier, they have to be viewed in the context of the relatively low expenditure on health compared to other countries in the region undergoing similar reforms.

While Tanzania is spending a meager US $ 6 per capita for these results, other countries in sub Saharan Africa are said to be spending about US $ 12 per capita or above (DFID 2005).

These successes would not have been achieved if there were no increased efficiency, effectiveness, harmony, commitment, and consistency within the government and the Ministry of Health on one side and likewise within the development partners group and the private sector on the other hand.

Our Sector Wide Approach (SWAP) modalities of successfully conducting jointly agreed interventions, year after year, for the benefit of the health sector is actually a model for our peers in other countries to learn.

Ladies and gentlemen,
This is not a minor achievement and let us all give ourselves a very big clap. I thank you all for this vision and wonderful partnership.

Ladies and gentlemen,
Turning to the theme for this year's review, I am happy that it was jointly agreed to focus on the important area of Public Private Partnership. This was articulated in the Proposals for Health Sector Reforms in 1994, as Strategy 7 in the Programme of Work of the 1st Health Sector Strategic Plan and subsequently, in the review of the National Health Policy in 2002 and presently in the second Health Sector Strategic Plan.

Experience shows that for a country like Tanzania, that at one stage of its development had instituted restrictions on private for profit health providers, the decision by the government to bring them back in 1991 into the mainstream, as collaborators rather than competitors, did arouse fear and mistrust from the private sector. Frankly speaking the government at the time had also little experience to work collaboratively with the private sector.

I am glad to say that this fear and mistrust is slowly being allayed, thus paving the way for the new relations under Public Private Partnership.

Ladies and gentlemen,
The private health sector for profit in this country is significant and gaining prominence, particularly in the urban areas. (In my own personal view there is no private health facility for profit in this country. I have not seen any private health facility for profit nor its owner getting rich). The voluntary health sector, which is a

part of the private sector, though not purely, since it receives subversions from government, is also large and provides health care services to nearly half of the Tanzanian population, especially in rural areas.

I take note of all these commendable achievements and congratulate all our partners in health service delivery for the good work and effort they are investing in health care of the people of this country.

The private sector therefore, is a vital component of Tanzania's health care system, and requires the due attention and support it deserves. The element of mistrust, where it still exists, has to be eliminated, and I should insist here, that it should be eliminated as quickly as it is possible, for the benefit of the people of Tanzania.

Records show that private health care was already in place in Tanzania since 1898, with some form of user fees. To date we have numerous private health facilities, all charging user fees of various types.

In 1993 the government shared some experiences on health financing with the private not for profit providers and introduced cost sharing, followed by Community Health Financing in 1996 and finally the National Health Insurance Fund in 1999. We value the inputs we received from the private sector towards enhancing health financing options.

As I make this appeal for the required partnership and collaboration between the public and private health providers, I would also like to re iterate the important role of the government, and specifically the Ministry of Health, in regard to policy, leadership and standards setting for quality assurance.

Increased recognition of the private health sector is not synonymous with government abdication of its responsibilities. We will strengthen supervision, legislation, regulation and inspection to further the sense of accountability and quality by all providers.

In this context, the role of Local Government Authorities, under whose's areas' of jurisdiction most of the basic health care services are being provided, their responsibility to ensure adherence to quality of health services cannot be over emphasized.

It is my sincere hope that the report of the technical review that preceded this main review forum will assist this meeting to take note and propose action on the issues raised and to help us chart a more constructive way forward in the area of Public Private Partnership which will be more effective and productive.

Ladies and gentlemen,

The way forward should be based on a foundation of trust, partnership, transparency on both sides, and respect of law and order, as this will enhance the welfare of our clients. The district level, where the majority of the people get their health services, should always be the focus of our attention in all our joint reviews.

We need to know, on a continuous basis, how the services are being delivered, whether they are accessible and the level of satisfaction of the ordinary citizens. We also need to track the satisfaction of the providers of these services. Providers are an important

element to the service equation and should not be taken for granted especially under the present climate of health human resource crisis.

Ladies and gentlemen,
At this juncture I would like to take the opportunity to turn to another important area that will warrant our joint attention. I say "joint" because that has been, and will continue to be so in the foreseeable future, our way of addressing problems of the health sector. When the reforms were initiated, one of the problem areas identified to be addressed was the financing gap and related to it was, and still is, the issue of ownership of health facilities and services by the users.

Concern had been raised about the lack of voice from the communities on matters pertaining to quantity and quality of health services being provided. The services were seen and believed to belong to the government and other providers.

To address these important issues, policy changes were instituted; among others they include the introduction of cost sharing. Within this new approach other complementary financing modalities in the form of Community Health Financing (CHF), National Health Insurance Fund (NHIF), and Drug Revolving Funds (DRF) are under implementation. These actions taken by government in health financing policy are bearing fruit. The quality of services has improved. Let me make it clear that cost sharing, or for that matter user fees, do not mean cost recovery. As I said earlier, the objective of cost sharing is not primarily to collect funds from the users. It is mainly to give them voice in health care, ownership in the form of share holding and instill a sense of accountability on the part of the service providers to the communities they serve. Transparency leads to prevention of corrupt practices and is a move to enhance good governance.

Cost sharing was, and still is, a means to give voice to the users of services and not intended to fully fill the funding gap in the sector. After all, the amounts in revenue collected usually do not exceed more than 15% of the total government budget; but with these token amounts contributed, the clients feel empowered to speak out as and when required to do so.

We have visited other countries with similar programs like Thailand and the Philippines. Their collections are within the range of 10 – 20% and their programs are viable. The Hydom Lutheran Hospital is collecting approximately 27% of their budget through user fees (I understand they have a presentation at this meeting). The other VA services collect even more.

Ladies and gentlemen,
It has to be said that most of these highly successful innovations are home grown. We appreciate the recommendations of the Commission on Macroeconomic and Health (CMH) and Millennium Project with regards to financing health services in developing countries. However in my personal view, the ongoing moves, initiated by certain quarters within the development partner groups, and presently outside the health sector, to abolish cost sharing is not appropriate, especially when the sector itself and its major stakeholders are sidelined. We think that each constraint should be looked at in its context.

