Sector Budget Support in Practice

Desk Study

Health Sector

in

Tanzania

Final Draft

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List of Acronyms

CCHP	Comprehensive Council Health Plan
DfID	Department for International Development, UK.
DP	Development Partner
DPP	Department of Policy and Planning
EC	European Commission
GHI	Global Health Initiatives
GBS	General Budget Support
GoT	Government of Tanzania
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
JAHSR	Joint Annual Health Sector Review
JAST	Joint Assistance Strategy Tanzania
LGA	Local Government Authority
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MIS	Management information system
MTEF	Medium-Term Expenditure Framework
MKUKUTA	National Strategy for Growth and Reduction of Poverty
MoU	Memorandum of Understanding
MoHSW	Ministry of Health and Social Welfare
MoFEA	Ministry of Finance and Economic Affairs
ODI	Overseas Development Institute
PFM	Public Financial Management
PMO-RALG	Prime Minister's Office -Regional and Local Government
POW	Programme of Work
PRSP	Poverty Reduction Strategy Paper
SBS	Sector Budget Support
SBSiP	Sector Budget Support in Practice
SPA	Strategic Partnership with Africa
SWAp	Sector Wide Approach
TA	Technical Assistance
TACAIDS	Tanzania Commission for Aids
Tsh	Tanzanian Shillings (approximately Tsh 1,300 per US$, January 2009)

Executive Summary

This is a case study examining Sector Budget Support in the Health Sector in Tanzania between 1999 and 2008. It forms part of a broader study commissioned by the Strategic Partnership with Africa task team on Sector Budget Support (SBS) which covers ten sector case studies from six different countries.

Sector Context

In the 1990s health outcomes were poor in Tanzania, and characterised by high infant and maternal mortality and low life expectancy. Since 1999 good progress in some sector outcomes must be considered alongside stagnation and even decline in others. Progress has been related to the 4th Millennium Development Goal (MDG) – under 5 mortality – that is on-track to be met and improved from 99 per 1,000 births in 1999/0 to 58 in 2007/8. However, less progress has been achieved in reducing maternal mortality or improving maternal health, and life expectancy fell from 52 years in 1996/7 to 48 years in 2004/5.

Since 1999 Health Sector activities have been guided by consecutive Health Sector Strategic Plans (HSSP). The first HSSP covered the period until June 2003, the second from 2003-2008 (now extending over part of 2009) and the third is currently being prepared for later in 2009. In addition there is the National Health Policy, sector milestones adopted at the Joint Health Annual Review and also annual targets articulated in the Medium-Term Expenditure Framework (MTEF) submissions.

The Health Sector receives funds from a variety of sources. Considered 'on-budget' are both central and local government funds, the national health insurance fund, the basket fund, General Budget Support (GBS) and some foreign projects and programmes (i.e. those that report expenditure). Considered 'off-budget' are user fees, community contributions, local government authorities (LGAs) own source revenues, and foreign projects and programmes that do not report expenditure. This multitude of funding channels makes ascertaining the overall health sector budget very difficult and quite often a variety of methodology and estimation of resources exist. One measure, used by the Joint External Evaluation of the Health Sector in 2007, estimates both off- and on-budget expenditure increased, in real terms, from US$ 143.6 million in 2000/1 to $427.5 million in 2006/7.

The Nature of Sector Budget Support

Since its introduction in 1999, basket funding to the health sector in Tanzania has fitted the study's definition of SBS. SBS funds are transferred to the exchequer via regular government procedures, and dialogue and conditions are predominantly focused on the Health Sector. Henceforth the terms 'SBS' and 'basket fund' will be used interchangeably to describe the modality under assessment.

Three phases of SBS have been covered by the analysis. The evolution of the SBS across these phases is characterised by growth in the discretion of funding and increased use of government systems over the period 1999 to 2008. The dialogue has also become less basket specific and been increasingly focused on wider sector issues. This evolution has in part been made possible by improved Government of Tanzania (GoT) systems but also from lessons learnt in providing the SBS. For instance the 2003/4 side agreement called for plans 'to review some of rigidities that prevented discretion, within the health sector, at the local level'. It was these reviews that fostered discussion geared towards reforming the basket fund mechanism.

Conduct for the development partners (DPs) and GoT in relation to the SBS is directed by the respective Memorandums of Understanding (MoU). The MoUs provide the arrangements for SBS

dialogue, conditionality, accountability and monitoring and they have evolved following lessons learnt from the previous MoU period and developments from within the Health Sector. The MoU signed in July 2008 came into being with a number of changes relative to the 2003-2008 MoU. Firstly, it required DPs to indicate at the annual review their projections for financing. Secondly, it obliges DPs to release their total commitment as early as possible during the financial year. Thirdly, it articulated procedures for transfers of basket resources via the Regional Secretariat. Finally, certain procurement procedure thresholds were raised. The evolution of the SBS is well documented and there has been an ongoing dialogue on reforming the SBS arrangements. In addition to the MoUs the government and development partners sign an annual 'side agreement' that covers certain issues particular to the respective financial year.

A total of US$ 68.1 million was provided as health SBS in 2007/8 up from US$ 53.9 million in 2006/7. Resources are currently disbursed and used at the central, regional and local level with resources allocated on the basis of the priorities of the Health Sector. Development partners do not engage directly in stipulating how such resources should be expended, although a guaranteed proportion of SBS resources must be released to lower levels of government as mandated by the relevant MoU and side-agreement. The first major derogation of the SBS provided is the existence of a holding account and a conditionality framework mandated by the MoU and respective annual side-agreements. The second major derogation is that SBS resources are also separately identifiable in the development budget and a parallel channel was created for funding LGAs on top of operational health transfers.

The Effects of Sector Budget Support

SBS provided to the Health Sector in Tanzania between 1999 and 2008 has made some important contributions to the improvement of Health Sector outputs in Tanzania:

Summary of Influence of SBS on Sector Outputs

Domain	Extent and description of Influence (Influence rated as slight or strong)
Sector policy, planning, budgeting, monitoring and evaluation	STRONG -The use of government systems by SBS in the context of the Sector Wide Approach (SWAp) has focused attention of dialogue, conditionality and technical assistance (TA) on GoT policy development, planning, budgeting and reporting, and review process at the national level. Subsequently the quality of all these processes and associated documents has improved to some extent. STRONG -The earmarking of a proportion of SBS to local authorities has helped ensure resources have been channelled to LGAs, putting into operation the policy of decentralised service delivery. This may not have been possible with other modalities such as project support and GBS. STRONG -The channelling of resources to LGAs has also provided an incentive to improve planning, budgeting and reporting at that level, whilst the dialogue and TA associated with this has helped improve these processes.
Procurement, expenditure, accounting and audit processes	STRONG -The traceable earmarking and parallel disbursement of SBS funding, in particular to local governments, helped early on in ensuring resources reached local authorities as planned (as government transfer mechanisms were unreliable from the outset). SLIGHT -The recent switch of attention more towards increased use of domestic public financial management systems by SBS funding has focused the attention of the dialogue on the strengthening of government procurement, accounting and audit. This has helped yield gradual improvements in audit follow-up and procurement.
Capacity of sector institutions and systems	SLIGHT -The main area where SBS has had a positive influence on the Ministry of Health and Social Welfare (MoHSW) is that the dialogue and conditions associated with SBS have created demands on the Ministry which

Domain	Extent and description of Influence (Influence rated as slight or strong)
for service delivery	have helped it move from being an implementer of services to one which sets policy, manages, monitors and supervises service provision.
Domestic ownership, incentives and accountability	SLIGHT -The main areas of good practice focus on core requirements in the domestic accountability cycle, such as budgets, reports and audits. SBS has helped raise the profile of domestic processes and therefore facilitated improved domestic accountability.

Despite such links there a number of areas in which improvements could have been greater and where SBS has potentially undermined progress. For instance:

- The dialogue and other inputs associated with SBS have failed to produce a comprehensive overview of Health Sector expenditures over time, which has undermined strategic resource allocation.
- The traceability of SBS funding involved the bypassing of government cash management systems, which has undermined the ability of the Ministry of Finance and Economic Affairs (MoFEA) to deliver a predictable budget to Ministries, Departments and Agencies (MDAs) overall, including the MoHSW. As the predictability of the GoT budget has improved, the argument for this parallel disbursement mechanism has diminished.
- The dialogue on procurement plans and audit reports has been time consuming and has tended to dominate the dialogue at the expense of substantive discussion on service delivery and linking expenditure to results. Delays have been evident in receiving requested audit reports and procurement plans despite them being a core part of the conditionality framework.
- SBS has failed to make an impact on the issue of human resources that represents a key impediment to progress.

Conclusions and Recommendations

The overall objectives of SBS have been to support both implementation of the Health Sector's strategic plans and to expedite reform of the sector. SBS can be credited with success – to some extent – in both these endeavours.

Chapter 4 highlights the effectiveness of SBS and provides a series of positive lessons from the provision of budget support. Chapter 5 suggests that SBS has indeed had an impact on health sector outputs and that these have in turn led to, or improved the conditions for, improved health sector outcomes. A key strength of SBS has been its role in transferring a fixed proportion of funds to the local level. Contrastingly, SBS has been unable to influence some of the key impediments to service delivery such as issues relating to human resources.

A number of lessons can be taken from the Health SBS in Tanzania, both from the positive and negative effects of SBS. These are summarised as follows:

Domain	Practice with positive effects	Practice with negative effects
Sector policy, planning, budgeting, monitoring and evaluation	-The use of government systems by SBS in the context of the SWAp has focused attention of dialogue, conditionality and TA on GoT policy development, planning, budgeting and reporting, and review process at the national level. Subsequently the quality of all these processes and associated documents has improved to some extent. -The earmarking of a proportion of SBS to local authorities has helped ensure	-The dialogue and other inputs associated with SBS have failed to produce a comprehensive overview of health sector expenditures over time, which has undermined strategic resource allocation. This has undoubtedly been made more difficult by the structure of the GoT budget, the nature of the budget process and the huge and fragmented external resources associated with the sector. Without such strategic oversight the discretionary nature of resources, combined with the nature of the

Domain	Practice with positive effects	Practice with negative effects
	resources have been channelled to LGAs, putting into operation the policy of decentralised service delivery. This may not have been possible with other modalities such as project support and GBS. -The channelling of resources to LGAs has also provided an incentive to improve planning, budgeting and reporting at that level, whilst the dialogue and TA associated with this has helped improve these processes.	MTEF process, has led to inefficient spending.
Procurement, expenditure, accounting and audit processes	-The traceable earmarking and parallel disbursement of SBS funding, in particular to local governments, helped early on in ensuring resources reached local authorities as planned (as government transfer mechanisms were unreliable from the outset). -The recent switch of attention more towards increased use of domestic public financial management systems by SBS funding has focused the attention of the dialogue on the strengthening of government procurement, accounting and audit. This has helped yield gradual improvements in audit follow-up and procurement.	-The traceability of SBS funding involves the bypassing of government cash management systems, which undermines the ability of the MoFEA to deliver a predictable budget to MDAs overall, including the MoHSW. As the predictability of the GoT budget has improved, the argument for this parallel disbursement channel has diminished. -The dialogue on procurement plans and audit reports has been time consuming and has tended to dominate the dialogue at the expense of substantive discussion on service delivery and linking expenditure to results. Delays have been evident in receiving requested audit reports and procurement plans despite them being a core part of the conditionality framework.
Capacity of sector institutions and systems for service delivery	-The main area where SBS has had a positive influence on the MoHSW is that the dialogue and conditions associated with SBS have created demands on the Ministry which have helped it move from being an implementer of services to one which sets policy, manages, monitors and supervises service provision.	-The management of SBS has been a burden for MoHSW, whilst DPs have offered technical assistance the sector has not been ready to accept. A key concern is that the SBS only requires key GoT documents that should be produced, and does not encourage it to make decisions that would improve the management of health services. -SBS has made good progress in enhancing service delivery by assisting in the development of a strategic framework. However, key impediments to progress persist, such as human resource problems; the question remains whether SBS could have been better focused on dealing with such a key issue.
Domestic ownership, incentives and accountability	-The main areas of good practice focus on core requirements in the domestic accountability cycle, such as budgets, reports and audits. SBS has helped raise the profile of domestic processes and therefore facilitated stronger domestic accountability.	-Placing too many conditions in the conditionality framework can result in delays in the disbursement of funds. Balance is needed between pushing more timely delivery of documentation and accountability and providing the discretionary resources needed for reform and service delivery to impact sector outcomes. -Whilst Basket Funds are popular within the MoHSW, especially because what donors provide is disbursed to the sector, this undermines domestic lines of accountability between the MoFEA and the MoHSW.

1. Introduction and Study Objectives

1. This is a desk case study examining Sector Budget Support (SBS) in the health sector in Tanzania between 1999 and 2008. It forms part of a broader study commissioned by the Strategic Partnership with Africa Task Team on SBS which covers ten sector case studies from six different countries.

2. The overall purpose of the study is to draw together experience of SBS to guide future improvements in policy and practice by partner countries and donors. The additional objective of this case study is to assess the lessons from experience to date in the health sector and to provide the Government of Tanzania (GoT) and donors with guidance that will help them improve the design and implementation of SBS in future.

1.1 Methodology

3. The case study has been carried out using a methodology (ODI and Mokoro, 2008) which draws from evaluation frameworks of General Budget Support (IDD and Associates, 2006; Lawson and Booth, 2004; Caputo, Lawson and van der Linde, 2007) and the specific requirements of the Terms of Reference for the Assignment. The assessment framework has four levels:

- Level 1 breaks down sector budget support into inputs, both financial and non-financial inputs such as dialogue, conditionality and associated technical assistance and capacity.
- Level 2 identifies the immediate effects of SBS inputs on the overall nature of external assistance to the sector.
- Level 3 examines the outputs influenced by SBS in terms of sector policy, budgeting, financial management, institutional capacity, service delivery and accountability systems and processes.
- Level 4 examines the likely influence of SBS on outcomes in the sector, in terms of the achievement of sector policy objectives and service delivery.

4. The assessment framework also recognises the importance of external factors on the effects of SBS, the context within which it is provided, and the existence of feedback loops between and within each of the levels. A diagram of the assessment framework is provided in Annex 1.

5. The primary question posed for the case studies by the terms of reference is as follows:

> *How far has SBS met the objectives of partner countries and donors and what are the good practice lessons that can be used to improve effectiveness in future?*

6. The key purpose of the study is the identification of good practice. Therefore the assessment framework will be used as the basis for the identification of cases of good practice. For the purpose of this study, good practice is defined as:

> *Instances where SBS inputs (level 1), and their influence on the overall nature of external assistance to the sector (level 2), have helped strengthen sector processes (level 3) in areas which have improved, or will plausibly improve, service delivery outcomes (level 4).*

7. The case studies follow four steps in applying the assessment framework:

- The first step involves analysis of the country, sector, and aid environment, in particular evolution of sector systems and service delivery outcomes (i.e. the context from levels 1 to 4).
- The second step involves documenting and assessing the specific nature of SBS provided to the sector, and its effects on the quality of partnership in the sector (level 1).

- The third step involves an assessment of the effects of SBS from inputs to outputs (i.e. across Levels 1 to 3). This is carried out along four dimensions:
  (i) Policy, planning and budgeting processes and monitoring and evaluation systems;
  (ii) Sector procurement, expenditure control, accounting and audit processes;
  (iii) Sector institutions, their capacity and service delivery systems; and
  (iv) Domestic ownership, incentives and accountability (See Figure 4).
- The fourth step involves an assessment of the contribution of outputs influenced by SBS to improvements in sector outcomes (level 4).

8. The approach of this desk study involved the collection and review of documentation and a limited number of stakeholder meetings. It also involved collaboration with stakeholders through Country Reference Groups, so that findings could be further interrogated and tested.

9. The structure of this report follows the four steps. Under each of the four steps 'Main Study Questions' have been identified, as shown in
10. Box 1.

Box 1: Main Study Questions

Step 1: Setting the Country, Sector and Aid Context

SQ1.1: What have been the main national trends in poverty, economic performance, governance, and public sector delivery prior to and during the provision of SBS?

SQ1.2: How have sector processes, institutions, accountability and service delivery outcomes evolved prior to and during the provision of SBS?

SQ1.3: What has been the environment for external assistance at the national and sector level?

Step 2: The Key Features of SBS Provided and its Effects on the Quality of Partnership

SQ2.1: What are the key features of the SBS that has been provided?

SQ2.2: Has SBS contributed positively to the quality of partnership and reduction in transaction costs between development partners, the recipient government and civil society?

Step 3: The Influence of SBS in Practice on the Sector and Lessons Learned

SQ 3.1: What has been the influence of SBS on Sector Policy, Planning, Budgeting, Monitoring and Evaluation Processes, and what are the constraints faced and lessons learned in practice?

SQ3.2 What has been the influence of SBS on Procurement, Expenditure Control, Accounting and Audit Systems at the Sector Level, and what are the constraints faced and lessons learned in practice?

SQ3.3: What has been the influence of SBS on Sector Institutions, their Capacity and Systems for Service Delivery, and what are the constraints faced and lessons learned in practice?

SQ3.4: What has been the influence of SBS on Domestic Ownership, Incentives and Accountability in the Sector, and what are the constraints faced and lessons learned in practice?

Step 4: The Effectiveness of SBS, and the Conditions for Success

SQ4.1: What are the main contributions that SBS has made to the improvement of sector policy processes, public financial management, sector institutions, service delivery systems and accountability, and what were the conditions for success?

SQ4.2: Have the improvements in sector systems and processes to which SBS has contributed had a positive influence on sector service delivery outcomes, and are they likely to do so in future?

11. The conclusion will draw out the answer to the primary questions, and examine how the practice of the provision of SBS to the health sector can be improved in future.

1.2 Activities Carried Out

12. This desk study focuses on the period 1999 to 2008, draws from available literature and was conducted in Tanzania during February 2009. Brief meetings or telephone interviews were held with selected key informants. The author is grateful for the kind and informative support provided by stakeholders involved in the Tanzanian Health Sector.

