# Strengthening Capacity in Health Financing in Tanzania

*End of Project Report*

*March 24, 2014*

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# ACRONYMS

| | |
|---|---|
| **COP** | Chief of Party |
| **FMR** | Financial Management and Reporting |
| **GoT** | Government of Tanzania |
| **HFS** | Health Financing Strategy |
| **HFU** | Health Financing Unit |
| **IR** | Intermediate Result |
| **ISC** | Inter-ministerial Steering Committee |
| **MBP** | Minimum Benefits Package |
| **MOHSW** | Ministry of Health and Social Welfare |
| **NHA** | National Health Accounts |
| **PER** | Public Expenditure Review |
| **PPP** | Public Private Partnership |
| **RMNCH** | Reproductive Maternal Neonatal and Child Health |
| **SCHF** | Strengthening Capacity in Health Financing |
| **SHA** | System of Health Accounts |
| **HFTWG** | Health Financing Technical Working Group |
| **TWG** | Technical Working Group |
| **USAID** | United States Agency for International Development |

# 1. INTRODUCTION

### *1.1 BACKGROUND*

The Strengthening Capacity in Health Financing, Tanzania (SCHFT) project was an 18-month Associate Award working with the Government of Tanzania (GoT) to improve health financing capacity and ensure long-term sustainability of health programs in Tanzania. This Associate Award followed the Health Systems 20/20 leader award that ran from October 2006 to September 2012. The period of performance for this cooperative agreement was September 25, 2012 – March 24, 2014.

The SCHFT team's goal was to enhance GoT capacity to ensure equity, access, and availability of appropriate health services across the country and to make certain that program decisions and the allocation of resources were linked to evidence-based processes. The project worked closely with the Ministry of Health and Social Welfare (MOHSW) Health Financing Unit (HFU), health sector development partners and Tanzanian organizations to achieve three Intermediate Results (IRs) and associated components:

**IR 1: Increased Effectiveness through Health Governance**

Component 1: Develop MOHSW's capacity to provide ongoing management oversight of health financing, specifically by monitoring resource allocation through Public Expenditure Reviews (PER) and National Health Accounts (NHA).

**IR 2: Improved Planning for Financial Health Services**

Component 2: Assist with completion of the national Health Financing Strategy (HFS).

**IR 3: Sustainable Operations Capacity**

Component 3: Provide technical assistance to MOHSW to evaluate/assess/model some of the agreed-upon approaches to expanding pooled-risk systems.

### *1.2 OVERALL PROJECT OBJECTIVES*

The SCHFT project contributed to attaining Tanzania's Health Sector Strategic Plan III (HSSPIII) key objectives and overall strategy which focus on addressing the following key issues:

- Reducing the budget gap in the health sector by mobilizing adequate and sustainable financial resources;
- Enhancing complementary financing for the provision of health services, increasing the total health budget's share to 10 percent by 2015;
- Improving equity of access to health services;
- Improving management of complementary funds raised at the local level; and
- Increasing efficiency and effectiveness in use of financial resources.

In addition, the project contributed to U.S. government (USG) initiatives in Tanzania, such as those outlined in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Partnership Framework 2009–2013 and USG/Tanzania Global Health Initiative (GHI) Strategy 2010–2015. The project was aligned with GHI's second IR for "Improved Health Systems to Strengthen the Delivery of Healthcare Services." Thus, more specifically, the overall objectives of the SCHFT project were to:

- Strengthen GoT capacity to effectively and efficiently allocate and use health resources by supporting the institutionalization and capacity to produce NHA and PER; and
- Support the process of developing the country's HFS as part of the implementation of the HSSP III by (1) analyzing the role and potential budgetary implications of government financing, private sector (including user fees) financing, and various types of donor financing; (2) evaluating and providing guidance on risk- pooling approaches and drawing up a plan for harmonizing the risk-pooling schemes operating in Tanzania; and (3) exploring innovative financing mechanisms, including special taxes or levies.

### *1.3 PROJECT METHODS AND APPROACHES*

SCHFT worked closely with MOHSW HFU and the MOHSW Sector Wide Approach (SWAp) technical working groups (TWG), particularly the Health Financing Technical Working Group (HFTWG), to collaboratively develop the HFS. The project also actively collaborated with the Ministry of Finance (MOF) and the Prime Minister's Office—Regional and Local Government (PMO-RALG). In addition, the SCHFT team also built the capacity of the Health Economics Department within the University of Dar es Salaam (UDSM) in resource tracking to ensure the sustainability of project interventions. The SCHFT project relied on three pillars to facilitate project implementation:

**Responding to country-led and country-defined priorities:** The SCHFT project consistently responded quickly to MOHSW and the HFTWG priority requests, even if they were not initially anticipated; for example, the SCHFT team developed TORs for HFS option papers and provided short term technical assistance (STTA) to undertake option studies that would feed into the HFS.