There is no room for ready made prescriptions, as was done in the past, often times with no success. Let us enhance our partnership through mutual respect, trust and support for government initiatives.

The ongoing contrary moves to abolish cost sharing are simply against the principles of encouraging home grown solutions to our problems. If they were to succeed they will have massive negative implications on the continued existence of Community Health Fund (CHF), National Health Insurance Fund (NHIF) and Drug Revolving Fund (DRF) as all of them are interdependent.

These initiatives have proved to be working, in this country. They have been designed by ourselves to suit our context at great financial cost. A policy change to remove user-fees in government health facilities will amount to substantial cost increase to the government. Moreover it will also be a loss to whatever gains we have made. The question to ask ourselves is, IS THIS SUSTAINABLE? HOW CAN WE IMPROVE? CAN THE HEALTH SECTOR RELY ON HAND OUTS FOR EVER?

We need to revisit the principle that poor nations have to participate fully in their development programmes and own those programmes. They should not be taken as objects of charity. (The Shanghai forum of leaders in June 2004). President Mkapa also addressed this forum with similar pronouncements.

Having come this far and having bitterly learnt the lesson that "FREE HEALTH SERVICES EQUALS TO NO SERVICES", moves to abolish CHF and the like, literally aim at crippling the health sector and ultimately turning the needy population to objects of charity. This is certainly not acceptable.

Ladies and gentlemen,
This forum has to have a common stand to protect successful local initiatives from international generic agendas, which disregard local circumstances and peculiarities. Abolition of cost sharing will effectively silence the communities from speaking up when required to. We would appreciate assistance that will consolidate our success in this area of cost sharing initiatives at the same time eliminate deficiencies rather than suggesting new initiatives which we have tried before and we know their results.

This move will also rock the two boats that also keep afloat the Faith Based Organization providers and the private for profit providers. It is then obvious that the change of health financing policy will also affect negatively our private/public partnership.

Faith Based providers and the private sector are also beneficiaries of the Community Health Fund (CHF), National Health Insurance Fund (NHIF) and Drug Revolving Fund (DRF) as these are sources for service agreements and service contracts to the private sector as well. Our analysis showed the only difference between the Fourth Based Organization (FBO)'s services and that of the public facilities was; one was charging fees and the latter was not. To be equitable the token fees' in public services are very essential.

Ladies and gentlemen,
The big question I ask is, whoever is pushing this agenda for free health services for whatever reason, will she/he offset the huge gap that will result in the government

budget, for it to be able to provide quality free services in a sustainable manner to all Tanzanians? and for how long can this support be guaranteed?

Or will it be for a few years, under the guise of support towards "poverty reduction" and then after it becomes another disastrous decision, we will be required, as a government, to make another U-turn in our policies?

The challenge is also for the private providers – are you ready to provide free health care or will you have to close your doors? I would like to make an appeal to our development partners to continue cooperating with us based on the premises of openness.

There are no generic solutions to all our problems; and sectors like education, though related, are not alike. Even in the education sector where today there are no fees being charged for primary education, parents continue to contribute in many other ways. For the rural water services the committees of the poor have taken over from the government and are Cost Sharing. Even in Malaria Control through "Hati punguzo" (the voucher system) the mothers are Cost-sharing the Nets.

The so called English medium schools that of recent have mushroomed in our society have come in for the better off children and are establishing a two tier system.

Constant changes with disregard to existing successes, stalls the process of development itself, instead of hastening it. I have always believed that cost sharing, with its related initiatives like Community Health Fund (CHF), National Health Insurance Fund (NHIF) and Drug Revolving Fund (DRF), has been a step forward as they ensure self reliance and sustainability to our systems. I still hold on to that view now.

Today the hoarding of drugs by households due to fear of shortages at the time of need is a thing of the past. Most important they give recognition to the contributors and the users of the services, giving them the power to speak out about what is provided and making the providers more accountable to the users. Making services free will only increase dependency of the people on their government, a stage of development I thought is well behind us.

Under the current exemption arrangements, the most vulnerable groups in our society, children under five, pregnant women, the poor and the elderly, and patients with diseases of public health importance like outbreaks, TB and leprosy; HIV/AIDS are all exempted from paying. Exemptions also include preventive interventions like immunizations, maternal care during pregnancy and after delivery, and family planning services. In short the government is financing the essential health package through budgetary provision.

There has always been misconception on the implementation of exemptions in cost sharing policy. The exemptions can be categorized into two major groups; one is meant for a range of services, groups or individuals and particular diseases; second is for those who cannot afford to pay. Failure of exemptions has always been looked at those who cannot afford to pay and not the first type of exemption, which has faired very well.

However, if we feel the exemption mechanisms are not working, then let us address that specific area and find more workable measures to protect the weakest amongst us and ensure that they, like all their fellow citizens have access to similar health care at the time of need.

Abolishing cost sharing and making people fully dependent on their government will only suppress initiatives, strengthen inertia among our people and breed further corruption among the "silenced".

Ladies and gentlemen,
Last year the issue of the health human resource crisis in our sector was deliberated. In the course of the discussions, concern was raised about the lack of sufficiently urgent and strong actions that were required to be taken, jointly by the stakeholders, worthy of the seriousness of the situation.

I would like to appeal to this most distinguished forum to seriously review whether since last year there has made any progress to address this crucial deficient area. So much depends on having the required skilled human resource in the correct numbers, skills mix for the facilities where they are required.

Continuing to just talk about the situation without resolving it with the seriousness it deserves will only undermine all the achievement we have jointly scored over the years. We need actions and not more reports and resolutions. The present bottlenecks to ensuring staffing of all the existing facilities simply have to be tackled now, not tomorrow! I am calling on our partners to help us in this area.

Ladies and gentlemen,
I would now like to say a few words on the problem of HIV/AIDS, Malaria and TB, a group of diseases set to be massively funded under the Global Fund and other international initiatives. While we appreciate the immense support being provided, caution has to taken not to derail the ongoing efforts of the Ministry and its development partners in the sector to address the sector in its entirety as this makes the health system functional. Health system must be holistic as the National Strategy for Growth and Reduction of Poverty (MKUKUTA).