2. Country, Sector and Aid Context

2.1 Country Context

SQ1.1: What have been the main national trends in poverty, economic performance, governance, and public sector delivery prior to and during the provision of SBS?

13. The United Republic of Tanzania is one of the largest countries in East Africa and has a population of approximately 40 million. Currently Tanzania is ranked 152 out of 179 countries in the United Nations Human Development Index.

14. Over the past ten years Tanzania has achieved high rates of economic growth and according to official data achieved 52% cumulative real GDP growth over the period 2001 to 2007. This success has been underpinned by an excellent record of macroeconomic stability and improved export performance[1]. However, recent results from the 2007 Household Budget Survey suggest slower than expected progress in reducing overall poverty between 2001 and 2007. Initial results presented by the National Bureau of Statistics (2008) suggest that the proportion of people living in poverty fell from 35.7% in 2001 to 33.3% in 2007.

15. Public expenditure since 2001 has experienced rapid growth due to significant increase in domestic revenues and scaled-up donor assistance. There is some evidence to suggest that such increases have fed in to improved service delivery, especially in the social sectors where much of the increased government expenditure has been focused. For instance, primary school enrolment increased from 59% to 97% between 2000 and 2007 and under five years infant mortality improved from 99 per 1,000 births in 1999/0 to 58 in 2007/8.

16. The development framework in Tanzania is directed by the 'National Strategy for Growth and Reduction of Poverty', known as the MKUKUTA[2] 2005 to 2010 and Vision 2025 that sets out economic and social objectives to be achieved by the year 2025. In support of strengthening government systems a number of reform programmes are in operation. These include the Local Government Reform Programme, the Public Sector Reform Programme and the Public Financial Management (PFM) reform programme.

2.2 Sector Context

SQ1.2: How have sector processes, institutions, accountability and service delivery outcomes evolved prior to and during the provision of SBS?

Health Sector Outcomes

17. In the 1990s health outcomes were poor, and characterised by high infant and maternal mortality and low life expectancy. Since 1999 good progress in some sector outcomes must be considered alongside stagnation and even decline in others. Table 1 highlights a reduction in the 4th Millennium Development Goal (MDG) (under 5 mortality), which is on-track to be met due to an improvement from 99 per 1,000 births in 1999/0 to 58 in 2007/8. However, less progress has been achieved in reducing maternal mortality or improving maternal health and life expectancy fell from 52 years in 1996/7 to 48 years in 2004/5. (Further information on outcomes is provided in Annex 2.)

[1] See Economic Survey 2007, the Ministry of Finance and Economic Affairs & IMF Country Report No. 08/178, 2008.
[2] MKUKUTA is a Kiswahili acronym that translates as the 'National Strategy for Growth and Reduction of Poverty'.

Table 1: Basic Health Indicators in Tanzania

Selected Health Indicators	Results
Under 5 Mortality rate (per 1,000 births)	1999/0 - 99 2004/5 - 68 2007/8 - 58
Maternal Mortality	1996/7 - 529 2005/6 - 578
HIV/ AIDS prevalence	2003/4 - men 3.0%, women 4.0% 2007/8 - men 1.1%, women 3.6%
Life Expectancy	1996/7 - 52 years 2004/5 - 48 years

Health Sector Policy Developments

18. In response to the poor state of health services and outcomes, "*the Government of Tanzania and Development Partners responded to this situation together in a process beginning with a joint planning mission convened by the Government in 1995. By 1999, this process resulted in the first strategic plan, the Health Sector Program of Work (POW) and an agreement that support to the Health Sector would take place in the framework of a Sector Wide Approach (SWAp)*" (Joint External Evaluation of the Health Sector in Tanzania, 2007).

19. Since 1999 Health Sector activities have been guided by consecutive Health Sector Strategic Plans (HSSP). The first HSSP covered the period until June 2003, the second from 2003-2008 (now extending over part of 2009) and the third is currently being prepared for later in 2009. In addition there is the National Health Policy (see Box 2 below), sector milestones adopted at the Joint Health Annual Review and also annual targets articulated in the Medium-Term Expenditure Framework (MTEF) submissions.

20. However, there is certainly a mist-match between plans and policies drafted and success in implementation. For many key problems identified the policy documents repeatedly voice the same solutions with meanwhile little evidence of progress in implementing agreed activities.

Box 2: National Health Policy 2007

The **vision** of the Government is to have a healthy society, with improved social wellbeing that will contribute effectively to personal development and the nation at large.

The **mission** is to provide basic health services according to geographical conditions, which are of acceptable standards, affordable and sustainable. The health services will focus on those most at risk and will satisfy the needs of the citizens in order to increase the lifespan of all Tanzanians.

Specifically the Government wants:
(i) To reduce morbidity and mortality, and increase the lifespan of all Tanzanians via quality health care;
(ii) To ensure that basic health services are available and accessible;
(iii) To prevent, control and sensitize citizens about communicable and non- communicable diseases;
(iv) To sensitize the citizens about preventable diseases;
(v) To create individual citizen awareness about his/her responsibility for personal health and health of the family;
(vi) To improve partnership between public sector, private sector, religious institutions, civil society and community in provision of health services;
(vii) To plan, train, and increase the number of competent health staff;
(viii) To identify and maintain the infrastructures and medical equipment; and
(ix) To review and evaluate health policy, guidelines, laws and standards for provision of health services.

21. The Health Sector policy framework has been developed and observably improved since 1999. This follows general advances in the quality of MTEFs and the issuing of the MKUKUTA that have both helped improve planning and budgeting across the GoT institutions. Also, sector specific policy advances have been registered, such as an improved series of HSSPs and Comprehensive

Council Health Plans (CCHP). Since 1999 the Health Sector has also experienced a significant decentralisation of health sector resources to the local level.

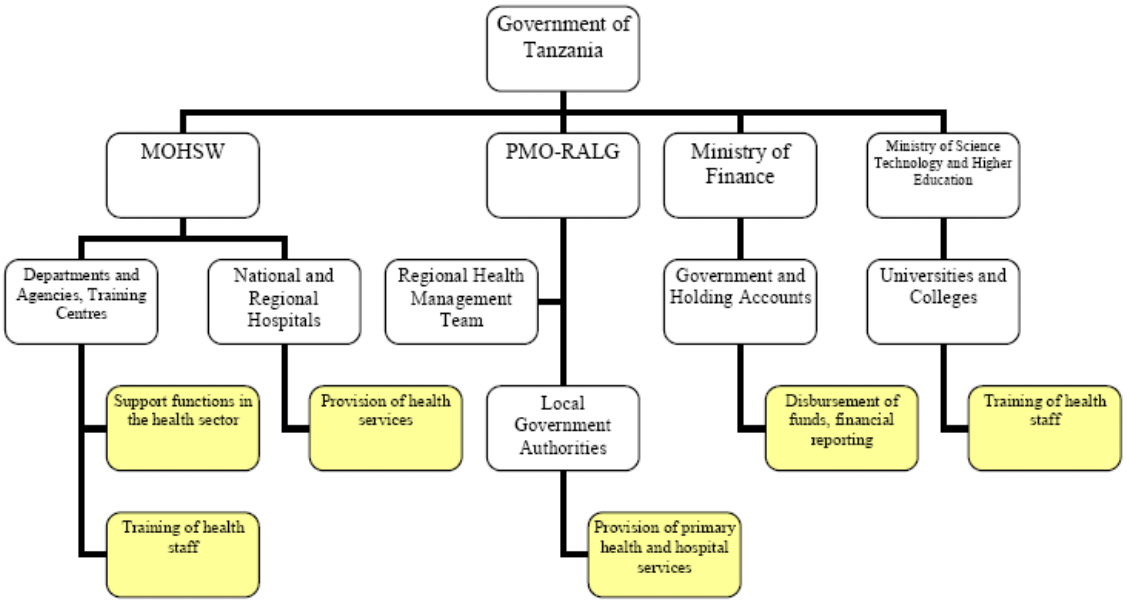
22. Under the general framework of the SWAp the previous situation of loosely or non-coordinated projects in the health sector has helped focus the policy agenda on health sector systems – especially when it comes to development partner (DP) and GoT dialogue. Despite these improvements, there has been a lack of progress related to strategic priorities in hospital reform, solving human resource related problems and public-private partnership.[3]

23. It should be noted that the Health Sector has always been highly political in Tanzania and has historically received significant attention from the political leadership. There are many dimensions to the political-economy of health sector reform and Buse and Booth (2008) suggest that populist and patronage politics have indeed played a part.

Health Sector Institutional Framework

24. The government remains the main provider of health services in Tanzania and owns approximately 64% of all health facilities (87% of all facilities are dispensaries; health centres and hospitals account for about 9% and 4% respectively). Administratively, the provision of health services is divided into three levels: national, regional and district or local government authority level (LGA). Figure 1 below sets out the structure of Government of Tanzania institutions involved in the sector, including the Ministry of Health and Social Welfare (MoHSW), the Ministry of Finance and Economic Affairs (MoFEA) and the Prime Minister's Office-Regional and Local Government (PMO-RALG)[4].

Figure 1: Health Sector Ministries Departments and Agencies



25. The role of the MoHSW has been in transition since 1999, switching from an operator of health facilities to more of a policy and technical support role. Administrative and financial responsibility for implementing health services at the district level and below has now effectively been transferred to PMO-RALG and LGAs. However, the MoHSW still retains administrative responsibility for the

[3] The Joint External Evaluation (2007) suggests that programmatic follow through in these areas has been lacking in comparison to others.

[4] Formerly known as PO-RALG when the department was under the President's Office

regional and national/referral hospitals, as well as technical responsibility for the quality of health services at every level.

26. During the study period it must be noted that there has been shift in policy when it comes to dealing with HIV/AIDS programming. Previously policy in this area was managed by the MoHSW but since 2001 it has been considered to be a multi-sectoral issue and has been managed by the Tanzania Commission for AIDS (TACAIDS) with activities occurring both inside and outside the Health Sector.

Health Sector Human Resources

27. A lack of trained personnel is highlighted as one of the biggest impediments to service delivery and the 2004 Joint Annual Health Sector Review uses the term 'human resource crisis'. The problems largely relate to retaining health workers, particularly medical doctors. The total number of active health workers in 2001/2 was estimated at 54,200, with unskilled workers forming the largest group (31%), followed by the professional group of nurses and midwives (24%) (quoted in Mtei et al. 2007). Between 1994/5 and 2001/2, the number of active health workers per 100,000 of the population, decreased by 35% and measures aimed at reversing this trend have not been sufficient to do so. The deployment of available health workers is also highly imbalanced (the 16% who are employed in urban areas represent a disproportionate share of the higher skilled cadres) and it remains very difficult to attract and retain staff with sufficient skills in hard to reach areas.

28. Poor health worker motivation and performance is also cited in many of the documented issues faced by patients. A lack of courtesy to patients, staff absenteeism, and illegitimate charging for drugs and equipment are all grievances raised by health system users (REPOA 2005).

Health Sector Budgeting, Reporting, Monitoring and Review

29. Over time the quality of agency MTEFs and annual budgets have been improving. However, significant problems have remained. MTEFs are prepared on an institution by institution basis, and are prepared in significant detail, being activity based. Historically MTEFs have not always entirely been consistent with the annual budget allocations approved by parliament. The health budget is split across the MoHSW, TACAIDS, PMO-RALG and Regional Votes. Local authority transfers form a subset of TACAIDS and PMO-RALG votes, and the MoHSW requires that LGAs prepare annual CCHPs. In sum budgeting is fragmented, and this makes it difficult to obtain an overview of resource allocations to the sector. To date there has been no effort to consolidate medium-term budget allocations for the sector.

30. This makes it difficult to direct sectoral allocations effectively towards HSSP objectives. Overall, spending plans, programmes and activities are still not sufficiently directed to achieving goals such as maternal mortality and public expenditure is overall not sufficiently results focused.

31. Reporting has historically been fragmented and routine data collection weak in the Health Sector, which is typical of other sectors in Tanzania, as Williamson (2006) describes in Box 3 below.

Box 3: Health Sector Reporting

A key gap that has been noted in Tanzania is the inadequacy of routine data on the implementation of services. For example Booth (2005) states:

"Routine data systems …. have continued to be unreliable, incomplete and wasteful….. The limitations seem to be worse in Health than in Education, but in both cases there is a lack of monitoring of agreed improvements in sector management as well as some duplication in data collection"

Sector monitoring and evaluation systems are therefore weak. Management information systems (MISs) are potentially important sources of information on service delivery, however where they exist (e.g. Health) there has historically been little incentive for service units or local authorities to comply with the reporting requirements.

One successful area has been the regular production of survey data, which is an important supplementary source of routine data, and there is an increasingly rich source of information. The National Bureau of Statistics has a 10 year survey calendar, which it has been able to adhere to. However the main problem is that there is no systematic integration of this information of MDA or sector level reporting.

Central government MDAs do report regularly to the Ministry of Finance in order to access disbursements, by preparing quarterly MTEF reports of expenditures against the targets and activities. They are detailed, yet do not present performance information, and are not well geared towards facilitating managerial decision making or accountability. There is little apparent follow up. Despite the functioning of the IFMIS, no routine reports on MDA budget implementation are produced on the system for managerial or public consumption, and MTEF reports are produced manually.

32. LGAs are required to report quarterly against their CCHPs, which are required for the release of funds. A series of health sector Public Expenditure Reviews have been carried out and the MoHSW produces Annual Sector Performance Reports. Such reports, unlike other sectors, have had a forum for discussion – the Joint Annual Health Sector Review, which is described by Evans (2006) in Box 4 below.

Box 4: Joint Annual Health Sector Reviews

"The Ministry of Health and its stakeholders have extensive experience with sector reviews. They began as a consultation mechanism[5] for the SWAp in the mid-nineties, revolving around two semi-annual conferences. Although the conferences are still held, sector reviews have evolved into a year-round mechanism for engaging donors and stakeholders more substantively in the ministry's policy and financial planning process. A technical committee, chaired by DPP and comprising approximately 20 members, meets monthly to review research and provide advice on policy and budgeting issues. Task forces reporting to the committee may be established to review specific issues (e.g., implications of demographic change to the health system). Quarterly reports from the ministry's MIS, commissioned reports and the annual PER provide the technical committee with monitoring and analytic information. The review process is integrated with the government's annual planning cycle.

The ministry remains very supportive of its sector review process although questions have been raised surrounding the Ministry of Finance's lack of involvement... the health sector clearly offers the most advanced model of a sector review process.

33. Underlying the improvements budgeting and reporting is a Department of Policy and Planning (DPP), which is relatively strong and dynamic.

Health Sector Expenditure

34. The Health Sector receives funds from a variety of sources. Considered 'on-budget' are both central and local government funds, the national health insurance fund, the basket fund, general budget support (GBS) and some foreign projects and programmes (i.e. those that report expenditure). Considered 'off-budget' are user fees, community contributions, LGAs own source revenues, and foreign projects and programmes that do not report expenditure. External funding is covered in greater detail in Section 2.3 below but it should be noted that health sector figures do not capture in full the considerable external financing flowing to the HIV/AIDS sector.

35. This multitude of funding channels makes ascertaining the overall health sector budget very difficult and quite often a variety of methodology and estimation of resources exist. One measure, used by the Joint External Evaluation of the Health Sector (2007),[6] estimates that both off- and on-budget expenditure increased, in real terms, from US$ 143.6 million in 2000/1 to $427.5 million in 2006/7[7]. In per capita terms expenditure increased from US$4.1 per capita in 2000 compared with $9.2 in 2005, and the health sector as a share of total public expenditure increased from 9% in 2000/1 to 12.5% in 2003/4. However, the growth in resources has slowed in recent years and still falls short of national and international targets (the sector share dropped to 11.8% in 2005/6).

[5] The health sector has diverse stakeholders from local governments to civil society to private sector service providers and involves multiple donors.
[6] Government of Tanzania (2007) 'Joint External Evaluation of the Health Sector in Tanzania, 1999-2006', October 2007.
[7] Boex (2008) updates the study and estimates a total of $483 million in 2007/08).

36. Focusing in on the period 2004/5 to 2007/8, Table 2 shows that of the resources made available to the sector in 2007/8 31% was managed by the MoHSW, 23% was spent at the LGA level and external sources provided 35% of overall financing.

Table 2: Health Sector Public Expenditure 2004/5 to 2007/8[8]

(Tsh Billion)	2004/5	2005/6	2006/7	2007/8
Ministry of Health	103.3	185.3	202.8	194.4
o/w MoHSW	*56.3*	*112.8*	*140.8*	*128.8*
o/w Hospitals	*18.3*	*19.1*	*21.3*	*27.9*
o/w Essential Drugs	*28.7*	*53.4*	*40.7*	*37.7*
Transfers to Regions	10.9	13.0	21.9	35.8
Transfers to LGAs	63.6	77.7	119.8	143.0
External Funds	116.3	116.3	115.2	219.5
o/w Basket Fund/ SBS	*66.5*	*65.1*	*73.3*	*90.1*
Other Funds	18.0	20.0	27.2	35.7
Health Sector Total	**312.0**	**412.3**	**487.0**	**628.4**

37. The resources involved in combating HIV/AIDS are vast and the multi-sectoral TACAIDS 2007 Public Expenditure Review estimated that total domestic resources (including those via the MoHSW) summed to $121 million in 2007/08, combined with vast external resources estimated at $437 million in the same year[9].

Health Service Delivery

38. A joint external evaluation of the Health Sector (covering the period 1999 to 2006) took place in 2007 and was led by MoFEA alongside DPs[10]. The evaluation points to the 1990's as a period of stagnation for the health sector in Tanzania and states that "*local health services were characterized by severe shortages of essential drugs, equipment and supplies and deteriorating infrastructure and were plagued by poor management, lack of supervision and lack of staff motivation*" (pp. 14).