A district that is functional is the key to our functional health delivery system and no vertical program initiatives, be it local or international, should be permitted to divert from this premise; modalities different from those of the government are neither workable nor sustainable. We ask you to support us to move forward instead of pushing us forward.

In conclusion, it is my sincere hope that this meeting will be another successful milestone in our joint efforts to address the challenges facing the health sector in Tanzania. It is also the expectation of my Ministry that the focus this year on the area of Public Private Partnership will effectively cover the gaps in our knowledge to complete the equation of quality health service provision especially at the district level. Do not spend too much energy on the process, as MKUKUTA is outcome oriented.

Once again let me say with confidence that we should all be proud of our joint achievements so far and I personally feel honored and privileged to be the Minister for

Health when some of these successful changes were being affected as part of the on going reforms of the health sector.

There is still a lot of ground to cover and we should therefore guard these achievements with all the power we can muster and agree not to be swayed from our chosen path.

With these remarks, I now have the honor and privilege to declare this year's Annual Joint Health Sector Review meeting formally open.

Thank you all for your kind attention.

ANNEX 2: List of Resource Documents and Presentations

Resource Documents

1. Joint Technical Preparatory Meeting, 15-17 March 2005, Belinda Hotel. Final Record of Technical Review Proceedings.
2. Progress against the milestones set in March 2004. Final Version 2 April 2005
3. Health Sector Performance Profile in Tanzania for the Year 2004. Draft Report Version 1.2. Ministry of Health, 1st April 2005
4. Strengthening of Health Information Systems in Tanzania. Implementation level of recommendations agreed by high level decision-makers from MOH and PORALG conducted at the Golden Tulip Hotel on 3rd September as per 30th March 2005. Ministry of Health.
5. Assessing trends in the overall performance of the health sector in Tanzania. The use of sector performance indicators from 10 selected districts. Final Report, January 2005. E. A. Makundi et al.
6. Review of the State of Health in Tanzania 2004. Unapproved Draft, 27th March 2005. N. Lorenz and C Mpemba, on behalf of MOH, PORALG and GOT.
7. Technical Review 2005. Public Private Partnership for equitable provision of quality health services. Final Draft, March 2005. HERA, on behalf of MOH, PORALG and GOT
8. [Summary] Recommendations from Technical Review (PPP) and Response from the Government. 3rd April 2005
9. Summary Presentation of Experiences and District Innovations – Key Points for policy debate. Ministry of Health.
10. The UMASIDA Mutual Health Care Scheme. A case study of an urban-based community health fund. March 2005. A.D. Kiwara, IDS, Muhimbili
11. Health system assessment of Mara, Mtwara and Tabora. Phase 1 Report (Vol 1-2). First Health Rehabilitation Project. Ministry of Health. 30th September 2004.
12. Health Sector PER update FY 2005, MOH. Zero draft, 10th March 2005
13. Issues Paper. DPG Health Preparatory Meeting for the Joint Health Sector Review
14. NGO Statement Joint Health Sector Review 2005 (1): Promoting effective partnerships in health
15. NGO Statement Joint Health Sector Review 2005 (2): Maternal and Child Health

Presentations

1. Opening Speech, Honourable Minister of Health, Anna Abdalla
2. Address by Dr G L Upunda
3. Progress against the milestones set in 2004. Dr F. Njau
4. Priority Health Outcomes and Programmes: Summary of Key Points from Technical Review. Ms. A. Nswilla
5. Health Sector Performance Measurement and Monitoring. Mr J.J. Rubona
6. 2004 State of Health in Tanzania. C. Mpemba.
7. Technical Review 2005: PPP for equitable provision of quality health services. Mr L. Deville
8. Urban Based Community Health Funds. A Case Study of Umasida Mutual Health Scheme. Prof. A.D. Kiwara
9. Experiences and Innovations: Key Points for Policy Debate. Mr J Kelya

10. Rehabilitation of Health Facilities. Mr A Sayile
11. Human Resources for Health. Dr G. R. Mliga
12. Public Expenditure Review for Health Sector 2005. Mr R Mkumbo
13. Preparation of the Budget Guidelines for 2005/6-2007/8. Mr N. Magambo, Commissioner of Budget, Ministry of Finance
14. Updates on the NSGRP. The MKUKUTA: what it contains and linkages to MDGs. Dr F. Njau
15. MOH MTEF for 2005/2006 in relation to MKUKUTA. Ms R.L. Kikuli
16. PORALG MTEF 2005/06: Support to the Health Sector. Mr M.W.F. Maganga

Tanzania Joint Health Sector Review 2005
Terms of Reference

Introduction

Every year a joint review is undertaken of health sector progress, constraints and future priorities. This process is lead by Ministry of Health and PORALG, with close collaboration of other parts of government, development partners, other health sector stakeholders and civil society. This year's Review marks the second year of implementation of the new Health Sector Strategic Plan taking into cognition changing conditions and new challenges facing SWAPs in the health sector such as shifting from health sector funding to general budget support global funds targeting selected vertical programmes or selected diseases which if not applied correctly may derail the gains attained so far at district level through development of comprehensive Council Health Plan and targeting of resources to priority interventions and disease burden in the district.

The review will be carried out taking into cognition new set of national strategy for growth and poverty reduction with Three cluster broad outcomes and goals under which health is clustered under cluster 2 dealing with Improvement of Quality of Life and Social Well Being.

The specific area of this years review will be to carry out a Technical Review on Public Private Partnerships the findings of which will be one of the agenda items of the main review.

A Technical review team comprising of (two) international consultant and two local consultants will undertake technical review in January 2005. Specific TOR for technical review will guide their work. Other areas to be discussed during main review are:

- Receive and comment on draft MOH- MTEF covering the period July 2005 to June 2006
- Assessment of progress made against milestones set in March 2004
- Review findings of study on 10 districts as relates to complete data set for HMIS related Sector Performance Indicators
- Review of State of Health in Tanzania Report
- Study Report on the 3 regions (Mtwara, Mara and Tabora)
- Receive, comment and make recommendations on way forward as regards report on update on addressing HR crises
- Discuss specific report on fighting HIV/AIDS
- Review Health Sector PER report for 2005

The process of the Review will proceed as follows:

- ❖ Discussion and agreement among stakeholders on the terms of reference, timing and organization of the Review Process
- ❖ Assembly of relevant documentation and reports, including further analysis where necessary
- ❖ Commissioning of Technical Review study/report on Public Private Partnership and deliberation on the findings and recommendations.
- ❖ Policy Review, comprising all health sector stakeholders, where all conclusions and recommendations are tabled for discussion and consensus is reached on conclusions and priority actions for the year ahead (FY 2005/6).