39. Assessment of health service delivery can be split into two categories, firstly those focusing on technical services (quality of diagnosis, treatment, etc.) and secondly other elements such as staff friendliness and attitude to patients, waiting times, cleanness of facilities, etc. Reported statistics suggest that:

- Percent of births attended by trained personnel increased from 36% in 1999 to 46% in 2004/05.
- Coverage of Diphtheria, Tetanus and Polio vaccines increased from 81% in 1999 to 86% in 2004/05 (making up for a decline in the late 1990's as coverage was reported to have been 85% in 1995).
- The proportion of children vaccinated against measles has stayed in the range of 78% to 81%.

In the second category the joint evaluation finds that "*on balance, the perception of community members about changes in service quality over the period 1999-2007 is positive*" (pp. 123).

Factors influencing Sector Outcomes

40. During the period 1999 to 2008 there have been a number contextual factors impacting on the health sector in Tanzania. These factors must first been considered before reviewing the effects of the SBS and later when making assessment in Chapter 5 on the overall likely impact.

[8] Source of data: Boex (2008).
[9] TACAIDS (2007), 'Tanzania Public Expenditure Review, Multi-Sectoral Review HIV/AIDS', December 2007.
[10] Government of Tanzania (2007) 'Joint External Evaluation of the Health Sector in Tanzania, 1999-2006', October 2007.

41. Health sector outcomes have been influenced by a wide range of factors – some more plausibly influenced by SBS than others. Masanja et al. (2008), when analysing child survival gains, reconcile influence from a range of contextual factors impacting on health care in Tanzania. They make a distinction between those relating to health systems and those that are not. Relating to health systems, the authors considered firstly the influence of relevant policy changes (regarding management, decentralisation and services) and secondly trends in public expenditure on health[11]. Unrelated to health systems the authors examine external factors such as fertility rates, GDP per capita, rates of poverty and major shocks (epidemics and food security).

42. When making an assessment of progress towards the MDGs the MoHSW identified important factors. Relating to management and finance they reported the advent of the SWAp, SBS provided and the increase in per capita health expenditure. In terms of health interventions they highlighted vitamin A supplementation, the number of districts implementing Integrated Management of Childhood Illnesses, households with at least one mosquito net, malaria preventive treatment during pregnancy, children sleeping under a recently treated bed net, iron supplementation, and breast feeding and measles immunization.

43. Potential constraints (cited in the literature) that are argued to limit progress in achieving improved health sector outcomes include:

- Continuing severe shortages of trained health workers;
- Deficiencies in infection control;
- Continuing intermittent shortages of essential drugs;
- Shortages of other medical supplies (syringes, gloves, x-ray film, reagents) at facility level; and
- Poor and/or expensive transport infrastructure, especially as it relates to emergency care.

44. For the purpose of this study the focus will be on factors that have influenced health sector outcomes directly (i.e. via health systems), specifically:

Table 3: Factors with a Positive Influence on Outcomes

Domain	Specific factors which have had a positive influence on Sector Outcomes
i) Institutional and organisational reform	• **Improved coordination of development partners** has ensured a greater harmonization of external support than otherwise would be the case. Poorly coordinated donors increase the burden on GoT institutions and leads to inefficient expenditure by reducing the MoHSW's ability to plan strategically. With poor coordination, there is also more scope for the duplication of activities. • **Improved public financial management in the sector:** PFM has improved across the GoT since 1999. Reform is currently slower than in the early years of the SWAp but overall progress has increased confidence in GoT systems and helped provide conditions necessary (though not sufficient) for effective use of financial resources. • **The movement of MoHSW from a service** has permitted increased focus on strategic management in the sector. MoHSW now spends a greater proportion of time setting policy and monitoring and supervising service delivery.
ii) Relevant Policy Changes	• **Improved strategic planning** has improved across GoT with the drafting of the MKUKUTA framework. All sector plans, budgets and activities must fit into this framework.

[11] Masanja et al. (2008), 'Child survival gains in Tanzania: analysis of data from demographic and health studies', The Lancet, Volume 371, 12 April 2008.

Domain	Specific factors which have had a positive influence on Sector Outcomes
	• **A strengthened policy framework** within the health sector has allowed better discussion of objectives and created an improved link between budgets and plans. • **Improved budgeting:** GoT has developed the MTEF framework as part of the budget process. Weaknesses remain but the system is stronger relative to 1999.
iii) Trends in Public Expenditures	• **The total resource envelope available**: Increased resources flowing into the sector raise the potential to impact on sector outcomes. These have increased considerably since 1999. SBS has increased but since 2004 projects have increased to a greater extent. An assessment of influences on health outcomes should also acknowledge the impact of disease-focused vertical funds and the vast external resources engaged in tackling problems associated with HIV/AIDs. • **Levels of discretionary finance**: Both SBS and scaled up mainstream GoT funds (due to increased domestic revenue and GBS since 1999) have provided increased choices for MoHSW and fiscal space to help fund activities identified in the respective strategic plans and MTEFs. Such funds have been provided through mainstream GoT systems. • **Proportion of resources decentralised**: The GoT has decentralised an increased portion of its budget since 1999, increasing the proportion of funds managed by service delivery units.

2.3 Context for External Assistance

SQ1.3: What has been the environment for external assistance at the national and sector level?

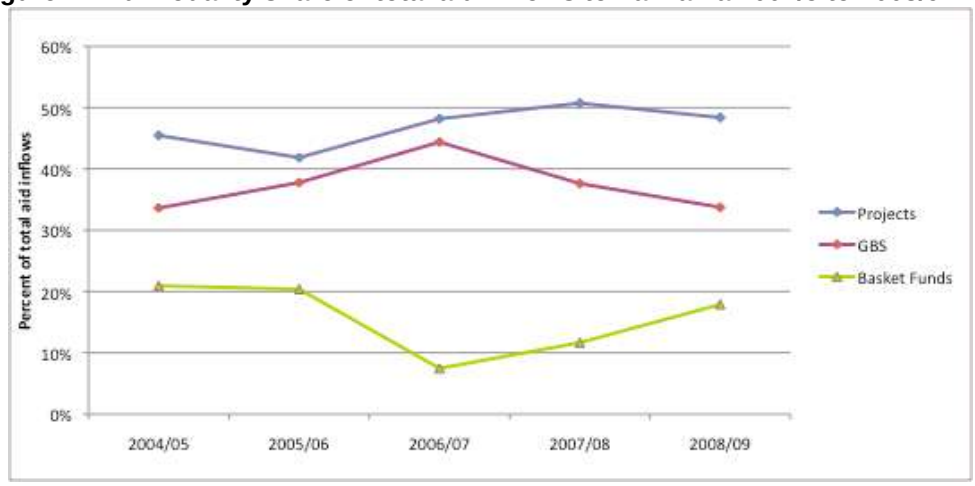
National Level

45. External support to Tanzania is guided by the Joint Assistance Strategy (JAST) 2006 that seeks to ensure that national and international commitments made on aid effectiveness, such as alignment and harmonization are adhered to[12]. Tanzania has been carrying out aid management reforms since the mid 1990's and given the multitude of development partners in Tanzania, it assists the government to take the lead in managing the development process including the implementation of the MKUKUTA. The JAST (2006) states that "*general budget support is the Government's preferred aid modality*" (pp.16) and that development partners "*will increasingly move to GBS from other modalities and adhere to criteria of 'good practise' for using basket funds and direct project funds*" (pp. 18).

46. Tanzania has attracted large numbers of donors and large aid inflows over the period 1999 to 2008. In fiscal year 2007/8 projects accounted for 51% of all recorded aid inflows, GBS 38% and basket funding to the sectors 12%. Tanzania, like Mozambique and Uganda, has experienced a more significant shift towards GBS than other developing countries. However, Tanzania has also seen an increase in the total amount of basket funds and projects over the same period. Tanzania currently has three remaining basket funds linked to key sectors (health, water, agriculture) and several others linked to GoT reform programmes (including the PFM reform programme, Public Sector Reform Programme, Local Government Reform Programme, and the Deepening Democracy programme). Figure 2 highlights the relative importance of each of the modalities over the period 2004/5 to 2008/9.

[12] Prescriptions in the JAST (2006) are consistent with messages and commitments associated with the 2005 'Paris Declaration' and 2008 'Accra Agenda'.

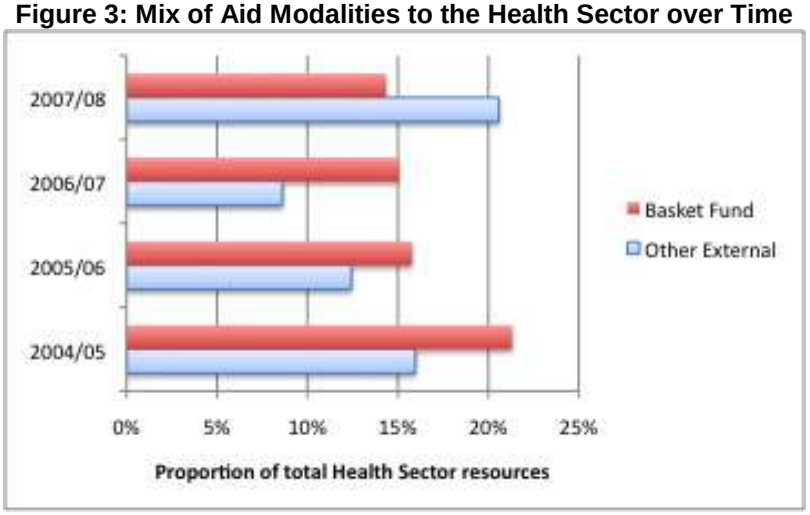
Figure 2: Aid modality share of total aid inflows to Tanzania 2004/5 to 2008/9



External Assistance to the Health Sector

47. The health sector is one of the largest beneficiaries of development co-operation in the public sector of Tanzania. Figure 3 highlights the main flows of external resources to the Health Sector between 2004/5 and 2007/8.

Figure 3: Mix of Aid Modalities to the Health Sector over Time



48. Boex (2008) in his study of Health Sector funding flows calculates that "*despite the prominence of the Health Sector Basket Fund as the main SWAp funding modality, the majority (and in fact, an increasing share) of external funding to the health sector is actually provided through program or project support outside the basket modality*". This has certainly been the case in the recent past following the rise in prominence of Global Health Initiatives (GHIs) since 2004.

49. GHIs and traditional donor projects represent a significant share of Heath Sector resources and do make a contribution to national goals and targets (especially in relation to HIV/AIDS, malaria and tuberculosis). However, much of resources are transferred outside the SWAp directly from development partners to the implementing agency often bypassing government systems entirely. This makes it difficult to get an accurate picture of resources and it is argued that support of this kind tends to divert human and financial resources from other priorities in the sector. For instance a programme focusing on a specific disease for example will liaise with a specific department; whist the SWAp and system based financing will raise the prominence of strategic planning and achievement of overall sector goals.

50. All stakeholders active in the Health Sector interact and reflect on sector objectives and goals, policies, strategies and budgets. The SWAp has shaped this dialogue since 1999 and created a

formal structure for discussion and debate including SWAp committee meetings, basket fund steering and technical committee meetings, the Joint Annual Health Sector Reviews and development partner Health Group meetings.

51. The actions of stakeholders operating under the SWAp are governed by a 'Code of Conduct' that has been subject to updates over the life of the SWAp. There are some development partners who are part of the SWAp but do not fund the basket and efforts are made to harmonise basket fund requirements with those of the SWAp. The 2007 'Code of Conduct' requires endeavour "*to improve the efficiency, effectiveness and impact of the SWAp by increasing transparency on all sides; improving predictability and allocation of financing; reducing transaction costs and the administrative burden placed upon the government; and better coordinating multiple inputs and activities which serve sector objectives*."

52. Before the SWAp the Joint External Evaluation 2007 states that there was "*little coordination of support to the health sector by Development Partners*" (pp.14) but that the period 1999 to 2006 had been "*characterized by a more harmonised and aligned system of development cooperation in the health sector, partly through the development of structures for formal dialogue*" (pp.20). Whilst the SWAp is broader than the basket fund this coordinated approach would not have been possible without presence of the basket fund financing mechanism that gives development partners an alternative method of support the sector, especially for those unwilling or unable to move fully to GBS.

3. The Key Features of SBS Provided and its Effects on the Quality of Partnership

3.1 The Key Features of SBS Provided

SQ2.1: What are the key features of the SBS that has been provided?

General Features of SBS and its Objectives

53. For the purposes of the overall SBSIP study[13], Sector Budget Support is defined as those aid programmes where:

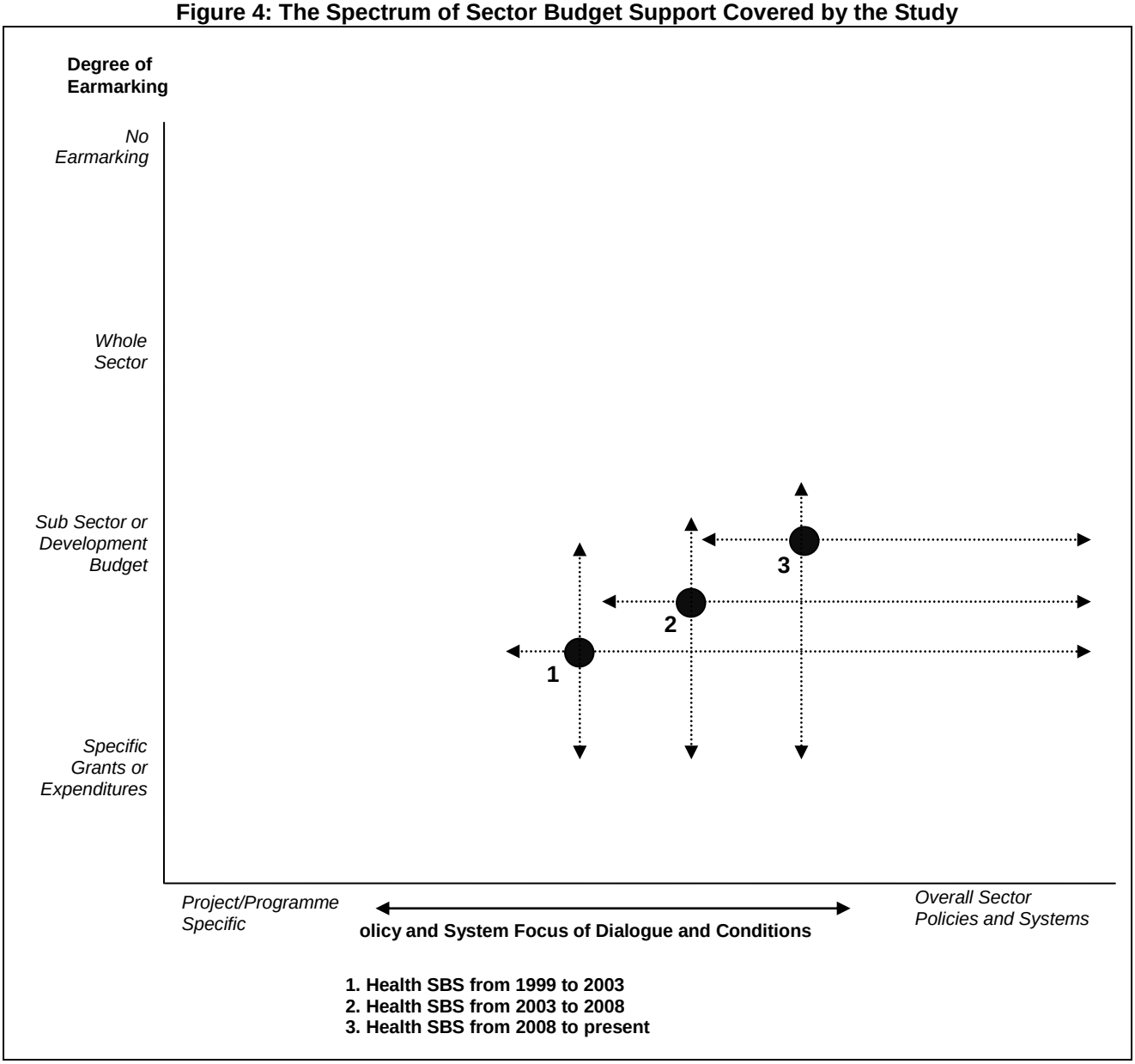
- Aid uses the normal channel used for government's own-funded expenditures. Aid is disbursed to the government's finance ministry (or "treasury"), from where it goes, via regular government procedures, to the ministries, departments or agencies (MDAs) responsible for budget execution.
- The dialogue and conditions associated with the aid should be predominately focused on a single sector.

54. Since its introduction in 1999, basket funding to the health sector in Tanzania has fitted the study's definition of SBS. SBS funds are transferred to the exchequer via regular government procedures, and dialogue and conditions are predominantly focused on the Health Sector. Henceforth the terms 'SBS' and 'basket fund' will be used interchangeably to describe the modality under assessment.

55. Three phases of SBS have been covered by the analysis, as mapped in Figure 4 below. The evolution of the SBS across these phases is characterised by growth in the discretion of funding and increased use of government systems. The dialogue has also become less basket specific and been increasingly focused on wider sector issues. This evolution has in part been made possible by improved GoT systems but also from lessons learnt in providing the SBS. For instance the 2003/4 side agreement called for plans "*to review some of rigidities that prevented discretion, within the health sector, at the local level"*. It was these reviews that fostered discussion geared towards reforming the basket fund mechanism.

[13] See SBSIP inception report pp. 7.

Figure 4: The Spectrum of Sector Budget Support Covered by the Study



56. Characteristics and events relative to each of the phases are illustrated in the time-line below (Table 4).

Table 4: Sector Budget Support Timeline

Year	Selected Events
Phase One 1999-2003	
1999, April	-A joint donor and GoT side agreement was signed by GoT and six donors (DANIDA, DFID, Irish Aid, NORAD, SDC and the World Bank) confirming their commitment to establish a joint funding mechanism as part of the SWAp.
1999, June	-MoHSW and DPs agreed a 3-year Programme of Work (POW) for 1999-2002.
1999, December	-First basket fund disbursement.
2000	-First annual joint review of the Health Sector Reform programme. A minimum of $0.5 per capita was released to each LGA.
Phase Two: 2003-2007	
2003	-MoU signed for period 2003-2008
2003, August	-New Swap "Code of Practise" signed between collaborating partners.
2003, June	-HSSP II begins, 2003-2008 (later extended through 2009).
2004	-Minimum of $0.75 per capita to be released to each LGA. Joint Rehabilitation Fund (JRF) started. MKUKUTA 2005-10 endorsed by Parliament.
2005, April	- GoT & DPs agreed to semi-annual deposits to the holding account.