The final Report of the Health Sector Annual Review will comprise the proceedings of the meeting, an agreed set of "milestones" for the year ahead, and a "side agreement" with Basket Fund contributors setting out mutual obligations and commitments (including financial commitments).

Objectives

1. Share information on developments, achievements and intentions in key areas of health sector strategy:
    a. Progress against prior year milestones
    b. Implementation of the Health Sector Strategic Plan 2003/2008. using routine annual and semi-annual reports submitted by MOH to Ministry of Finance
    c. Budget execution on approved budget; actual disbursements of the budget and actual expenditure against disbursements and releases
    d. Service delivery performance (health sector performance profile, Poverty and Human Report, HMIS/routine data system, and other sources of service delivery performance which may be available)
2. Receive, deliberate on the findings of the PPP technical review and identify pertinent issues and actions
3. Review resource allocation and management; specifically the findings of the Public Expenditure Review, the health sector expenditures, and proposed allocation of resources (draft MTEF) covering the period July 2005 to June 2006.
4. Review implications of changing conditions and challenges on SWAPS brought arising due to new PRS II as relates to change in strategy from sector priorities to clustering of broad outcomes and goals taking into account that some targets/outcomes are multisectoral and are better financed through budget support and including challenges brought about by global funding mechanisms that are targeting selected diseases.
5. Ask the PRS Secretariat to present a paper that will elaborate more on cluster 2 dealing with improvement of quality of life and social well being and to get clarity on some of the statements contained in this cluster of new PRS II under health e.g. "that the government will therefore increase financial, human and technical resources in the health sector to target the needs of under served populations, including the vulnerable groups and that The strategic plan for the health sector 2003-2008 will be implemented fully" then make some conclusions and way forward
6. Receive progress from Human Resources Working Group on steps taken by the two ministries (MOH and PORALG) to urgently address the human resources crisis in the health sector the way crises are supposed to be handled. The report will take into account recommendations arising from the last SWAPs meeting that was held on 23rd of September 2004
7. Receive summary reports on findings and recommendations emanating from the Joint Government Donor Review of the LGRP of October 2004, Joint evaluation of General Budget Support in Tanzania, Joint Government Partners evaluation of the health sector in Tanzania, and identify some relevant if any lessons that can feed into Policy and Strategy development of the sector
8. Receive and discuss summaries and issue papers from the technical meeting analysing important experiences from projects and programmes and results from recent studies[9]
9. Determine and formulate milestones for FY2005/6.

Linkages

As in previous years, the Joint Annual Health Sector Review will seek to harmonise its work with related government processes, specifically:

- The new HSPS II especially operational modalities and financing mechanisms
- The routine narrative and financial reporting on progress and expenditures against disbursed funds

[9] as e.g.: study report of 10 districts with complete data set for HMIS, 3 regions health study report, implications of Tanzania's Mortality burden summary report AMMP, fixing health systems TEHIP experiences, , receive report on ECD-HIV/AIDS sector review study, Nutrition study and study on the Kibaha and Kilosa Insecticide Treated Nets discount Voucher schemes

- ❖ The Public Expenditure Report, National Audit reports, Budget Guidelines and Medium Term Expenditure Framework.
- ❖ Public Service reforms and Local Government Reforms

Similarly, the conclusions and recommendations of the Joint Annual Health Sector Review should be widely disseminated and should feed in to discussions on health sector progress and resource bid (MOF, Social Services Budget Committee, Parliament), and the interface between the Health Sector strategies with the crosscutting reforms.

Lessons from last year's Review

Last main review preparations by the government and partners was excellent. The main review was well attended and documents to be tabled at the main review were received well in advance. There was also good and active representation from both the Districts and Regions. The lessons learned last year should be borne in mind for the coming Review:

- ❖ The Presentations from 4 DMO enriched discussion of the main review, this will be continued this year with presentation by 3 districts presentation focusing on service delivery[10] and 3 other districts will make presentations focusing on the main theme Private Public Partnership (PPP)
- ❖ Despite the setting up of taskforces on human resources and financing there was little progress made to meet expectations of the main review in these areas.
- ❖ Conveners of taskforces should ensure that they meet regularly and deliver according to their TOR
- ❖ There was active participation of the management team of MOH, PORALG and other government ministries representatives although the Hon Minister of Health was not able to attend the last review; it is the wish of the review members that efforts be made to make it possible for the minister to attend.
- ❖ Good forward planning, preparation and time management is essential
- ❖ The Technical committee should again appoint a Facilitator to assist MOH HSRS to coordinate the process of Review, synthesis of comments and drafting of reports (Technical and Main sessions).
- ❖ Again keep to a minimum the number of recommendations and milestones and allocate adequate time between Technical Review and Main Review so that MOH/GOT and partners have enough time to deliberate on recommendations, milestones and prepare adequately for Main Policy Review
- ❖ Secure formal agreement with Basket Partners on a limited number of specific commitments (milestones).
- ❖ Since PER Sector Working Group will not need clearance of the PER document with MOF the PER should therefore ensure that the document is made available in time before the review
- ❖ Assure full participation of PORALG and other vital stakeholders by ensuring that intended dates/venue are communicated as early as possible and official invitations are issued.
- ❖ Participation of all RMOs and a selected number of DMOs is essential.

Process and Preparation

The MOH HSR Secretariat will take overall responsibility for the planning, preparation and co-ordination of the Review and will draw upon other Government personnel, funding partners and consultants as necessary. During the Technical Review and Main Review the HSR Secretariat will be assisted by a facilitator appointed by the Technical Committee for the SWAP committees who will be responsible for collaborating with the HSR Secretariat to facilitate the Review, assist in the collation of technical reports

[10] 10 minutes not more than 10 slides

and recommendations, assist in the drafting of the final Review report, and provide a liaison point for Partners

Relevant GOT personnel relating to the full range of HSR strategies / Departments will form working groups (distinct from the Technical Groups) to undertake the preparatory work necessary for reporting on implementation, progress against milestones and other key documentation.

Deliverable

The final output of the whole Review Process will be a Main Report, which captures the proceedings of the Review, conclusions reached and milestones agreed for the year ahead and the Basket Partner/GOT side agreement. This Main Report will be supported by the report of the Technical Review, together with other documents tabled for discussion at the Review.

Timing

The Technical Review work will be carried out from Mid January 2005 and completed by first week of February so that the report can be finalized and discussed during the 2nd week of February. Other documentation in preparation for the Policy Review will be assembled over the same period. Invitations to the Policy Review will issue during the 4th week of February. All documentation for discussion at the Review will be circulated to participants 2 weeks before the main review.

TOR Annex 1: Timeline for Joint Health Sector Review Preparation

S/N	Activity	Period		Responsibility	Remarks
		Start	End		
1	Prepare report outlining progress to implement some of agreed milestones of main review 2004 to SWAp meeting in September	01/08/04	31/08/04	DPP/HSRS	Done
2	Conduct SWAp Committee Meeting	23/09/04	23/09/04	DPP/HSRS	Done
3	Agree on discussion topics for both technical and main review	01/09/04	01/11/04	Technical committee	Agreed
4	Preparation of ToR for Health Sector Technical Review on Private Public Partnership (PPP) in the delivering of health services to the people	01/09/04	10/11/04	Technical Committee	Done
5	Identify and select consultants to assist the MoH during technical and main review scheduled for January and March 2005 respectively	01/09/04	10/11/04	Technical Committee	Done
6	Preparation of ToR for Joint Health Sector Review and State of Health in Tanzania	01/09/04	10/01/05	Technical Committee	Done
7	Finalise and prepare a consolidated latest progress report outlining implementation by MoH/PORALG and others for main review 2004 milestones	01/01/05	10/03/05	HSRS/MoH and DLG, PORALG	In progress
8	Undertake Technical review on PPP	10/02/05 5/01/05	25/02/05	DPP (HSRS)	Done
9	Ensure that all documents/reports needed for main review are finalised in readiness for the technical and main review	01/01/05	15/03/05	DPP (HSRS)	In progress
10	Invitations and dissemination of documents reports and papers to be tabled at main review scheduled for April 2005	17/02/05	19/03/05	HSRS	In progress
11	Conduct Technical Review workshop	15/03/05	17/03/05	HSRS and Partners	Done
12	Finalise Agenda and topics for Main Review	25/02/05	23/03/05	HSRS	Done
13	Conduct April 2005 Main Review	4/04/05	6/04/05	DPP	Done
14	Signing of the Side Agreements	07/04/05	07/04/05	Govt and DP	
15	Produce and disseminate report on the Main Review 2005	4/04/05	30/04/05	HSRS	

TOR Annex 2: Timetable (presented separately)

TOR Annex 3: Participants at Annual Review

Ministry of Health Tanzania Mainland and Zanzibar
PORALG
MOF
CAG
VPO
OPSM
Sector Ministries reps
Regional Health reps
District Health and Council Directors reps
Development Partners
Faith-based orgs, CSSC, Bakwata
NGOs and Civil Society Orgs reps
Private Health Sector reps
Media reps (TVT, ITV, DTV, Daily News, Guardian, Mwananchi and Mtanzania).

TOR Annex 4 : TOR for Technical Review 2005 Public Private Partnership for equitable provision of quality health services

INTRODUCTION:

As an input and an important resource document for the Annual Joint Health Sector Review it has been decided to conduct an independent technical review with a focus on **Public Private Partnership (PPP) for equitable provision of quality health services**. The purpose is to assess progress, constraints and opportunities in the PPP for health service delivery, focusing on equity, financing and quality. The report need to be concise, targeting priorities and be implementable within the available health sector budget and in line with the NATIONAL STRATEGY FOR GROWTH AND REDUCTION OF POVERTY (NSGRP) and the Health Sector Strategic Plan, 2003-2008 (HSSP).

In conducting this study, it has to be considered that the Private Health Sector in Tanzania is marked by distinct sub-sectors: Private not-for-profit (Mainly religious or faith-based institutions and Voluntary Agency units) and Private for-profit (licensed and tax paying)
It is therefore expected that the study should cover these sub-sectors. Any information and/or conclusions should be specific and clarify separately the state of each sub-sector in the PPP review as regards equitable provision of quality health services.

Weak collaboration between the Public and Private Health sectors was identified in the 1993 sectoral analysis as one of the areas that needed attention. Strategy 7 in the HSSP (2003-2008) is geared towards addressing this weakness. A Public Private Partnership (PPP) Steering Working Group consisting of members from the MOH providing a Coordinator of the group, Private Health sector, Faith-Based Health sector (CSSC, BAKWATA and others) Development Partners (GTZ, DCI, CORDAID etc) and TPHA

was set up to address issues that will strengthen the required collaboration between the Public and the Private Health sectors.

According to the Health Sector Strategic Plan 2003-2008 (HSSP) the role of the Government (MOH) will be more of a facilitator in creating a conducive environment for the growth of private sector in the provision of equitable health service by both public and private sector. The focus of the government will be more on policy formulation, governance, regulation, financing, monitoring and quality assurance. Included will be its role in standardisation of equipment, devising quality assurance schemes and strengthening of Health Management Information System (HMIS).

One of the main objectives of the ongoing Health Sector Reform is to utilize available resources through participation of the private sector in the implementation of the reforms and the integration of the private services in the decentralized district health care systems. The private sector is partly represented by different umbrella organisations, which are supposed to play a key role in the partnership approach. Up to date, however, capacities on both sides remain weak and cooperation and collaboration are insufficiently institutionalised and depend mainly on individual efforts, relations and motivation.