Year	Selected Events
2006, December July 2007	- New JAST signed. - Treasury disburses basket funds direct to LGAs rather than passing PMO-RALG (Vote 56) accounts. Also there was a shift from a minimum of US$0.5 to US$1 per capita at LGA level.
Phase Three: 2008-ongoing	
2008, July	-MoU signed for period 2008 to 2015. Includes proposals for $1 per capita to be transferred to LGAs. -Joint Rehabilitation Fund (JRF) ended. NB HSSP III being drafted as of January 2009 (expected mid-2009).

57. The overall objective of the basket fund has been to support both implementation of the Health Sector's strategic plans and to expedite reform of the sector. Several other objectives can be identified from the literature. One of these has been the intention to provide a stable and predictable resource base for local councils. Another was the rehabilitation of dilapidated health infrastructure that occurred via the Joint Rehabilitation Fund started in 2004 and ended in June 2008.

58. Conduct for the development partners and GoT in relation to the SBS is directed by the respective MoUs. The current MoU began in July 2008 and covers the period July 01 2008, to June 30 2015[14]. The MoUs provide arrangements for SBS dialogue, conditionality, accountability and monitoring and have evolved following lessons learnt from the previous MoU period and developments from within the Health Sector.

59. The MoU signed in July 2008 came into being with a number of changes relative to the 2003-2008 MoU. Firstly, it required DPs to indicate at the annual review their projections for financing. Secondly, it obliges DPs to release their total commitment as early as possible during the financial year. Thirdly, it articulated procedures for transfers of basket resources via the Regional Secretariat; and finally certain procurement procedure thresholds were raised. The evolution of the SBS is well documented and there has been an ongoing dialogue on reforming the SBS arrangements.

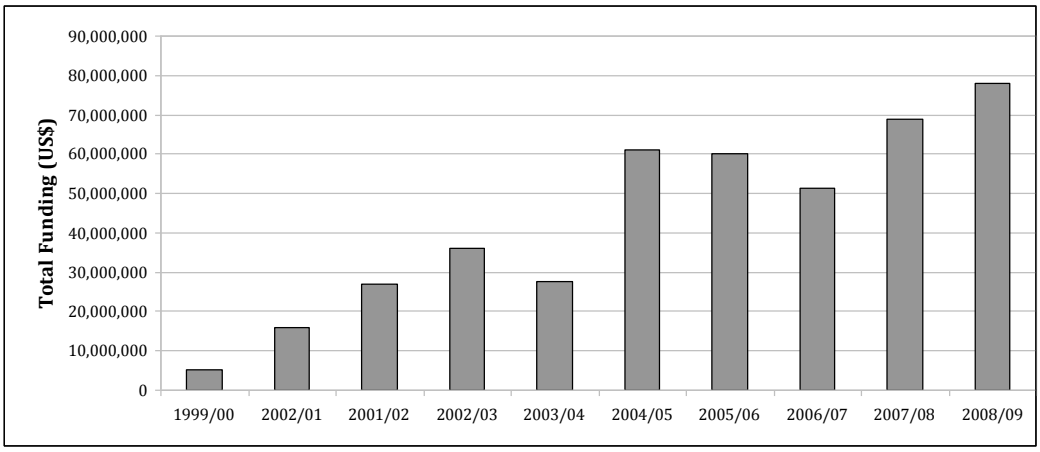
60. In addition to the MoUs GoT and development partners sign an annual 'side agreement' that covers certain issues particular to the respective financial year. The 2002/3 side agreement pledges the commitment to unearmarked support but requests that the MoHSW share its draft MTEF document before it is submitted to MoFEA and that the Ministry works with development partners when setting medium-term objectives. The side agreement also called for discussion over the results of that financial year's Public Expenditure Review.

The Level of SBS Funding and its Predictability

61. A total of US$ 68.1 million was provided as health SBS in 2007/8 up from US$ 53.9 million 2006/7. Figure 5 below shows the increase in total funding over the study period (individual donor contributions are provided over the same period in Annex 2).

[14] Signatories include: Permanent Secretary MoHSW, Permanent Secretary PMO-RALG, Permanent MoFEA, Irish Aid, CIDA, DANIDA, GTZ, Netherlands Embassy, Norwegian Embassy, Swiss Agency, UNFPA, UNICEF, World Bank, UN systems in Tanzania.

Figure 5: Total Health Basket Inflows 1999/00 to 2008/09



62. Whilst predictability was reported as poor in the early years of the Basket, Table 5 summarises the projected and actual contributions by development partners over the period 2005/6 to 2007/8.

Table 5: Budgeted and Actual disbursements of Phase 3 SBS

	2005/6			2006/7			2007/8		
(US$ Million)	Proj.	Actual	Perf.	Proj.	Actual	Perf.	Proj.	Actual	Perf.
Danida	11.4	10.3	90%	10.5	11.2	107%	12.0	12.3	103%
Ireland	2.8	2.5	89%	7.5	7.3	98%	9.3	9.3	100%
Netherlands	8.0	6.5	81%	8.9	8.9	100%	9.3	9.89	106%
Switzerland	4.5	4.8	107%	4.6	4.6	100%	4.2	4.2	100%
KfW	3.1	3.1	101%	2.5	7.2	283%	4.6	-	0%
World Bank	20.0	29.0	145%	13.8	13.8	100%	20.0	20.0	100%
UNFPA	0.6	0.6	100%	0.6	0.6	100%	0.6	0.6	100%
CIDA	-	3.5	-	2.7	0.3	10	3.8	4.0	106%
UNICEF	-	-	-	-	-	-	0.5	0.5	100%
Norway	-	-	-	-	-	-	-	7.4	-
Total	**50.4**	**60.3**	**84%**	**51.1**	**53.9**	**95%**	**64.3**	**68.1**	**94%**

63. There is widely held opinion in Tanzania that basket funds are often released late in the financial year and that actual funds turn about to be less than projected or budgeted resources. Table 5 compares the DPs pledges with actual releases into the holding account over the period 2005/6 to 2007/8. The data shows that actual releases have been 84%, 95% and 94% in the three respective years. This level of predictability is quite reasonable, especially in the latter two years, when firstly compared to off-budget health sector financing and secondly to the predictability of other resource flows to the sector[15]. Boex (2008) finds that mainstream Treasury releases to the MoHSW were 87.4%, 95.5% and 78.8 % respectively over the period 2005/6 to 2007/8.

64. In terms of in-year timeliness Figures 6 and 7 illustrate the quarterly breakdown of SBS funding flows in 2005/6 and 2006/7. In 2005/6 by the end of the second quarter approximately 60% of funds had been deposited into the holding account by development partners. However, in the first half of the year only approximately 40% had been released from the account and only approximately 30% released by the Exchequer. This indicates that there are both delays in approving the release of funds from the holding account and also in releasing the resources once

[15] The Joint External Evaluation (2007) finds that overall 'on-budget' resources are much more effectively executed (pp. 97)

transferred from the holding account. Delays are also evident in 2006/7 when over 50% of resources were released in the final quarter of the financial year.

Figure 6: 2005/6 Health Basket Funding Flows

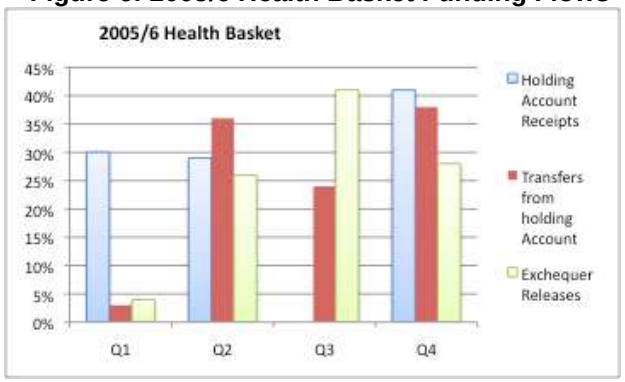
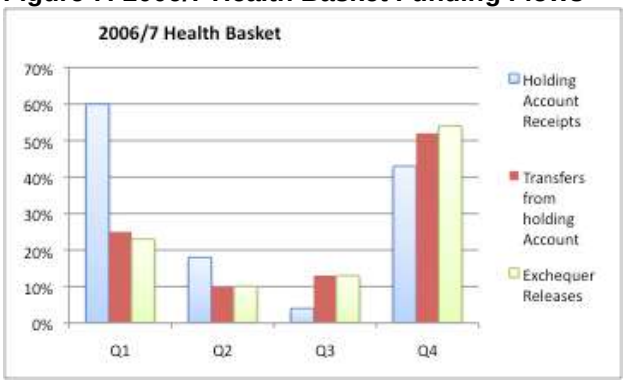


Figure 7: 2006/7 Health Basket Funding Flows



65. The predictability of resources improved in 2007/8 and the 2008 to 2015 MoU has provoked reform to the basket fund mechanism, including annual approval for releases that will ensure more resources are released earlier in the financial year.

Earmarking, Additionality, Traceability and Financial Management Arrangements

Box 5: Earmarking, Traceability and Additionality

Earmarking is a requirement that all or a portion of a certain source of revenue, such as a particular donor grant or tax, be devoted to a specific public expenditure. The *extent* of earmarking can vary. It involves the *ex ante* assignment of funds to a particular purpose and can range from the very broad and general to the narrow and specific.

Traceability refers to whether donor funds are separately attributable to a specific use. Funds are either traceable, or not:

(i) **Traceable**, whereby allocation, disbursement and spending of funds is via specified and separately identifiable budget lines. This bypasses the normal procedure by which revenue is pooled with all other revenue in a general fund and then allocated among various government spending programmes. *De facto*, a traceable aid instrument must involve a degree of earmarking, although this may be very broad - this is often referred to as *real earmarking*.

(ii) **Non traceable**, whereby external funding is not identifiable by separate budget lines. If earmarked, the allocation of funds is justified against budget allocations to pre-agreed institutions or budget lines, and is pooled with other government revenues in the general fund. When non traceable SBS is accompanied by earmarking - this is often referred to as *notional earmarking*.

These two dimension combine to form three main types of SBS funding:

	Earmarked	**Un-earmarked**
Non Traceable	Non-traceable Earmarked SBS	Un-earmarked SBS
Traceable	Traceable Earmarked SBS	

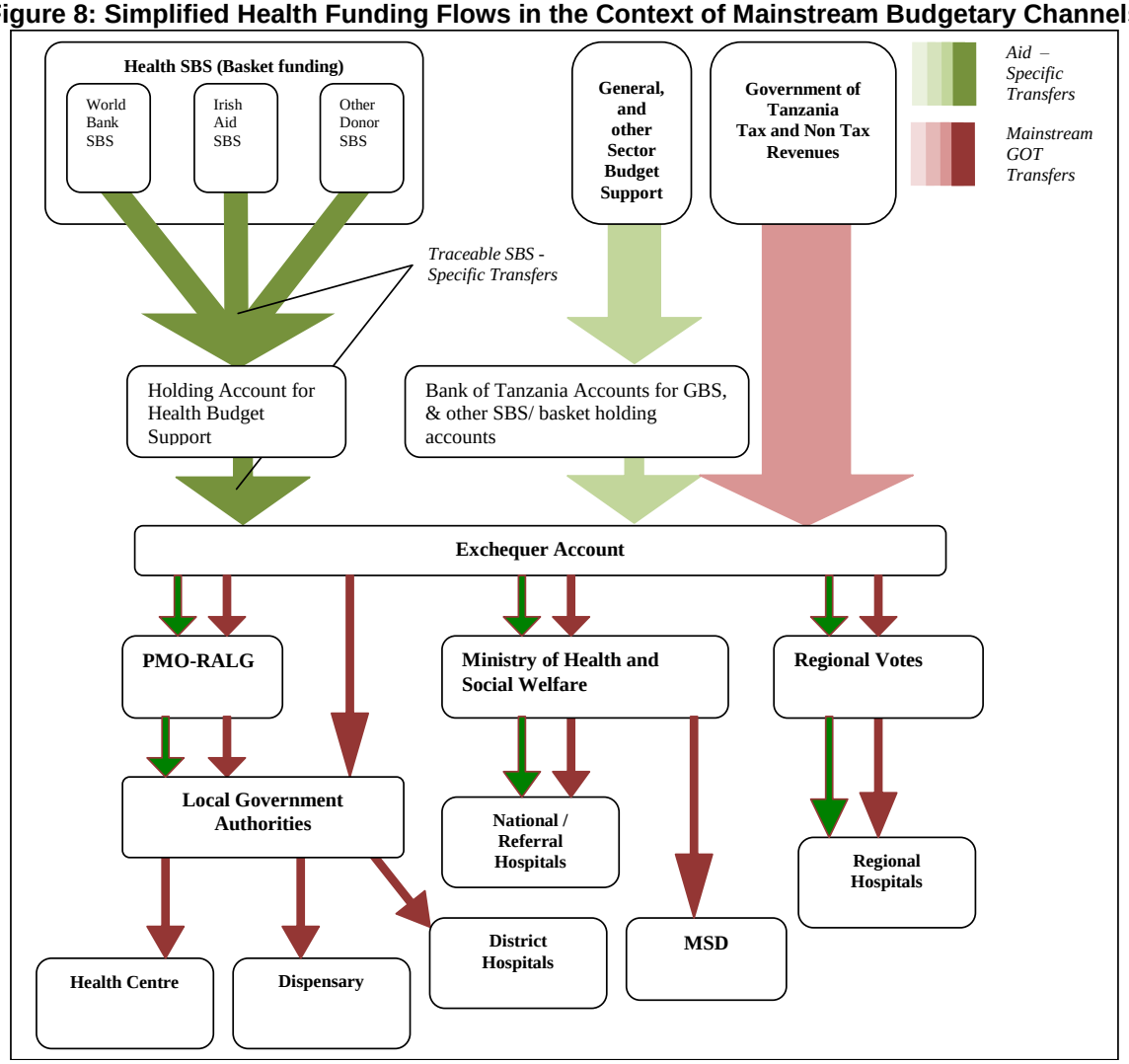
Additionality refers to requirements from the donor that the provision of external funding earmarked to a set of expenditures leads to an increase in total expenditure allocations to those expenditures. Additionality attempts to address the problem of fungibility, which arises because government resources can be substituted for aid resources. If aid finances any activity that the recipient would otherwise have financed itself, the resources that the recipient would have spent on that activity become available to finance something else.

Source: SBSIP Literature Review

66. SBS resources are currently allocated, disbursed and used at the central, regional and local level. Resources are allocated on the basis of the priorities of the Health Sector. Development partners do not engage directly in stipulating how such resources should be expended, although a guaranteed proportion of SBS resources is earmarked and must be released to lower levels of government as mandated by the relevant MoU and side-agreement.

67. SBS funded expenditures are traceable. They are separately identifiable in MTEF and annual budget documents (with their own budget codes). Basket allocations are made in the development budgets for MoHSW, PMO-RALG and Regional Votes. Figure 9 below sets out the flow of funds from development partners through to the different spending agencies at the central, regional and local level.

Figure 8: Simplified Health Funding Flows in the Context of Mainstream Budgetary Channels



68. Development partners release resources into the Basket Fund Holding Account (henceforth the holding account) and from there funds flow into the Exchequer account along with other GoT resources[16]. Once SBS resources reach the Exchequer account they become much like any other government funds, the difference only being their origin (i.e. from the basket holding account and not general revenue funds of government) and that they are separately identified as basket funding

[16] Note that it is a slight simplification to talk of only one holding account. For instance the Joint Rehabilitation Fund (JRF), active 2004 to 2008, has it's own holding account funds are deemed to be part of the mainstream basket fund.

in the development budget. Furthermore, the amount transferred out of the exchequer is based on the amount of SBS funds that have been transferred from the holding account by donors.

69. From the outset a separate transfer mechanism to local authorities for health basket funds to local authorities was put in place, and separate reporting mechanisms for the basket transfers to LGAs were also developed.

70. SBS resources have also been subject to higher audit requirements than mainstream sector resources. Up until the current financial year an external audit firm has been contracted to support GoT audits of the sector and to provide a separate audit of SBS resources.

Mechanisms for Policy Dialogue and Conditionality

71. SBS stakeholders generally use the SWAp mechanism for dialogue in the Health Sector although there are several mandated opportunities for basket fund dialogue. The latest MoU (2008 to 2015) requires three scheduled occasions per annum, as outlined in Box 6 below.

72. Burki (2001) points to some contention between DPs financing the basket and those using traditional projects in the early years of the SWAp. Those that could not or simply did not fund the basket considered that the effective health sector policy and dialogue process was only occurring with the members of the Basket Funding Committee. Despite potential for rifts and animosity the general movement has been towards increased coordination and the MoHSW has actively encouraged DPs to join the basket fund.

Box 6: Dialogue Requirements (2008-2015)[17]

i) Representatives of the GoT and DPs will hold the main annual BFC meeting the third week of May. This meeting will review progress, and discuss specifically:
- Assessment of the CCHP and RHMT plans;
- Draft procurement plan for the next fiscal year plus the progress in implementing planned procurement;
- Summary of income and expenditures; and
- Actions taken in follow up to any and all audits of the health sector.