OBJECTIVES OF THE STUDY:

1. To assess the state of the Private Health sector in Tanzania: Trends, opportunities, strengths, weaknesses and constraints that need to be addressed in order to strengthen PPP and raise the quality of healthcare provision.
2. To analyze the roles of Regulator, Provider, Purchaser and Client in the Tanzanian Health System and its implications for the Private Public Partnership
3. To asses the existence of partnership arrangements in the field of health and how far rules and principles are in harmony with national health policy; and HSSP
4. To assess partnership/contractual policies in view of maximizing impact on the performance of health systems, how they harmonize practices of all parties in a transparent way, and how they avoid adverse effects.
5. To provide a concise report of the findings and recommend tangible recommendations on how to move forward in strengthening the partnership in health services provision between the Public and Private Sectors in line with health sector strategic plan (HSSP, 2003-2008), the NSGRP 2004 (draft) and in the larger context of Vision 2025.

The following specific areas need to be addressed:

<u>Regarding Policy and Planning:</u>

- How to further a pluralistic policy environment, including a fruitful policy dialogue between MoH, and the private sectors.
- attitude of government (How do planning modalities (guidelines, practice, supervision etc.) integrate the private sector? mainstreaming or focal point in MoH? Are policies of PORALG, of Decentralisation conducive?)
- MOH – private sector participation in Policy formulation, monitoring and evaluation

- Role and capacity of organisations of private sector associations to assist MOH in evaluation and monitoring of the Private Health Sector. (Need for all "private for profit" to be members of a recognised association)
- Development Partners' relationship with the private sector in view of their desire to raise the quality of care in Tanzania and taking into consideration the fact that Private sector contributes nearly 40% of care, and is growing.
- How much government resources contribute to financing the private sector and how much is spent out of pocket? (if possible according to location and level of health service)

Regarding Human Resources:

- Assess how planning of Human Resources for Health (HRH) is taking care of the interest of both the public and the private providers ("user" of the workforce)
- Consider competition for the same staff categories between the private and public sector and interchange of staff between public & private. Consider the full equation in terms of input, process, outputs, quality outcomes, and quality of health services
- comment on how public and private institutions of basic and continued education are contributing to the provision of the health work force in adequate numbers and quality.

(take into consideration recent studies on Human Resources for Health in Tanzania)

Regarding Quality assurance

- How is quality of care assured in both Private and Public Health Facilities? What can be improved?
- Regulations and enforcement (Inspection)
- Role for self-regulation (Role and membership of Professional Associations)
- Role of accreditation and franchising
- Comparative assessment of quality of care within the Public sector
- Incentives for the private sector, particularly encouraging to work towards the GoT's goals (in terms of PRS, HSSP etc.),
-

(take into consideration recent studies and the proposed Framework for quality improvement)

Regarding Financing:

- How are GOT and DP subsidies to the Health Services enhancing PPP? What can be improved? Long-term perspective?
- How does the policy on cost recovery, the policies of pricing (both public and private) and the interaction of prices in the public and private influence consumer choices in terms of availability, physical access and cost of services at the point of use of care?
- How do CHF, NHIF and Private Insurance Companies support funding of equitable provision of quality health services through both private and public health services

Regarding collaboration between the two sectors at district level:

- How does PPP support efficient coverage of equitable quality health services in the districts including quality of care?
- How does the private sector contribute to the general improvement of quality of care – that is equitable and gender sensitive are essential interventions being implemented (and to what degree) through both public and private health care providers according to EHP guidelines with focus on disease and health conditions responsible for disease burden (HIV/AIDS, Malaria, TB, IMCI, EPI, SMI and Nutrition)
- How far do private providers participate in joint planning? Are there comprehensive facility plans available which include the private sector? What can be improved?
- Are allocations of subsidies (basket, block grants, projects, others) used in a way to strengthen PPP (e.g. through service agreements and contracting out of none core health services) and making use of the comparative advantages of different types of health care providers
- Accountability on subsidies and funds from different sources in both public and private structures
- Relate cost and funding of private health services and the accessibility for the sick poor who cannot pay for care?
- Are potentials for outsourcing of certain services to the private sector identified and used?
- Is the referral system integrating health facilities from both sectors according to their comparative strength and advantages?
- Is there joint planning and sharing of human resources including personnel development and continued education
- Access to essential drugs and medical supplies
- Roles of drug sellers/Pharmacists and traditional healers

Methodology/Approach

Given the limited time available, the assessment cannot be expected to gather primary data. The team should rely upon interviews with key informants, documentation already prepared, and relevant data available at the national and district levels. The study team is encouraged to split up to be able to cover the scope of work as described above.
Also due to time limits, it will not be feasible to cover a large sample of districts.
It is proposed that at least four districts be covered.
The mission should start with a meeting with members of the TC and the PPP working group to clarify the scope of work and receive inputs and recommendations on the details of the approach

The team should:

- review relevant literature, studies, available milestone progress reports, etc
- assess activities of the PPP Steering Group so far in enhancing PPP objectives as regards:

- interview representatives of the MOH, PORALG, CSSC and other Christian Health organisations, BAKWATA, APHTA and other relevant organisations and some key stakeholders to get their impression on progress or lack of progress.
- Undertake field visits to a few selected regions and at least 4 districts (interview CHMTs, health care providers (both private and public), drugs store and pharmacist sellers, some traditional healers and users of health services)

Outputs

An Inception Report to be circulated to key stakeholders for comments and input due

Debriefing Note and presentation to the Ministry Management Team and Technical Committee February 2005

A Report, with a short main text, supplemented by annexes if deemed necessary, and as much as possible referring to existing texts and documentation 14th March 2005

A presentation at the Main Sector Review Meeting – April 2005.

A final Report - due on 30th of April and forming part of the final documentation of the 2005 Joint Annual Review of the Health Sector - should take into consideration major amendments from the Review Meeting.

Composition of the Team

Two international (one as team leader), 30 WD each
Three (3) nationals, 30 WD each

The team leader will be responsible for the output of the team as a whole, including managing and quality-assuring the contributions of individual team members.