The Basket Partners present at this BFC meeting will also approve the disbursement for the coming fiscal year, decide the content of the Side Agreement and sign it.

ii) The JAHSR scheduled for the 1st quarter of each fiscal year will serve as the opportunity for the second BFC meeting, as all DPs are expected to provide information on their financing for the coming fiscal year, and as the JAHSR is expected to discuss priorities for the budget guidelines and CCHP guidelines. Any proposed changes in the share of the allocation to the district health basket would also be presented and discussed during a specific agenda item at the JAHSR.

iii) The SWAp meeting scheduled early in the 3rd quarter of each fiscal year will provide the opportunity for a third BFC meeting discussing implementation progress and budget performance. The meeting is also intended to ensure that the minimal requirements for disbursement for the following fiscal year are met and delays in disbursements can be avoided.

73. In terms of a conditionality framework the SBS funding is dependent on adherence to the MoUs and side agreements that have evolved over the study period. Overall the basket fund has matured to try and reduce derogations from GoT systems and to only request documents that are also required by the GoT systems. However, a considerable amount of time is invested following–up the sector's generation of a large number of these documents including:

- Health Sector Performance Report (prior year)
- Controller Auditor General Audit of the Health Sector (prior year)
- Summary and analysis of CCH plans and RHMT plans

[17] MoU, 2008 to 2015, pp. 5.

- Summary of consultations held on budget guidelines
- Consultations on draft MTEFs of the MoHSW & PMO-RALG
- Quarterly progress on procurement
- Summary of total expenditure in the health sector twice annually
- Regular submission of the financial statements of the holding account

74. The 2000/1 side agreement placed the following restrictions on LGAs use of SBS resources: i) funds may not be used for capacity building initiatives; and ii) allowances should not exceed 20% of total expenditure funded from SBS funds. These types of soft 'conditionalities' from the side agreement along with 'undertakings' agreed at the Joint Annual Reviews all add up to a significant number of requirements on the Health Sector.

Links to Capacity building and Technical Assistance

75. DPs active in providing SBS are motivated by reform of the Health Sector as well as providing finance for service delivery. The basket fund does provide finances for reform and capacity building but there is currently no pooled mechanism for technical assistance (TA), although talks are in progress. Instead there are some DPs providing TA as part of their wider health programme. For example, Danida provide financing for the basket and run a project that provides full-time TAs to the MoHSW. Overall DPs take care to coordinate TA to prevent duplication as part of their commitment to the SWAp and harmonisation in general.

Links to Other Modalities

76. There has in the past been momentum for DPs to switch over from SBS and basket modalities to the provision of GBS (the governments preferred aid modality). However, currently only one DP, the UK's DfID, has actively switched from funding the health basket to GBS. They ceased to fund the basket at the close of the 2002/3 financial year[18]. Smithson (2002) discusses the potential move of DfID and cites push factors such as: delays in financing flows, extra administrating and "*an 'externalisation' of accountability to the detriment of a nationally owned and accountable resource allocation and management process*". He does suggest though that the basket mechanism is justified, in particular for health financing at the local level, but DfID eventually concluded that the time was apt for a switch to funding MoHSW via mainstream GoT systems.

77. Following the move by DfID to GBS, and despite previous assurances, the overall resources flowing to the Health Sector declined. This has made other DPs slightly more reserved about any potential shift and the issue of the SBS providing additionality to Health Sector remains a key motivator for the Health Sector and DPs to maintain the basket[19].

3.2 Derogations from Country Policies, Systems and Processes

SQ2.2: To what extent have SBS inputs derogated from country policies, systems and processes, and are these a result of country specific concerns and/or headquarter requirements?

78. The first major derogation of the SBS provided is the existence of a holding account and a conditionality framework mandated by the MoU and respective annual side-agreements. The holding account gives DPs an extra level of control of resources (as well as helping to ensure additionality). The presence of the holding makes it easier to hold back resources for a period of time until certain conditions are met (such control is not evident in the provision of GBS, especially if releases are made in full and in the first quarter). As the amount disbursed from the exchequer is based on the SBS funds that have been transferred from the holding account by donors, normal

[18] Other DPs thought about switching to GBS at the time and the World Bank having repeatedly voiced intentions although they still remain indecisive (at least up until the close of 2008/9).

[19] That said many DPs cannot switch further resources to GBS, even if such additionality was guaranteed.

cash management and budget disbursement procedures are not used. The holding account is evident in each of the sector baskets in Tanzania (health, water and agriculture) and is hence a derogation tolerated elsewhere in the Tanzania external assistance framework. Box 7 illustrates the guiding principles for basket fund conduct in Tanzania.

Box 7: JAST (2007)

'Guiding principles for the design and conduct of basket funds', JAST (2006), (pp.19)
a) They support national, sector and local priorities, strategies, plans and programmes, and are based on the Government's request to undertake such activities outside GBS. The request among others should explain why the basket fund or direct project fund approach is necessary or appropriate and how it is designed to support and be integrated in local, sector and national strategies and plans.
b) They are integrated in the national budget process and hence subjected to contestability of resources within the Government budget process.
c) They operate within Government structures, systems, regulations and procedures and are consistent with achieving sustainability, complementarity, low transaction costs and local ownership.
d) They are designed and implemented under the same conditions as other Government funded activities.
e) They follow the proper Government process for project and programme approval.

79. The second major derogation is that SBS resources are also separately identifiable in the development budget and a parallel channel was created for funding LGAs on top of operational health transfers. Basket funds have flowed via PMO-RALG to local authorities, and not via regional votes which is the case for operational transfers. Although the establishment of reporting process was put in place for basket funding was important for accountability of basket funding, no such reporting was required for the pre-existing transfers. Additionally SBS resources have also been subject to higher audit requirements than mainstream sector resources (up until the current financial year an external audit firm has been contracted to support GoT audits of the sector and to provide a separate audit of SBS resources).

80. As discussed above the basket has evolved and become less rigid over-time but still conditions remain, especially in assuring the timely submission of required documents to the Basket Fund Steering Committee. The current conditionality framework, described in Section 3.1, only requires documents that the sector would have to otherwise produce although the rigorous follow-up from external parties represents derogation in itself (provoking a possible 'externalisation' of accountability).

3.3 The Effects of SBS on the Quality of Partnership in the Sector

SQ2.3: Has SBS contributed positively to the quality of partnership and reduction in transaction costs between development partners, the recipient government and civil society?

Effects on Quality of partnership

81. Mapunda (2003) asserts that the "*the adoption of SWAp has increased the visibility of the resource allocation and expenditure in the sector"* and that *"it has also opened a space of discussions between the government and donors that is supportive rather than confrontational*" (pp.5). This view echoes a general feeling that the SBS has been an instrument for improving Tanzanian ownership of an increasing proportion of Health Sector activities. This has in turn ensured a satisfactory level of partnership.

82. Issues still remain preventing further improvement in the quality of partnership. DPs still do not provide accurate forward projections for financing (often just the next financial year) that could be improved to cover the MTEF period. The GoT management of the SBS is also viewed as being a constraint to better partnership and the continual follow-up needed to gain access to key documents, such as audit and procurement reports, puts strain on the relationship and diverts the dialogue away from matters focused on improved service delivery or sector reform.

83. Despite the efforts of the SWAp and SBS to coordinate DPs there is still often a lack of a common DP position on key issues (such as solving problems relating to human resources) and in some instances varying opinion among DPs (user fees for example). This serves to reduce the quality of partnership as guidance is less effective.

Effect on Transaction Costs

84. The move to SBS is frequently viewed as one method of reducing transaction costs vis-à-vis project aid modalities. Although it is difficult to see evidence of reduced overall transaction costs due to an increase in project financing to the sector over the period, it is widely believed without the SWAp the transaction costs would be greater. For instance Paul (2005) finds that "*the SWAp has somewhat reduced overall government transaction costs in the health sector – but definitely not in a spectacular way*." (pp.53).

85. It may be that the nature of transaction costs may have changed more than the overall burden given the focus of the SBS dialogue on GoT systems as opposed to the requirements of a particular project. That said the Joint External Evaluation (2007) reported that a number of GoT and DP officials felt that there was still significant process overload in the interaction over the SBS.

4. Sector Budget Support and its Effects in Practice

4.1 SBS & its influence on Sector Policy, Planning, Budgeting, Monitoring & Evaluation Processes

SQ 3.1: What has been the influence of SBS on Sector Policy, Planning, Budgeting, Monitoring and Evaluation Processes, and what are the constraints faced and lessons learned in practice?

Effects on Systems for Sector Policy, Planning and Budgeting, Monitoring and Evaluation

86. The Plan of Work (PoW) and subsequent Health Sector Strategic Plan 2 (HSSP2) strongly supported a process of Health Sector reform aimed at addressing the recognizable deficiencies in the sector. These plans were part of the SWAp but a particular focus of the SBS stakeholder attention and resources. The plans helped understand and focus activities on achieving specific goals and targets in the Health Sector. Stakeholders report an improvement in quality of strategic planning in the sector since 1999.

87. The SBS has also helped facilitate a changing role for the MoHSW both via encouraging the decentralisation of resources and by focusing support through Health Sector systems. Administrative and financial responsibility for implementing health services at the district level and below has now effectively been transferred to PMO-RALG and LGAs. The MoHSW does still retain administrative responsibility for the regional and national/referral hospitals, as well as technical responsibility for the quality of health services at every level.

88. Despite being mandated in the MoU basket financing DPs at times don't get the impact on policies they would like. For instance it is expected that the sector's draft MTEF be shared with the basket fund committee for comments prior to its submission to MoFEA. However, this did not occur in 2007/8 although DPs sent input as guidance on priorities.

89. As well as increased resources flowing down to LGAs, SBS has helped improve the quality of planning and budgeting at the local level. Basket funding requires LGAs to draft a Comprehensive Council Health Plan (CCHP). CCHPs still represent some of the most advanced planning at the LGA level in Tanzania. LGAs are required to quarterly narrative and financial reports as a prerequisite for the release of funds (biannual). Compliance has been reported as very good in this area and systems are in place to appraise the quality of reports, although it is noted that the reports are largely narrative and are insufficient to make a verdict on past results.

90. As stated above during the provision of SBS both HSSPs and CCHPs have been initiated and subsequently improved upon. However, there is no comprehensive framework for reviewing and allocating overall sector resources. There still remains an absence of results-orientation in the sector and despite the sector performance reports and the introduction of PlanRep the links between budgets and sector outputs has been weak. Efforts are engaged in monitoring and evaluating how in general Health Sector funds are being targeted to the agreed priority interventions as elaborated in the HSSPs and MKUKUTA but this has progressed slower than many stakeholders had hoped.

91. The SBS stakeholders have requested Health Sector Performance Reports to illustrate what had been achieved with the resources expended. Over the last two years the MoHSW has contracted external expertise to produce a sector performance report that along with the dialogue surrounding the Joint Sector Annual Review have provided that main recurrent evaluation of the sector. The review's coverage has improved over time but much work on these reports has been externally driven and results sourced from surveys as opposed to routine data collection.

92. The Health Management Information System (HMIS) does produce routine data but it has historically been faced with operational problems that cause under-reporting, incompleteness of

reports, poor timeliness and weak capacity in data analysis at all levels of health delivery systems (see MoHSW 2008).

Effects on Sector Expenditure

93. SBS has provided a flow of discretionary expenditure to the sector that has become increasingly reliable over time. Discretionary funds are provided at both the central and LGA level and (as discussed in Section 3.1) sector resources would not necessary be as large if funding were instead provided by GBS.

94. The Health Basket has, as stated above, been a major driver in decentralising resources to the Local Government Authority (LGA) level. In 2000 it was required that a minimum of US$0.5 per capita of SBS resources was spent at the local level but this rose to US$0.75 per capita in 2004 and to US$1 per capita in 2008. Mapunda (2003) recognises the early impact the basket had on encouraging decentralisation policy in Tanzania.

95. As SBS ensures a minimum level of expenditure is transferred down to LGAs so in effect the remaining resources are used at the central level (a small proportion has recently been allocated to the regional level). This has meant that central allocation has been equal to the total basket minus funds used at the local level.

96. There is concern that too high a proportion of the Health Sector budget begin spent on workshops, allowances, and training abroad rather than the on the delivery of core health care services. This trend is evident at both central and local level. The excessively detailed MTEF process also contributes to such inefficiencies at the centre. Beyond these broad statements it is difficult to state specifically what SBS funding has been spent on, despite the fact that SBS is traceable.

Lessons learnt

97. SBS has had a positive influence on policy, planning, budgeting, reporting and monitoring in the health sector in three main areas:

- The use of government systems by SBS in the context of the SWAP has focused attention of dialogue, conditionality and TA on GoT policy development, planning, budgeting and reporting, and review process at the national level. Subsequently the quality of all these processes and associated documents has improved to some extent.
- The earmarking of a proportion of SBS to local authorities has helped ensure resources have been channelled to LGAs -putting into operation the policy of decentralised service delivery. This may not have been possible with other modalities such as project support and GBS.
- The channelling of resources to LGAs has also provided an incentive to improve planning, budgeting and reporting at that level, whilst the dialogue and TA associated with this has helped improve these processes.

98. The dialogue and other inputs associated with SBS have failed to produce a comprehensive overview of health sector expenditures over time, which has undermined strategic resource allocation. This has undoubtedly been made more difficult by the structure of the GoT budget, the nature of the budget process and the huge and fragmented external resources associated with the sector. Without such strategic oversight, which incorporates vertical health funding alongside more discretionary forms of aid such as SBS, the discretionary nature of resources, combined with the nature of the MTEF process, has led to inefficient spending.

4.2 SBS and its Influence on Sector Procurement, Expenditure, Accounting and Audit Processes

SQ3.2 What has been the influence of SBS on Procurement, Expenditure Control, Accounting and Audit Systems at the Sector Level, and what are the constraints faced and lessons learned in practice?

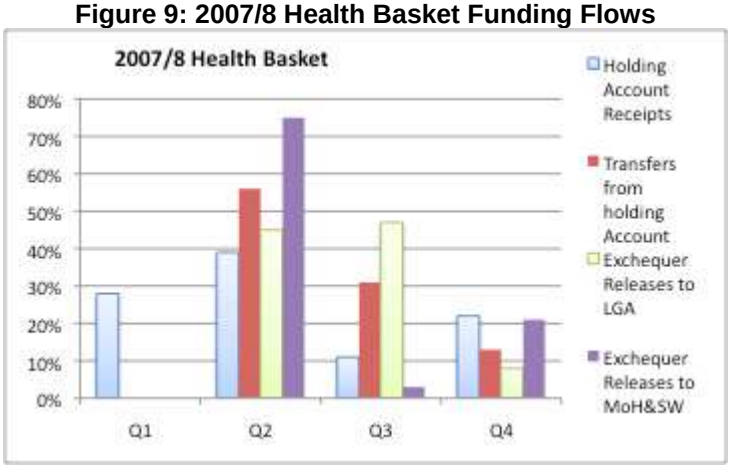
Predictability of Budget Execution

99. At the time of the introduction of the basket fund in 1999, sector recurrent resource transfers to local authorities, including salaries, were vastly unreliable. In addition, the annual budget was unreliable for central votes, such as the Ministry of Health. Although it was not possible to verify, it is reasonable to assume that this was one of the motivations behind the development of a parallel transfer mechanisms for SBS resources to local authorities, and separate budget lines for the MoHSW. This ensured LGAs received increasing resources. However, it also had the effect of fragmenting sector funding at the local level, when capacity was weak.

100. As the amount transferred out of the exchequer is based on the SBS funds that have been transferred from the holding account, SBS runs parallel to the overall government cash management system. Whilst from a Health Sector perspective this might be desirable, from an overall cash management perspective, it is not.

101. The literature quotes readily the delay in release of SBS funds to LGAs, however recent improvement must be acknowledged. Figure 9 shows the releases of funds from the holding account and then subsequent Exchequer releases to LGAs and MoHSW in 2007/8 for basket funding. By the close of the second quarter 74% of resources had be released to the MoHSW and 45% to LGAs. Whilst LGAs had received proportionally less of their budget than the MoHSW they had still received 90% of their half year budget. This graph also highlights a derogation of SBS resources, i.e. that resources do not follow normal cash management procedures. It appears that the exchequer waits for basket funding to turn up before funds are released rather than treating SBS sourced expenditure like mainstream GoT funding.

Figure 9: 2007/8 Health Basket Funding Flows



Accounting and Auditing

102. Audits for SBS resources, as stipulated by the 2008-2015 MoU, are currently conducted by the Controller and Auditor General (CAG) as they are for all mainstream GoT resources. The SBS arrangements require that development partners receive a copy of the report within 14 days of its release. The Health Sector also has an Audit Sub-Committee, attended by representatives of the basket fund committee, who discuss, follow-up and implement issues and recommendations relating to audit reports.

103. The work of the Audit Sub-Committee has helped improve the scope and scrutiny of government audits. The committee meets on the last Thursday of every month inclusive of both

government and development partner staff with relevant technical skills. In addition in 2006/7 a plan was launched to increase in the number of internal auditors and trained accountants at LGA level.

104. Prior to the current MoU SBS resources have been audited by Price Water House Coopers (as well as within the Controller and Auditor Generals coverage of the Ministry and LGAs). The role of the external auditor has been to audit resources and also build sector capacity for auditing. When such audits were carried out, follow-up on issues raised was not consistent, as follow-up required ownership of the issues or recommendations made, which was not always evident.

105. The decision was taken recently to solely rely on CAG audits following improved quality and a desire for SBS resources to utilise GoT systems more fully.

Procurement

106. The 2008-2015 MoU mandates that procurement must take place in accordance with the Public Procurement Act (No. 21), 2004. All procurement is thus covered by one procurement plan currently covering both GoT and SBS expenditure. Improvements in the timeliness and quality of such plans has accelerated in recent years but over the life of the SBS problems have been associated with accessing such plans in a timely fashion and encouraging open discussion of issues arising from the reports[20]. Huge efforts and follow-up have been needed to ensure that procurement reports and plans are produced and utilised.

107. Minutes of a development partner meeting convened on 12 December 2006 highlight concerns raised about the audit report findings from fiscal year 2004/5. These largely related to a lack of compliance with GoT regulations and procedures (e.g. Public Procurement Act 2001 and Public Finance Regulations 2001). Whilst some improvement had been noted (the number of qualified opinion increased from 37% in 2002 to 52% in 2004) a coherent action plan (inclusive of target and clear deadlines) was requested from government to secure confidence needed for future support. Similar concerns are evident throughout DP meetings over the period 2000 to 2006 and procurement appears to rank as one of the major issues to provoke correspondence.

108. Procurement audits are also mandated by the SBS MoU but problems are evident in their timely completion. Additional pressure has been applied by DPs to ensure that compliance in this area is improved. A good example is December 2006, a time when a procurement audit had been outstanding for two years. Following a long dialogue on this topic, fear over losing the World Bank's SBS support to GBS eventually prompted compliance and also a pledge by MoHSW to relocate experienced staff to a 'procurement examination section' that would examine payments and ensure accuracy and compliance with procurement plans.

Lessons learnt

109. SBS has had a positive influence on budget execution, procurement, accounting and audit in the health sector in two main areas:

- The traceable earmarking and parallel disbursement of SBS funding, in particular to local governments, helped early on in ensuring resources reached local authorities as planned (as government transfer mechanisms were unreliable from the outset).
- The recent switch of attention towards increased use of domestic public financial management systems by SBS funding has focused the attention of the dialogue on the

[20] The 2003/4 side-agreement pointed out that at the time, there were still no audit reports for 2001/2 (central) and 2002/3 (local government) nor was there a plan for addressing irregularities. Funding for 2003/4 became contingent on this as stated in the side agreement.

strengthening of government procurement, accounting and audit, and this has helped yield gradual improvements in audit follow-up and procurement.

110. The traceability of SBS funding involves the bypassing of government cash management systems, which undermines the ability of MoFEA to deliver a predictable budget to MDAs overall, including the MoHSW. As the predictability of the GoT budget has improved, the argument for this disbursement channel has diminished.

111. The dialogue on procurement plans and audit reports has been time consuming and has tended to dominate the dialogue at the expense of substantive discussion on service delivery and linking expenditure to results. Delays have been evident in receiving requested audit reports and procurement plans, despite them being a core part of the conditionality framework.

4.3 SBS and its Influence on the Capacity of Sector Institutions and Systems for Service Delivery

SQ3.3: What has been the influence of SBS on Sector Institutions, their Capacity and Systems for Service Delivery and what are the constraints faced and lessons learned in practice?

Overall Capacity and Systems Development

112. The capacity of sector institutions has been influenced by the focus of the SBS dialogue on GoT systems and also by technical assistance (TA) provided by the SBS DP stakeholders. This can also be credited with improving the capacity of the MoHSW in planning, budgeting, procurement and accounting. The Department of Policy and Planning in particular has benefited from this. By focusing on the quality of GoT documents the SBS dialogue can be credited at enhancing the ability of institutions to complete such documentation well.

113. The dialogue associated with SBS in the context of the SWAP has also helped increased focus on improvements in health systems development, despite the increase in project funding flows bypassing GoT systems. The focus of the MoHSW has successfully been shifted from delivering services, to managing and overseeing the delivery of services.

114. Although the SBS in principle does not ask much of the GoT beyond completion of policy documents, plans, budgets and reports that must otherwise be drafted, interaction with DPs is time consuming. Many DPs are frustrated with the delay in receiving many of the core documents and suggest that TA could be the answer. MoHSW feels that the drafting of such documents should be government business. There is a general dislike of TA by the GoT who in the sector balance the benefits of TA against full Tanzanian leadership and ownership of the process. Currently much of the TA in the MoHSW concentrates mainly on managing external funds, although a transfer of skills is argued by stakeholders directly involved[21].

Local Authority Capacity and Service Delivery System

115. Capacity at district level has improved in terms of budgeting (the existence and current quality of CCHPs is a good example) but there is little evidence of a link between such budgeting exercises and results in service delivery. SBS rewards LGAs for presenting good plans but there is little to incentivize improved results from service delivery.

116. Buse and Booth (2008) find that donors themselves reported a lack of donor leadership on the key issues of human resources. SBS has failed to make serious head way with influencing this

[21] SBS DPs are trying to switch the focus of current TAs in the MoHSW to assist more with basket management; this should in turn reduce the burden and assist in enhancing the quality of key documents.

issue and these problems among health staff have continued to have a negative affect on quality of care, as well as reducing the utilization of health services and ultimately impacting negatively on health outcomes.

Lessons learnt

117. The main area where SBS has had a positive influence on the MoHSW, is that the dialogue and conditions associated with SBS have created demands on the Ministry which have helped it move from being an implementer of services to one which sets policy, manages, monitors and supervises service provision.

118. Yet, the management of SBS has been a burden for MoHSW, whilst DPs have offered technical assistance the sector has not been ready to accept. A key concern is that the SBS only requires key GoT documents that should be produced, and does not encourage it to make decisions that would improve the management of health services.

119. SBS has made some good progress in enhancing service delivery by assisting in the development of a strategic framework. However, key impediments to progress persist, such as human resource problems and a weak link between planning and actual expenditure.

4.4 The Influence of SBS on Domestic Ownership, Incentives and Accountability in the Sector

SQ3.4: What has been the Influence of SBS on Domestic Ownership, Incentives and Accountability in the Sector, and what are the constraints faced and lessons learned in practice?

Domestic Ownership

120. Buse and Booth (2008) in their study of the political dimensions of health sector reform in Tanzania quote an informant as suggesting "*the MoHSW prefers the basket to GBS but likes projects even more*". Attracting projects and baskets provides guaranteed funding to the Health Sector and quite often opportunities for individuals to benefit via training and workshops. This suggests that there is ownership of SBS from inside the sector, a point backed up by the fact that MoHSW and PMO-RALG have been active in supporting DPs to justify the continuation of the basket.

121. SBS inputs include the Health Sector Annual Review and sector strategies but it is unclear whether these processes are owned by GoT outside of the Health Sector. It does not appear that MoFEA participates fully nor references these inputs fully. The MoHSW must engage to get resources but there is little incentive for MoFEA to play a more active role (for instance in rigorously checking that MTEFs are fully linked to HSSPs).

Incentives and Accountability

122. The Common Basket Fund Steering Committee is DP dominated and spends a significant proportion of contact time with the MoHSW following-up when key documents are to be submitted. These documents form part of the conditionality framework and although Health Sector officials have to draft them anyhow (MTEF for MoFEA and audit reports for Parliament for example) there is often a delay in their submission, and consequently delays in disbursement have occurred.

123. The incentive for the sector to improve the management of the SBS, including the timeliness of reports, depends on whether GoT thinks funding would flow if the conditionalities are not met. Or that more funds would be received (and possibly greater discretion) if circumstances improved further. Annex 2 shows that in most years the level of funding has increased although a credible threat was presented by DPs in 2005 and 2006 over submission of a back-log of audit and procurement reports. In this instance fears over losing the World Bank basket contribution to GBS led the MoHSW to increase compliance and advance the finalisation of the required reports.

124. The documents however should be produced without DP involvement and mechanisms in the domestic accountability system should provide follow-up and carrot or stick to ensure compliance. However, ownership is not consistent across GoT and just because MoFEA requires a particular document or reform it is not necessarily owned by the Ministries. Unless MoHSW feels there is some incentive for timely provision of a document, or indeed credible threat from non-compliance, it may not be prioritised despite being a government owned document.

125. Yet, focusing conditionality on GoT documents has raised the prominence of domestic processes. MoHSW staffs are now reporting more via domestic accountability processes as opposed to specific project's requirements as a result of the shift to SBS. LGAs have experienced scrutiny as a result of SBS but it is unclear whether this has strengthened upward accountability at the expense of local accountability.

126. The Joint Health Sector Annual Review is the main annual assessment of the sector and this has been largely donor driven with little interest from GoT leadership. A satisfactory health sector review is also a trigger for the disbursement of some DPs GBS and this has in years of perceived weak performance provoked wider interest into the issues raised at the sector's review.

Lessons learnt

127. The main area of positive influence is the focus on core requirements in the domestic accountability cycle, such as budgets, reports and audits. This has helped raise the profile of domestic processes and therefore facilitated stronger domestic accountability.

128. Yet, placing too many conditions in the conditionality framework can result in delays in the disbursement of funds. Balance is needed between pushing more timely delivery of documentation and accountability and providing the discretionary resources needed for reform and service delivery to impact sector outcomes.

129. In addition, whilst Basket Funds are popular within the MoHSW, especially because what donors provide is disbursed to the sector, this undermines the conventional domestic lines of accountability between the MoFEA and the MoHSW.

5. The Effectiveness of SBS and the Conditions for Success

5.1 The Main Outputs of SBS

SQ4.1: What are the main contributions that SBS has made to the improvement of sector policy processes, public financial management, sector institutions, service delivery systems and accountability?

130. SBS provided to the Health Sector in Tanzania between 1999 and 2008 has made some important contributions to the improvement of Health Sector outputs in Tanzania. These influences on sector outputs are identified in Table 6.

Table 6: Summary of Influence of SBS on Sector Outputs

Domain	Extent and description of Influence (Influence rated as slight or strong)
Sector policy, planning, budgeting, monitoring and evaluation	STRONG -The use of government systems by SBS in the context of the SWAP has focused attention of dialogue, conditionality and technical assistance (TA) on GoT policy development, planning, budgeting and reporting, and review process at the national level. Subsequently the quality of all these processes and associated documents has improved to some extent. STRONG -The earmarking of a proportion of SBS to local authorities has helped ensure resources have been channelled to LGAs putting into operation the policy of decentralised service delivery. This may not have been possible with other modalities such as project support and GBS. STRONG -The channelling of resources to LGAs has also provided an incentive to improve planning, budgeting and reporting at that level, whilst the dialogue and TA associated with this has helped improve these processes.
Procurement, expenditure, accounting and audit processes	STRONG -The traceable earmarking and parallel disbursement of SBS funding, in particular to local governments, helped early on in ensuring resources reached local authorities as planned (as government transfer mechanisms were unreliable from the outset). SLIGHT -The recent switch of attention more towards increased use of domestic public financial management systems by SBS funding has focused the attention of the dialogue on the strengthening of government procurement, accounting and audit, and this has helped yield gradual improvements in audit follow up and procurement.
Capacity of sector institutions and systems for service delivery	SLIGHT -The main area where SBS has had a positive influence on the MoHSW, is that the dialogue and conditions associated with SBS have created demands on the Ministry which have helped it move from being an implementer of services to one which sets policy, manages, monitors and supervises service provision.
Domestic ownership, incentives and accountability	SLIGHT -The main areas of good practice focus on core requirements in the domestic accountability cycle, such as budgets, reports and audits. SBS has helped raise the profile of domestic processes and therefore facilitated improved domestic accountability.

131. Despite such links there a number of areas in which improvements could have been greater and where SBS has potentially undermined progress. For instance SBS has failed to influence the following:

- The dialogue and other inputs associated with SBS have failed to produce a comprehensive overview of Health Sector expenditures over time, which has undermined strategic resource allocation.
- The traceability of SBS funding involves the bypassing of government cash management systems, which has undermined the ability of the MoFEA to deliver a predictable budget to MDAs overall, including the MoHSW. As the predictability of the GoT budget has improved, the argument for this parallel disbursement channel has diminished.
- The dialogue on procurement plans and audit reports has been a time consuming and has tended to dominate the dialogue at the expense of substantive discussion on service delivery and linking expenditure to results. Delays have been evident in receiving requested audit reports and procurement plans despite them being a core part of the conditionality framework.
- SBS has failed to make an impact on the human resources issue that represents a key impediment to progress.

5.2 The Sector Outcomes Influenced by SBS

SQ4.2: Have the improvements in sector systems and processes to which SBS has contributed, had a positive influence on sector service delivery outcomes, and are they likely to do so in future?

132. Three gaps which SBS has failed to address make it is difficult to make specific assertions of the influence of SBS on sector outcomes. These are: (i) the absence of a clear picture of what SBS has been spent on; (ii) the lack of a comprehensive overview of sector expenditures; and (iii) the paucity of information on service delivery.

133. Nevertheless, as discussed above SBS can be viewed as a positive influence on sector outputs. These judgements have been made on the basis of conventional wisdom –largely the literature reviewed and brief interviews conducted as part of this desk study. Some of these improvements can be linked to improvements in sector outcomes or at least to progress in developing the necessary conditions for improvements in sector outcomes. However, to make a fair judgement of the influence of SBS, other factors as outlined in Chapter 2 must be considered in conjunction with SBS.

134. SBS can be credited as having its greatest influence via the provision of discretionary resources to lower levels of government. For this the link with SBS is clear cut as it was the major driver behind early transfer of resources to local governments in the health sector. Other links between SBS and sector outcomes are not as clear cut but it can be plausibly assumed that SBS is linked to each of the factors said to influence sector outcomes in Table 3.

135. Despite gains in some areas SBS has failed to make progress in alleviating all the impediments to improved service delivery. The major failing relates to the issue of human resources. Human resources issues are argued to be a major factor limiting further progress in Health Sector outcomes and SBS has not been able to make or support significant gains in this key area.

6. Conclusion

Primary Study Question:	**How far has SBS met the objectives of partner countries and donors and what are the good practice lessons that can be used to improve effectiveness in future?**

136. The overall objectives of the SBS have been to support both implementation of the Health Sector's strategic plans and to expedite reform of the sector. SBS can be credited with success to some extent in both these endeavours.

137. Chapter 4 highlights the effectiveness of the SBS and provides a series of both positive lessons from the provision of budget support. Chapter 5 suggests that the SBS has indeed had an impact on health sector outputs and that these have in turn led to, or improved the conditions for improved health sector outcomes. A key strength of the SBS has been its role in transferring a fixed proportion funds to the local level. Contrastingly though SBS has been unable to influence some of the key impediments to service delivery such as issues relating to human resources.

138. When reviewing the Health Basket in 2008 stakeholders justified it's continuation on the following grounds. Firstly, the Basket fund has proved to be a viable financing instrument for strengthening health services in the country (especially at the LGA level). Secondly, it offers DPs not able or willing to fund GBS (or GBS further) a method of moving away from projects towards the use of GoT systems. Thirdly, the SBS is flexible enough to deal with a changing environment, new DPs etc. Finally, it has evolved considerably already and stakeholders should be prepared to continually adapt. These justification and the overall findings of this desk study support the decision to continue the provision of SBS all be it with improved alignment to GoT systems.

139. A number of lessons can be taken from the Health Sector SBS, both from positive and negative effects of the SBS. These are summarised in Table 7.

Table 7: Summary of Lessons Learnt

Domain	Practice with positive effects	Practice with negative effects
Sector policy, planning, budgeting, monitoring and evaluation	- The use of government systems by SBS in the context of the SWAP has focused attention of dialogue, conditionality and TA on GoT policy development, planning, budgeting and reporting, and review process at the national level. Subsequently the quality of all these processes and associated documents has improved to some extent. - The earmarking of a proportion of SBS to local authorities has helped ensure resources have been channelled to LGAs putting into operation the policy of decentralised service delivery. This may not have been possible with other modalities such as project support and GBS. - The channelling of resources to LGAs has also provided an incentive to improve planning, budgeting and reporting at that level, whilst the dialogue and TA associated with this has helped improve these processes.	-The dialogue and other inputs associated with SBS have failed to produce a comprehensive overview of health sector expenditures over time, which has undermined strategic resource allocation. This has undoubtedly been made more difficult by the structure of the GoT budget, the nature of the budget process and the huge and fragmented external resources associated with the sector. Without such strategic oversight the discretionary nature of resources, combined with the nature of the MTEF process, has led to inefficient spending.
Procurement, expenditure, accounting and audit processes	-The traceable earmarking and parallel disbursement of SBS funding, in particular to local governments, helped early on in	-The traceability of SBS funding involves the bypassing of government cash management systems, which undermines the ability of the

Domain	Practice with positive effects	Practice with negative effects
	ensuring resources reached local authorities as planned (as government transfer mechanisms were unreliable from the outset). -The recent switch of attention more towards increased use of domestic public financial management systems by SBS funding has focused the attention of the dialogue on the strengthening of government procurement, accounting and audit, and this has helped yield gradual improvements in audit follow up and procurement.	MoFEA to deliver a predictable budget to MDAs overall, including the MoHSW. As the predictability of the GoT budget has improved, the argument for this parallel disbursement channel has diminished. -The dialogue on procurement plans and audit reports has been a time consuming and has tended to dominate the dialogue at the expense of substantive discussion on service delivery and linking expenditure to results. Delays have been evident in receiving requested audit reports and procurement plans despite them being a core part of the conditionality framework.
Capacity of sector institutions and systems for service delivery	-The main area where SBS has had a positive influence on the MoHSW, is that the dialogue and conditions associated with SBS have created demands on the Ministry which have helped it move from being an implementer of services to one which sets policy, manages, monitors and supervises service provision.	-The management of SBS has been a burden for MoHSW, whilst DPs have offered technical assistance the sector has not been ready to accept. A key concern is that the SBS only requires key GoT documents that should be produced, and does not encourage it to make decisions that would improve the management of health services. -SBS has made good progress in enhancing service delivery by assisting in the development of a strategic framework. However, key impediments to progress persist, such as human resource problems; the question remains whether SBS could have been better focused on dealing with such a key issue.
Domestic ownership, incentives and accountability	-The main areas of good practice is that on core requirements in the domestic accountability cycle, such as budgets, reports and audits has helped raise the profile of domestic processes and therefore facilitated stronger domestic accountability.	-Placing too many conditions in the conditionality framework can result in delays in the disbursement of funds. Balance is needed between pushing more timely delivery of documentation and accountability and providing the discretionary resources needed for reform and service delivery to impact sector outcomes. -Whilst Basket Funds are popular within the MoHSW, especially because what donors provide is disbursed to the sector, this undermines domestic lines of accountability between the MoFEA and the MoHSW.