Reporting Arrangements
The team will through its team leader, liaise with the HSRS Secretariat for coordination, logistics support and time tabling of the planned steps and activities by the team

Timing

February 2004

The Team Leader and the National consultants will attend the Main Health Review on 4th – 6th of April 2005 and present the findings and recommendations of the team

ANNEX 4: LIST OF PARTICIPANTS

S/NO.	NAME	TITLE	ORGANIZATION/ADDRESS
1.	Hon. Anna M. Abdallah (MP)	Minister for Health	Ministry of Health , P.O.Box 9083
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Annual Joint Health Sector Review, 4th-6th April 2005: Timetable

Monday 4th April 2005				
No	**Time**	**Session**	**Time Allocation**	**Responsible**
1	08.00-08.30	Registration	30	Secretariat
2	08.30-09.00	Self-Introduction	30	Participants
3	09.00-09.10	Welcome Note	10	Ag. DPP (R. Kikuli)
4	09.10-09.30	Opening Speech	20	Hon Minister for Health (Anna M. Abdallah)
5	09.30-09.40	Vote of Thanks	10	CSSC Representative (Dr A. I. Kimambo)
6	09.40-09.50	Group Photograph	10	Secretariat
7	09.50-10.20	Tea Break	30	All
8	10.20-10.40	Opening Remarks	20	CMO (Dr G.L. Upunda)
9	10.40-11.10	Presentation: Progress against **Milestones**	30	Head HSRS (Dr F.N. Njau)
10	11.10-11.30	Presentation: Progress on **priority health issues**	20	District Health Coordinator (Anna Nswilla)
11	11.30-12.10	Discussion on Milestones and Priority Health Issues	40	Chairperson – Permanent Secretary, MoH. (M. Mwaffisi)
12	12.10-1.10	Lunch Break	60	All
13	1.10-1.40	Presentation: Health Sector **Performance Profile** and the use of Sector Performance Indicators from 10 selected districts	30	Head HIR (J.J. Rubona)
14	1.40-1.55	Presentation: **State of Health** in Tanzania	15	Consultant (C.Mpemba)
15	1.55-2.35	Discussion on Health Sector Performance	40	Chairperson (M. Mwaffisi)
16	2.35-3.05	Tea Break	30	All
17	3.05-3.35	Presentation: Findings and Recommendations of **PPP Technical Report**	30	Team Leader Technical Review (Leo Deville)
18	3.35-3.45	MOH Response to Recommendations	10	HSRS (Dr F.N.Njau)
19	3.45-4.45	Discussion on PPP Report and MoH response	60	All

Annex 5: Timetable

Tuesday 5th April 2005				
No	**Time**	**Session**	**Time Allocation**	**Responsible**
20	08.30-09.00	Recap of points from Day 1	20	Masaule
21	09.00-09.15	Presentation on Prepayment scheme for informal sector in an urban setting (**UMASIDA)**	15	Prof A.D.Kiwara
22	09.15-09.35	Summary Presentation of **Experiences** and **District Innovations** – Key points for policy debate & decision-making	20	J.Kelya
23	09.35-10.05	Discussion on experiences, innovations & policy options	30	Chairperson
24	10.05-10.35	Tea Break	30	All
25	10.35-11.05	Presentation: "**3 Regions** Study" and (PORALG): Health **infrastructure** rehabilitation	30	Coordinator, DHIRC (A. Sayile)
26	11.05-11.35	Discussion on Rehabilitation	30	Chairperson
27	11.35-11.55	Presentation: **HR Crisis** – what must we do now	20	DHRD (Dr G. Mliga)
28	11.55-12.10	Presentation: Key messages and concerns arising from **Public Expenditure Review**	15	PER Secretariat (R. Mkumbo)
29	12.10-1.10	Lunch Break	60	All
30	1.10-1.40	Presentation (MOF): **Budget guidelines**: health in context, new developments in budget process, messages for the health sector from budget support review	30	Commissioner for Budget MoF (N.B.S. Magambo)
31	1.40-2.40	Presentation on **MKUKUTA/** Implications for health sector MTEF for 2005/2006	60	Head HSRS and Ag. DPP (Dr F.N.Njau and R. Kikuli)
32	2.40-3.00	Presentation: **PORALG and local government Health MTEF 2005/06**	20	DLG PORALG (M.W.F.Maganga)
33	3.00-3.30	Tea Break	30	All
34	3.30-4.15	Discussion on Health Financing	75	Chairperson

Annex 5: Timetable

Wednesday 6th April 2005				
No	**Time**	**Session**	**Time Allocation**	**Responsible**
35	08.30-09.00	Recap of Points from Day 2	30	Masaule
36	09.00-09.30	Draft **milestones**: presented for discussion	30	Dr. F. N. Njau
37	09.30-10.30	Discussion on milestones	60	Chairperson
38	10.30-11.00	*Tea Break (secretariat works on milestones consensus*)	30	All
39	11.00-12.00	Plenary: Reaching consensus on the milestones	60	Chairperson
40	12.00-12.10	Closing remarks from Development Partners, NGOs Representative, MoH Zanzibar	10	Rep of Partners, NGOs and MoH Zanzibar
41	12.10-12.30	Official Closing	20	Chairperson
42	12.30-1.30	Lunch Break	60	All
43	2.30-5.00	**Side Agreement** Negotiations MoH and Basket Partners	2 Hours 30 Minutes	Govt. and Partners

Note: Chairpersons for the Main Review are: Permanent Secretary, MoH; Permanent Secretary, PORALG and Chairperson of the Development Partners.

RECOMMENDATIONS FROM TECHNICAL REVIEW (PPP)

Prepared by Review Team.

Review Focus	Recommendation	Timing	Level	Responsible	Need for additional Resources	Response from the Government
General framework of the health sector	• Define more clearly the present and future roles of different players as regulator/policy maker, purchaser and /or fund-holder (s), providers of services • Define the concepts of PPP and partnership in the above framework • Decide on critical issues such as moving from institution-based financing to output-based financing • Consider decentralizing drug budgets to council level • Develop medium term vision/action plan to move from present situation (roles, change process, output based financing etc) • Develop PPP action plan as part of the above action	2005	Central	MOH, PORALG, MOF representatives of FBO, PFP, NGO	No (workshops)	All the recommendations key word is to define roles. The MoH will continue to refine the definitions in collaboration with the key stakeholders. This will require revisiting the legal instruments and regulations

Annex 6: Recommendations from Technical Review PPP and Government Response

Review Focus	Recommendation	Timing	Level	Responsible	Need for additional Resources	Response from the Government
General framework of the health sector	Undertake a comprehensive private sector study: • Study of the capacity and utilization of private sector providers (FBOs and PFP) • Study of the source of capital and recurrent income in FBO (and possibly PFP) health units • Comprehensive inventory of private for profit institutions (service providers, drug outlets, maternity homes, laboratories, etc	2005	Central	MOH, PPP Unit, PPP SG	Yes (out –source study)	PPP need to propose what more is needed and inform the Govt through strategy 7
	Allocate public budget finances based on services being delivered: - • Review present procedures of allocation of financial and human resources to DDH and VA • Develop and test several scenarios for output-based/performance-based financing to public and FBO facilities • Test out-sourcing/contracting/service agreements of specific/selected EHP services to PFP in pilot urban settings	2005-2006	Central	MOH, FBO, PFP	No	**Service agreements are on the making.** This requires further analysis, to see if it is practicable at the current financing levels. This can be practiced by NHIF, CHF but not the grants as this doesn't cover full cost of services

Annex 6: Recommendations from Technical Review PPP and Government Response

Review Focus	Recommendation	Timing	Level	Responsible	Need for additional Resources	Response from the Government
Use of resources and contractual arrangements	Use public and private providers where they are available to deliver the EHP (or elements of EHP) • Develop strategies for using selected PFP providers where public providers are limited • Provide conducive environment for PFP to open practices in peri-urban areas, • Introduce quality standards and accreditation as part of testing contracting of/out-sourcing to the PFP	2005-2006	Central	MOH, PPP Unit, PPP SG, PFP	Yes	Recommendation noted for action This is a function of economic performance more and market forces and pricing other than the public network. The policy is very clear it is more of complementarity than competitiveness.
	Address the issue of human resources for public and FBO providers: • Address council's capacity to attract staff • Address budgetary constraints • Consider reviewing staff establishment in function of volume of work • Remove inequitable conditions of service between seconded and non-seconded staff • Provide similar work conditions for public and FBO staff	2005	Central	MOH, CSC, MOF, PORALG, FBO	Budget	The human resource issue is critical and need to be addressed as an emergency. Last years HRH committee will require its mandate to be extended and propose the next steps to be followed.

Annex 6: Recommendations from Technical Review PPP and Government Response

Review Focus	Recommendation	Timing	Level	Responsible	Need for additional Resources	Response from the Government
	Finalise and insitutionalise the service agreement between Councils and FBO	2005	Central Councils	MOH, PORALG	No	Advise noted, More work is needed on this are. Service Agreements to be completed strategy 7 Learn more from NHIF &CHF
Regulatory frameworks	Review and update health legislation, taking into account PPP and the role of the private sector	2005	Central	MOH	No	This is under consideration.
	Support APHTA to become a representative body for PFP actors	2005-2006	Central	APHTA, MOH, PFP	Yes, (small seed money-limited in time	The decision lies with PFP. If APHTA is chosen, the support is already there. May only need to be strengthened.
	Support CSSC to effectively develop the Inter-Faith Forum as representative organization of FBOs	2005-2006	Central	CSSC, MOH	Yes, (small seed money-limited in time	Agreed
Monitoring and Evaluation	Publish examples of best practices of PPP	2005 onwards	Central	MOH, PPP Unit, PPP SG	Yes (as par of operational budget)	We need to develop clear criteria for what is a best practice. We need a benchmark.
	Review the efficiency of the registration process for service providers (also including drug outlets laboratories, etc)	2005	Central	MOH, TFDA	No	Yes
	Install national standards for accreditation and QA for both public and private providers as per QIP	2005-2006	Central	MOH	No	Agreed

Annex 6: Recommendations from Technical Review PPP and Government Response

Review Focus	Recommendation	Timing	Level	Responsible	Need for additional Resources	Response from the Government
	Streamline policies on user fees throughout public and private sectors	2005	Central	MOH, MOF, PORALG, FBOs	No	National workshop of the financing options is scheduled on May 2005. In the public services yes, but in the private sector will require a study, this may not be feasible. The services are price in elastic.
	Consider introducing mechanisms for setting prices in PFP sector (e.g. drugs, services)	2005	Central	MOH.MOF,TFDA,PFP	No	Yes this is regulatory function of the government.
Institutional set-up and coordination mechanisms	MoH and PORALG to actively promote PPP in health promotion and health care	Continues	Central Council	MOH, PORALG	No	Yes, This is already covered in the National Health Policy and HSSP 2003/08 and in MKUKUTA
	Quarterly meetings of the sector coordination forum with FBOs PFP, NGOs	As from 2005 onwards	Central	MOH, PORALG, FBOs, PFP NGOs	No	Strategy 7 Coordinator link with MTEF
	Institutionalise and resources the PPP desk as a semi-independent entity. Provide full-time local champions to (wo) man the unit	2005	Central	MOH	Yes, (HR and operation budget	Under consideration MoH restructuring need. This recommendation needs to be evaluated.
	Continue using the PP working group as a broker to engage with private sector representative bodies and build trust. Transform the PPP steering Group in the PPP Forum with formal mandate and TOR	Continuing until PPP desk could take over this role	Central	MOH, PPP SG WG	Yes (operational budget, studies, pilot testing	The PPP desk is there it may need strengthening, working group to link with strategy 7 Coordinator

Annex 6: Recommendations from Technical Review PPP and Government Response

Review Focus	Recommendation	Timing	Level	Responsible	Need for additional Resources	Response from the Government
	Encourage the NGO Policy Forum to establish it self in a coordinating role	2005	Central	MOH, PPP SG NGO PF	No	Encouraged
	Consider housing the Medical council outside MOH	2005	Central	MOH, Medical Council	NO	When time it is ripe. There are several professional councils. This recommendation needs further evaluation.
Monitoring and Evaluation	Support MAT (or another representative professional association) to become an umbrella organization for professional associations	2005-2006	Central	MAT, MOH Professional associations	Yes (small seed money for capacity building –limited in time)	The associations need to decide themselves democratically which one umbrella the others.