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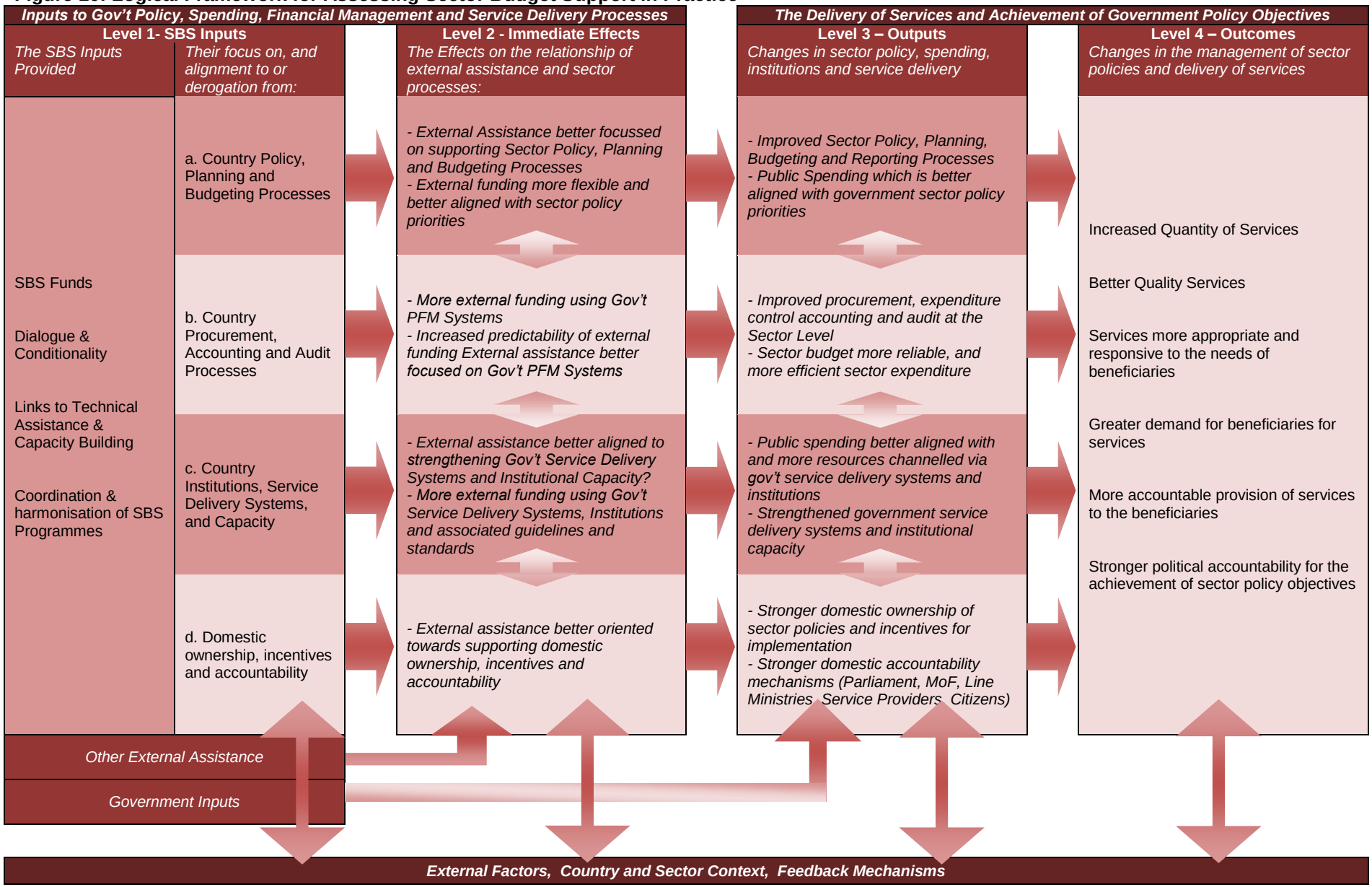
People Interviewed

Despite this being a desk study a number of brief interviews took place in February 2009.

- Mariam Ally, MoHSW
- Torben Ulstead, Health Sector Programme Support (Danida)
- Rik Peeperkorn, Embassy of the Kingdom of the Netherlands
- Jacques Mader, Swiss Development Agency
- Colleen Wainwright, Irish Aid
- Paul Smithson (telephone interview) IFAKARA Tanzania

Annex 1 – Summary of Findings against Logical Framework

Figure 10: Logical Framework for Assessing Sector Budget Support in Practice



a) Context in which SBS has been Provided

	Country context	Sector context	Aid management context
1999- "Early comer": Common Basket Fund with start of policy/ planning reform and SWAp	Policy: Vision 2025, National Strategy for Growth and Poverty Reduction (2005-10). Growth: High, cumulative 52% (real terms) over period 2001 to 2007. Poverty reduction: slower than expected, from 36% to 33% in the same period. Recent trend of rising inequality. Institutional set-up: Decentralisation under way (LG Reform Programme), including political, administrative and fiscal decentralisation "on paper". Slow progress; Mixed messages (e.g no legal framework yet; resistance of line ministries to decentralise staff; centrally decided erosion of local tax basis). Reform of public sector/civil service has a very long history in Tanzania (1991), with initial progress e.g. in down-sizing, but little success in tackling basic issues e.g. low pay, motivation and service delivery quality. Recent trends: Tanzania has been a quiet donor darling but this is under strain as corruption is said to be mounting or at least not decreasing. PFM Public spending (including increasing aid flows) related to GDP almost doubled from 1995 to 2008 (focus on priority sectors).	Policy/plan/M&E: First joint (GOT/donor) planning mission 1995; 1st sector strategic plan (1999) together with commitment to SWAp; 3rd plan under preparation. Health Policy 2007. Sector milestones and annual targets in annual reviews/ MTEF submissions reveal uneven progress in tackling long-standing issues (e.g. HR crisis, hospital reform, public-private partnership). Progress in (i) significant "decentralisation" of service management and sector resources[22]; (ii) shifting MOH role to policymaking and regulation. Spending levels Health budget split; To this date, no overview of total health funding (thus not possible to assess link funding – policy priorities). Various estimates show substantially increasing spending (e.g. per capita 4.1US$ in 2000/1 to 9.2US$ in 2005) but still below international targets. Very large recent increase in vertical funding focused on HIV/AIDS. Sector results Poor outcomes in 1990s (strategic plan developed as a response to this); Some progress since 1999 (e.g. in Under-5 mortality) but mixed (no progress in maternal mortality). HIV/AIDS is a major issue; Life expectancy down from 53 years in 1999 to 46 years in 2004. Some progress in coverage (e.g. births attended	General aid trends Net ODA as a share of GDP averaged 12.9% in the 1995-2003 period; In 2006/7 external funding approximately 40% of public spending (up from 25% in 1998) and 80% of development budget. JAST 2006: GBS preferred modality. But after initial (pre-2004) shift to BS (42% of ODA in 2006/7), no clear trend; Thus in 2008/9, back to 2004/5 split BS (34%), projects (48%) and Common Basket Funding (18%). Aid to LG sector Commitment to SWAp and 1st agreement in 1999 (six donors including WB). First disbursement of Common Basket Fund Dec 1999. MOU and new code of practise in 2003; then 2006; then MOU 2008. SWAp dialogue broader than Common Basket Fund/SBS but Common Basket Fund has been "main SWAp support instrument"; "SWAp would not have been possible without it". Substitute to project aid for non-GBS donors. Ten donors in 2008/9. Significant and continuing increase in volume (2008/9 level more than 8 times 1999 level). However, recent decrease in terms of its share in total sector funding

[22] A large part of the Basket Fund was channelled to districts and earmarked on district plans (aggregated from the bottom up). Elected councils are involved in these processes. However broadly speaking, in Tanzania at this stage accountability for service delivery and local management is still strongly upwards and health (and other sector) staff are still centrally managed. This is thus intermediary between decentralisation and deconcentration.

	From very weak in mid-1990s PFM system now considered among most robust in Africa (early focus on spending control, improved cash management etc.; gradually improved policy-budget link though much progress yet to be done; weak reporting and fiscal decentralisation).	by trained personnel; vaccination) but not spectacular. HR crisis: From 1994/5 to 2001/2 health staff/ population ratio got worse; High urban/rural imbalance; No reversal of these trends to this day.	(from 22% in 2004/5 to 14% in 2007/8). Progressive growth in discretion in use of Common Basket Fund funding, and greater use of GOT systems. However, donors end up having to drive demand for "domestic accountability" systems. SBS management overshadows policy dialogue ("form over content").

b) Nature of the SBS Provided

	Types:	**Timescale:**	**Donors:**
Tanzania Health	Phase One	1999-03	Danida, DFID, Irish Aid, NORAD, Switzerland, World Bank
	Phase Two	2003-07	Danida, Ireland, Netherlands, Switzerland, KfW, World Bank, UNFPA, CIDA, UNICEF, Norway
	Phase Three	2008-	? (Donors active in phase two have pledged support)

	Funds and Financial Management	**Dialogue and Conditions**	**T/A and Capacity Building**	**Links to other Aid**
Tanzania Health	Funding Level: Started small, less than $10m in 1999/00, rising to $68m in 2007/08. Represented a switch early on, and then funding additional. Now funding is now large in absolute terms, is small relative to vertical health financing. Earmarking: SBS is broadly earmarked to sector expenditures in MoH and Local Governments, and forms part of the development budget. A guaranteed share must be transferred to LGs, and some conditions are attached to this funding. However, otherwise funding is largely discretionary. Traceability: Separately identifiable in the development budget of MoH and the	Dialogue Structures: SWAP mechanisms developed alongside SBS, although a separate Common Basket Fund committee exists. Conditionality Framework: GoT are required to prepare a number of documents in the context of the SWAP and Common Basket Fund. In addition undertakings are agreed at the Joint Sector Review, and side agreements signed each year. Focus: Although the framework is intended to be sector-wide, much dialogue is focused on process issues and following up on documentation. This is at the expense of overall policy	Part of SBS Instruments: SBS funding itself supports TA and capacity building activities. However there is no pooled fund for capacity building activities. Links to other initiatives: Donors take care to coordinate TA and prevent duplication as part of their commitment to the SWAP.	Links to Project Funding in the sector: Links to other aid modalities is carried out in the context of the SWAP. Links to GBS: There is little explicit link to GBS.

	Funds and Financial Management	Dialogue and Conditions	T/A and Capacity Building	Links to other Aid
	LG ministry development budgets. Cash Management: Funds are transferred from a holding account into the exchequer account. Only the amount received from donors is then transferred to the MoH and local governments. Use of Other Gov't FM Systems: Funds use government procurement and financial management arrangements. Additional audit requirements are also in place. Derogations: The main derogations relate to the traceability, cash management and audit procedures associated with SBS.	dialogue. Derogations: Side agreements and separate Common Basket Fund meetings represent derogations from the overarching SWAP arrangements.		
	Other important design features			
	Derogations: From the outset a mechanism parallel to the usual transfers for health operational funding to LGs was created. The justification was that the government transfer mechanism was too unreliable.			
	Effects of SBS on the Quality of Partnership			
	Quality of Dialogue: The SWAP increased the transparency of resource allocation in the sector opened space for dialogue between donors and government which is constructive. However unreliability in donor resource projections, and a perceived reluctance of the health ministry to release documents undermines the quality of partnership. There is also often a lack of a common position amongst donors. Transactions Costs: In the absence of a SBS, it is likely that transaction costs would be higher. However they are high already because of the proliferation of other aid instruments. The nature of transactions costs has changed more than the burden, and there is concern that there is process overload, at the expense of substance.			

c) The Effects of SBS in Practice

i) Policy, Planning, Budgeting, Monitoring, Evaluation and Expenditure

	Inputs	**Effects**	**Outputs**
	SBS funding is on budget, is aligned with government policies and is reported on using government systems. Focus (TA/CD, dialogue, conditions) on sector policy, planning, budgeting, monitoring and evaluation processes?	External funding more flexible and better aligned with sector policies overall; assistance better focused on supporting sector policy, planning and budgeting processes.	SBS contribution to: ▪ Public spending is better aligned with government sector policies. ▪ Improved Sector policy, planning, budgeting and reporting Processes
	Derogations: why, justified, temporary?	*Effects of derogations*	*How do derogations affect outputs?*
Tanzania Health	**Contextual factors:** Increase in domestic budget allocations from GBS and tax revenue to health sector; major increase in vertical funding to the health sector; improvements in national budget process in the context of PRS undermined by an excessively detailed MTEF process and no framework for consolidating sector expenditures by the Ministry of Finance.		
	Policy, Planning, Budget, M&E: SBS donors supported development sector policies and plans including the Plan of Work and Health Sector Strategic Plan in the context of the SWAP. SBS donors have continued to support subsequent iterations of sector plans. Use of Joint Sector Annual review as the main focus of discussing performance. Through TA support, SBS donors have supported the preparation of health sector performance reports which are discussed at these reviews. Common Basket Fund donors also request to provide input on the health sector MTEF before it is submitted to the ministry of finance, however this does not always occur. Donors routinely provide comments on budget priorities and have supported a series of Public Expenditure Reviews in the sector to inform the budget process. A guaranteed share of SBS resources was required to be channelled to local governments, and this focused	Dialogue and conditions associated with SBS have become more focused on government policies, plans and budgets. However donors do not always feel adequately engaged in the budget process. TA and capacity building support has been similarly focused on government systems, including at the LG	SBS has contributed to a process of health sector reform which has been aimed at addressing deficiencies in the sector. This includes the establishment of a clear strategic planning framework and associated Joint Annual Sector Review Process. Whilst the quality of plans and budget documents have improved there is still no comprehensive picture of health sector expenditure as MTEF submissions are prepared on an agency by agency basis and not routinely consolidated, despite a series of health sector PERs. The links to results are also weak. The budget process is not as transparent as some stakeholders, including donors, would like. SBS has provided impetus to decentralisation of health resources (see below) and supported complementary improvements in planning and reporting at that level. This has been through a combination of requirements to access SBS funding, and capacity building support. Although CCHPs represent the most advanced planning tools in LGs,

	Inputs	Effects	Outputs
	dialogue on planning and budgeting at this level. Complementary support to planning and budgeting at the local level through requirements for Comprehensive Council Health Plans and quarterly reporting against these plans linked to release of SBS funds to LGs.	level.	weaknesses in planning and reporting remain. A key problem is the absence of routine service delivery data, with the HMIS suffering operational problems. Annual sector review processes have improved over time and are an important forum for discussing sector performance. However, given the lack of routine data on performance, Annual Health Sector Performance Reports draw from surveys, and appear externally driven.
	<u>Resource Allocation:</u> SBS has provided a major flow of discretionary expenditure which has become increasingly reliable over time. Discretionary funds are provided at both the central and local governments with. A grant to local authorities was provided in parallel with normal recurrent health transfers, which was not considered a reliable channel. A minimum of $0.5 per capita being transferred to LAs up to 2003, $0.75 up to 2008 and $1 thereafter. The balance of funds is provided to the MoH, although recently regional votes have received funding. SBS funding is separately identifiable in the budget. Through dialogue donors do provide inputs into the budget process, through commenting on MTEF documents and supporting PERs, as discussed above.	SBS has provided a substantial amount of flexible funding to the health sector, which also contributed to increases in external funding. However, alongside, there has been an increase in vertical health funding, which means the relative flexibility of external funding has not improved.	The major positive effect SBS has had on resource allocation has been the channelling of significant volumes of funding to local authorities for health service delivery. However, there is too high a proportion of the Health Sector Budget being spent on workshops and allowances at both the central and local level, a lot of which are funded by SBS. The excessively detailed MTEF process contributed to such inefficiencies at the centre. There is no overall picture of resource allocation in the sector or past expenditures which undermines the ability of the government to make strategic resource allocations linked to the HSSP. This is a failure of DP TA and dialogue, despite their routine support to PERs. The scale of vertical funding in the sector is also likely to have undermined the overall links between policy and resource allocation.

ii) Procurement, Accounting and Audit

	Inputs	Effects	Outputs
	SBS funding uses government expenditure control, accounting and audit processes. Focus (TA/CD, dialogue, conditions) on strengthening government expenditure control, accounting and audit processes at the sector level?	External funding uses government FM systems more and is more predictable; assistance better focussed on gov't FM systems.	SBS contribution to: ▪ Improved sector procurement, expenditure control, accounting and audit at the sector level; ▪ Sector budget more reliable and sector expenditure more efficient.

	Inputs *Derogations: why, justified, temporary?*	**Effects** *Effects of derogations*	**Outputs** *How do derogations affect outputs?*
	Contextual factors: At the introduction of SBS in 1999 sector recurrent transfers to LAs were unreliable; and the annual budget for central votes was unreliable. Since then overall government financial management has improved markedly, with improved reliability of budget execution, better expenditure controls and improved audit. Procurement has also undergone reform.		
	SBS uses a separately identifiable channel of funds, which it is reasonable to assume, was created because of donors concerns over the reliability of the mainstream budget (although these concerns are no longer valid as budget predictability has improved). The amount transferred out of the exchequer is based on the SBS funds that have been transferred from the holding account, and therefore bypasses government cash management systems. Procurement and audit have key concern and feature strongly in dialogue and conditions. All procurement must take place in line with government regulations which stipulates that it is covered by a single procurement plan for GoT and SBS expenditure. Prior to 2008 SBS funds have been audited by private audit firms, with the auditor supporting sector capacity for auditing. Since 2008 Audits of SBS funding carried out by the Controller and Auditor General following improved quality and a desire to use government systems. Both Procurement and Audits have taken up a lot of the dialogue time. There have been problems in accessing audit documents and procurement plans despite being part of the conditionality framework.	SBS is separately identifiable and runs in parallel to the government's cash management system. Otherwise it uses government systems. However the overall share of aid using government systems has been undermined as a result of high levels of vertical funding. Dialogue and other SBS inputs are more focused on government FM systems, however a disproportionate amount of time is spent on the.	The earmarking of SBS resources to LAs combined with parallel disbursement of SBS funds helped ensure resources reached LAs in the context of unreliable government transfers. However, the use of parallel channel fragmented funding at LAs where capacity was weak. Initially transfers were fraught with delays, however the situation improved somewhat over time. This has done little to strengthen the overall predictability of sector resources, however, and bypasses government cash management procedures. There have been improvements in timeliness and consistency of procurement plans, however problems in transparency and follow up. Similarly Government follow up on private audits were not consistent, as follow up required ownership of the issues or recommendations made, which was not always evident. Whilst the use of the statutory audit is a positive step, it remains to be seen whether audit follow up improves. Overall dialogue has yielded some results in terms of audit and procurement follow up, however this is not commensurate with the time and effort devoted to the dialogue.

iii) Capacity of Sector Institutions and Systems for Service Delivery

	Inputs	**Effects**	**Outputs**
	SBS use of Gvt mainstream funding mechanisms and sce delivery institutions (structures, guidelines, stds)	SBS contribution to focus aid (funds and other	SBS contribution to: ▪ Increased **total** funds flows through mainstream govt channels for sce delivery, & used within regular institutional sce delivery framework

	Inputs Focus (TA/CD, dialogue, conditions) on devt and strengthening of mainstream sce delivery institutions? Derogations: why, justified, temporary?	**Effects** inputs) on sce delivery systems & capacity	**Outputs** ▪ Stronger sce delivery systems and institutions How do derogations affect outputs
Tanzania Health	**Contextual factors:** High political importance of health sector (patronage and popular politics); Following stagnation in the 1990s', mixed trends in service delivery (improvement in some areas, and people's perceptions of positive change; degradation or lack of progress in other areas); PFM reform and CSR ongoing; Decentralisation (LG reform) was emerging when SBS[23] started (1999); Non-SBS funding consistently high in the sector, and recently increasing (vertical funds).		
	SBS funds use GOT mainstream funding mechanisms and service delivery institutions albeit following parallel routes. TA, dialogue and conditions aim to strengthen GOT core functions at all levels (central policymaking, monitoring and supervision; LG service delivery management). In particular, SBS prompted the development of planning, reporting and review systems and practices at LG level, linked to earmarked transfers of SBS resources to LGs. SBS finances CD activities as part of the sector institutions' annual plans and budgets, but it is not clear how well this has been used. Through conditionalities ("side agreements"), donors felt that they had to limit the use of SBS in this respect (curtail focus on training and workshops). Some donors (including SBS donors) provided TA in addition (with a focus on MOH planning	SBS did not rein in the recourse to projects and programmes outside of the Common Basket Fund. This is actually increasing with the global/ regional vertical funds. There are talks about the establishment of a CB pooled fund.	SBS funding and systemic capacity effects (especially on planning/budgeting) are undeniable. In particular, the traceable earmarking of resources to LGs helped ensure that resources flowed for service delivery (especially in the early stage of decentralisation when GOT transfers were unreliable) and made it possible to operationalise the policy of decentralised service delivery management (including shifting the management responsibility away from MOH), as well as providing incentives to improve LG planning, budgeting and reporting, with support by TA/ dialogue inputs. However, it is not clear how systematic TA/CD has been (including at LG level) and to what extent the TA provided focused on skill transfers (as opposed to external fund management). At MOH level, the management of SBS[24] is seen as time- and capacity-consuming, at the detriment of attention to policy and decisionmaking that would be necessary to address service delivery issues. There still is not a clear link between plans/budgets and service delivery results. This is partly due to continued fragmentation in sector financing. SBS contributed to this fragmentation as it follows parallel routes, and this has, in itself, been a strain on LG capacity. The initial trade-off of privileging reliability of resource transfers (supposed to enhance service delivery performance) over reducing financing fragmentation (associated with greater demand on capacity) has not been revised even though GOT transfer systems have improved. Fragmentation may be further worsening with the increase in

[23] SBS in the health sector in Tanzania is provided to a Basket Fund (funds are earmarked and managed separately from GOT funds in terms of cash management).
[24] That is, the activities required to meet the associated accountability requirements, which are many and detailed (see below).

	Inputs	Effects	Outputs
	department). There has been no attention/donor leadership on the key issue of human resources in the sector (2004: "HR crisis").		vertical funding, which, in turn, generates greater demands in terms of management capacity away from mainstream systems. SBS failed to focus on (and therefore failed to contribute to address) the HR crisis, even though lack of trained personnel, inability of retaining it, highly imbalanced personnel deployment[25] and poor health worker motivation and performance are well-known to be major impediments to improved health care in Tanzania.

iv) Domestic Ownership, Incentives, and Accountability

	Inputs	Effects	Outputs
	How do SBS inputs support ▪ Stronger ownership of policies (all levels) and incentives to implement them (any particular effort)? ▪ Stronger domestic accountability[26]/avoid parallel requirements & biasing accountability to donors? Derogations to domestic accountability systems: why, justified, temporary	SBS contribution on ownership, incentives and domestic accountability Effects of SBS derogations	SBS influence on ownership, incentives & domestic accountability (stronger sense of responsibility & demand for performance etc.)
Tanzania Health	**Contextual factors:** High political importance of health sector (patronage and popular politics); Following stagnation in the 1990s', mixed trends in service delivery (some improvement, including people's perceptions of positive change; some degradation or lack of progress e.g. decline in health staff/population ratio; unbalanced staff deployment); PFM reform and CSR ongoing; Decentralisation (LG reform) was emerging when SBS[27] started (1999); Non-SBS funding consistently high in the sector, and recently increasing (vertical funds).		
	SBS funding raised the volume and proportion of sector resources that are visible in GOT systems, and provided	SBS (the Common Basket Fund) has	SBS has been an instrument for improving Tanzanian ownership of an increasing proportion of health sector activities. In

[25] Between 1994/5 and 2001/2 the ratio of trained health personnel per 100,000 population actually decreased, and measures taken to address this have not been sufficient to reverse the trend.
[26] Understood as accountability to parliament, of sector spending agencies to Min Finance, of sce providers to sector ministry/LG, of sce providers to citizens, of LGs to sector ministries (within respective mandates)
[27] SBS in the health sector in Tanzania is provided to a Basket Fund (funds are earmarked and managed separately from GOT funds in terms of cash management).

	Inputs	Effects	Outputs
	a flow of discretionary resources increasingly reliable over time, initially in stark contrast with GOT resources, especially at LG level. However, it is noteworthy that when DFID moved from (sector earmarked) SBS to (unearmarked) GBS, the decrease in donor earmarked funding was not compensated by an increase in GOT resource allocation. Over time (3 phases) SBS followed a trend of increased GOT discretion over the use of SBS resources within the sector, gradual relaxation of the derogations to the use of GOT systems (e.g. most recently with regard to audit and procurement), and expanding dialogue ("less basket specific" and focused on wider sector issues). SBS accountability requirements increasingly focused on not going beyond GOT's system. However, they appear to be very detailed (e.g. the MOU 2008 foresees that the Basket Fund Committee will assess all district and regional health plans); a considerable amount of time is expended in preparing (GOT) and following up on the preparation of (donors) a large number of documents; the practice of annual "side agreements" allows donors to add "soft conditionalities", which further adds on the requirements and the time necessary to meet them. There used to be no reporting system in place for GOT operational transfers for health services from the regions to LGs but this has now changed. Yet, LGs continue to report separately on SBS funding, through PMO-RALG and not through the regions.	been a critically important vehicle for the SWAp since its outset in 1999. Coordination between SBS and non-SBS donors has improved and the dialogue has become more inclusive of all donors. However, there are divergences among donors on key policy issues (e.g. how to address the "HR crisis", relevance of the user fee policy) SBS did not rein in the recourse to projects and programmes outside of the Common Basket Fund. This is actually increasing with the global/regional vertical funds.	particular, it significantly contributed to operationalising the decentralisation policy, which presumably improved ownership of health activities at LG levels too. With resources flowing reliably it became possible to demand accountability for service delivery results from LGs. However, it is not clear that this has been done systematically. The focus with regard to SBS funding seems to be on plan preparation and financial reports. LG accountability lines are split, following different fund routes which continue to proliferate in the sector. The HMIS does not provide the information that would be required to hold LGs to account. Moreover, it is not clear how local accountability systems and practices have evolved. Generally, the "donor tag" coming with SBS funds appear to incentivise the use of these resources for activities which are not directly linked to service delivery (training, workshops etc.). By its design and the way it is used, SBS contributes to mis-aligning ownership and incentives for different GOT agencies. MOF has little incentive to get involved given the traceable earmarked nature of the health SBS funding. In turn, MOF's weak ownership of the health policy and plans may explain why it didn't compensate when the sector "lost" SBS resources. This negative experience then reinforced MOH in its preference for traceable earmarked funding, which continues to distort accountability away from GOT mainstream mechanisms. Donors "play" on these factors in unhelpful ways (threatening to move to GBS if SBS accountability requirements continue to be met late etc.). The gradually higher alignment of SBS supported greater ownership and raised the profile of domestic accountability systems. However, incentives to conform to these systems appear to have remained weak in the sector. It is not because a procedure is asked by MOF that it is owned by MOH. The detailed form of and donor-driven nature of the follow-up o, the accountability requirements associated with SBS mean that even though these are domestic requirements, there is

	Inputs	Effects	Outputs
			"externalisation of accountability" (which pushed DFID to move to GBS).

d) The Outputs and Outcomes of SBS

	Main SBS Outputs Influencing Outcomes	Outcomes Influenced by SBS
	Changes in sector policy, spending, institutions, service delivery systems and accountability influencing sector outcomes	Changes in the implementation of sector policies and delivery of services influenced by SBS
Tanzania Health	The earmarking of a proportion of SBS to local authorities, helped putting into operation decentralised service delivery, and this has provided an incentive to improve planning, budgeting, financial management and reporting at that level. TA and capacity building has supported this. Traceability requirements helped early on to ensure predictability, but government transfers are now reliable and traceability now unduly undermines government cash management and fragments transfers to local authorities. Non financial SBS inputs, combined with the use of government systems, has helped improve the quality of policy development, planning, budgeting and reporting in the sector, through focussing attention and support on them. However the dialogue and TA inputs have failed to deliver an overall picture of sector resources, or service delivery levels which has undermined strategic resource allocation and M&E systems respectively. SBS inputs have had less strong, albeit net effects on overall PFM at the sector level; capacity development, and accountability. However in areas such as PFM the gains have been small relative to the effort put in. Probably the largest gap in the outputs of SBS has been the failure to make an impact on human resources issues in the sector.	SBS has had its greatest influence via the provision of increased and discretionary resources to lower levels of government supporting an expansion of service delivery at that level, which it is reasonable to assume has had a positive influence on health sector outcomes. Other SBS funding has less directly influenced the expansion of services, but is likely to have a positive effect. Other outputs of SBS are likely to have had a less strong influence on sector outcomes, through improving the efficiency and quality of service delivery. SBS has failed to make progress in some key impediments to service delivery, most notably human resources. Other gaps and failures in sector outputs are likely to have undermined the other effects of SBS on sector outcomes.

Annex 2 – Country and Sector Data

a) Core Country Data

Tanzania	1990	1995	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	SSA (2007)
Exports of goods and services (% of GDP)	13	24	15	15	17	16	17	20	22	21	22	-	**34**
GDP growth (annual %)	7	4	4	4	5	6	7	6	7	7	7	7	**6**
GNI per capita, Atlas method (current US$)	190	160	230	250	260	270	270	290	310	350	370	410	**951**
GNI per capita, PPP (current international $)	590	640	700	720	750	800	850	890	950	1,040	1,120	1,200	**1,869**
Gross capital formation (% of GDP)	26	20	16	16	18	17	19	19	18	16	17	-	**22**
Inflation, GDP deflator (annual %)	22	27	14	12	7	7	6	7	9	20	4	6	**6**
GDP (current US$m)	4,259	5,255	8,383	8,638	9,079	9,441	9,758	10,283	11,351	14,142	14,178	16,181	**847,438**
Official development assistance and official aid (%GDP)	27	17	12	11	11	14	13	17	16	11	13	17	**4**
Official development assistance and official aid (current US$m)	1,163	869	1,000	990	1,035	1,275	1,257	1,721	1,765	1,491	1,825	2,811	**35,362**
Revenue, excluding grants (% of GDP)	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Total debt service (% of exports of goods, services and income)	33	18	20	19	13	8	6	4	4	4	3	3	**5**
Fertility rate, total (births per woman)	6	6	-	-	6	-	6	-	-	5	5	5	**5**
Population growth (annual %)	3	3	2	2	2	3	3	3	3	3	3	2	**2**
Population, total (m)	25	30	32	33	34	35	36	37	38	38	39	40	**800**
Income share held by lowest 20%	-	-	-	-	7	-	-	-	-	-	-	-	**-**
Poverty headcount ratio at national poverty line (% of population)	-	-	-	-	-	36	-	-	-	-	-	-	**-**
Agriculture, value added (% of GDP)	46	47	45	45	45	45	45	45	46	46	45	-	**15**
Primary completion rate, total (% of relevant age group)	-	-	48	57	-	55	59	-	59	56	74	85	**-**
Ratio of girls to boys in primary and secondary education (%)	-	-	98	99	-	-	-	-	-	-	-	-	**-**
Births attended by skilled health staff (% of total)	-	-	-	44	-	-	-	-	-	43	-	-	**45**
Contraceptive prevalence (% of women ages 15-49)	-	-	-	25	-	-	-	-	-	26	-	-	**23**
Immunization, measles (% of children ages 12-23 months)	80	78	78	72	78	83	89	97	94	91	93	90	**73**
Life expectancy at birth, total (years)	51	49	-	-	49	-	50	-	-	51	52	52	**51**
Malnutrition prevalence, weight for age (% of children under 5)	-	-	-	25	-	-	-	-	-	17	-	-	**27**
Mortality rate, under-5 (per 1,000)	157	154	-	-	143	-	-	-	-	124	-	116	**146**
Prevalence of HIV, total (% of population ages 15-49)	5	7	7	7	7	7	7	7	6	6	6	6	**5**
Roads, paved (% of total roads)	37	4	4	4	4	-	-	9	-	-	-	-	**-**
Improved sanitation facilities, urban (% of urban population with acces	29	30	-	-	31	-	-	-	-	-	31	-	**-**
Improved water source (% of population with access)	49	50	-	-	53	-	-	-	-	-	55	-	**-**

b) Additional Sector Data

Health Sector Outcomes and Goals (Source: Joint Evaluation 2007, pp. 128)

Indicator	1996	1999	2004/5	PRS Goals (2003)	MKUKUTA Goals 2010[107]	MDG Goals (2015)[108]
Infant Mortality Rate[109]	88	99	68	85	50	40
Under Five Mortality Rate[110]	137	147	112	127	79	47
Prevalence of stunting in under five year olds	44	44	38		20	23.3
Prevalence of moderate or severely underweight (wasting) in under five year olds		29.5	21.9			14.4
Proportion of Children Vaccinated Against Measles[111]	81	78	80	85	85	90
Coverage of Diphtheria, Tetanus and Polio Vaccine among 12-23 months[112]	85	81	86	85	85	
Maternal Mortality Rate	529[113]		578		265	133
Percentage of births attended by trained personnel		36	46		80	90
% HIV/AIDS Prevalence among Adults		9.4 (2000)[114]	7			<5.5
Number of People Living With HIV/AIDS Receiving Anti-Retro-Viral Drugs (ARV)			125,312 in AIDS Care and Treatment and 60,341 on ARVs[115]		100,000 by Dec 2006	

107) MKUKUTA Status Report 2006
108) Millennium Development Goals Implementation Report 2006 (2nd Draft)
109) Using DHS data
110) Using DHS data
111) Using TRCHS/DHS data, which does not coincide 100% with EPI data of Ministry of Health
112) Using TRCHS/DHS data, which does not coincide 100% with EPI data of Ministry of Health
113) A number of key informants point out that this estimate for maternal mortality is contested with some analysts and agencies suggesting it may have been much higher in 1996.
114) As reported in the MDG Implementation Report 2006.
115) Presentation by NACP, January 2006.

Financial Contributions over Time (US$ '000)

Donor (US$ '000)	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009	TOTAL
DFID	1,679,975	6,344,282	12,130,581	13,677,907	-	-	-	-	-	-	33,832,745
Ireland	1,500,000	1,764,656	2,761,178	3,100,000	5,013,304	3,870,750	2,446,250	7,371,000	9,310,000	12,900,000	50,037,138
Switzerland	750,000	2,548,838	2,324,126	2,500,000	3,200,000	4,040,000	4,800,000	4,600,000	4,200,000	?	28,962,964
DANIDA	571,875	2,566,687	4,625,050	6,682,594	8,675,936	11,370,373	10,255,455	11,184,320	12,300,000	10,300,000	78,532,290
Norway	630,756	1,862,612	1,429,100	-	-	-	-	-	7,350,000	7,000,000	18,272,468
KfW	-	-	2,059,352	2,299,960	7,874,028	3,405,874	3,121,945	7,200,000	-	7,750,000	33,711,159
Netherlands	-	917,912	1,272,558	1,300,000	1,120,602	3,149,657	6,501,594	8,893,500	9,896,000	22,500,000	55,551,823
GTZ	-	-	301,969	316,670	-	-	-	-	-	-	618,639
World Bank	-	-	123,175	6,317,307	1,820,370	35,009,823	29,088,865	13,800,000	20,000,000	15,000,000	121,159,540
UNFPA	-	-	-	-	-	300,000	600,000	600,000	600,000	1,150,000	3,250,000
CIDA	-	-	-	-	-	-	3,432,965	270,240	4,002,000	?	7,705,205
Sweden	-	-	-	-	-	-	-	1,716,000	-	-	1,716,000
UNICEF	-	-	-	-	-	-	-	-	500,000	1,500,000	2,000,000
UNDP	-	-	-	-	-	-	600,000	-	600,000	-	1,200,000
Total	5,132,606	16,004,987	27,027,089	36,194,438	27,704,240	61,146,477	60,247,074	51,417,860	68,758,000	78,100,000	431,732,771