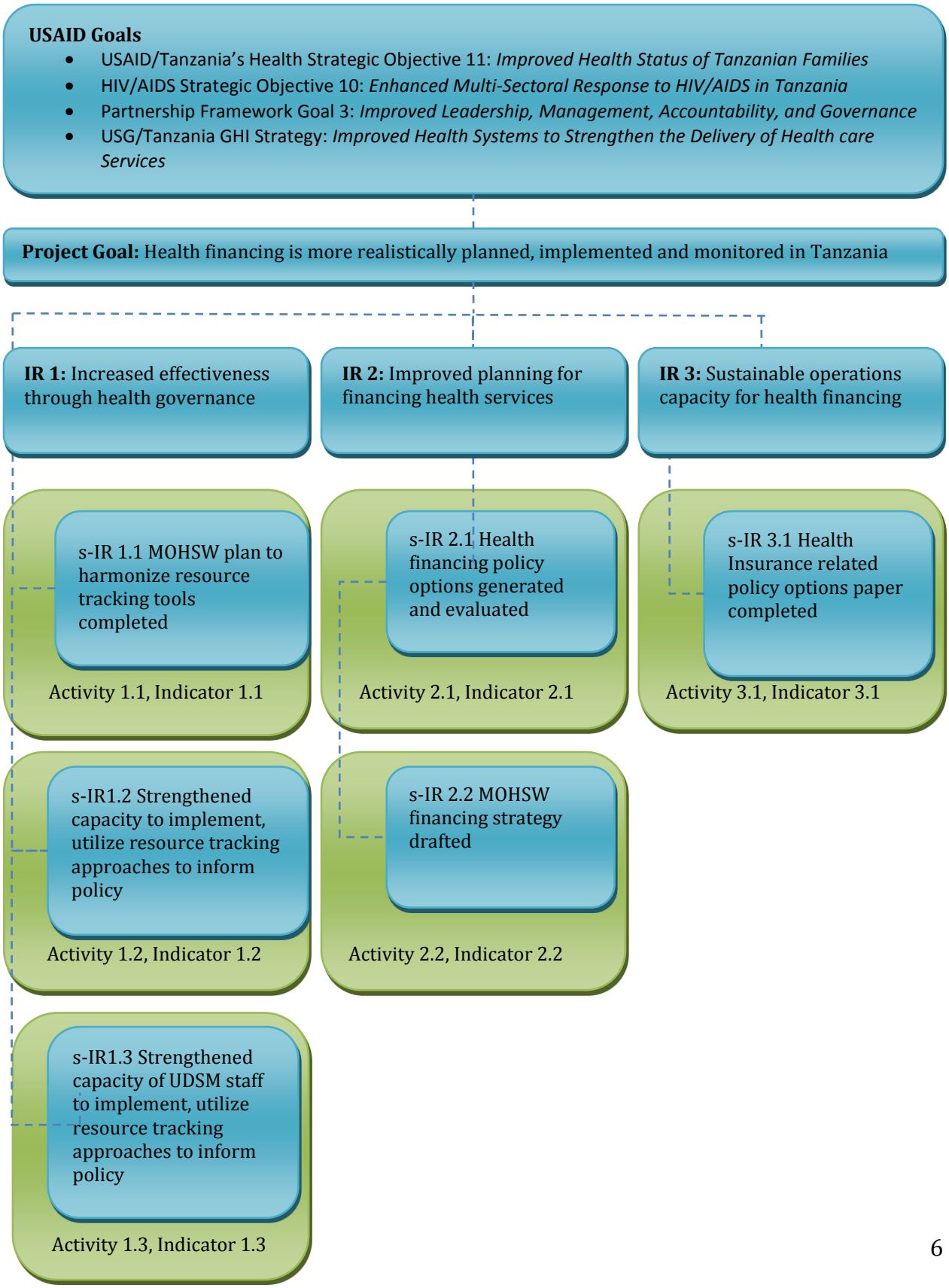
**Active stakeholder collaboration, participation and involvement:** Developing and implementing a national HFS involves engaging a broad set of stakeholders. The SCHFT project engaged actively with the MOHSW HFU as a member of the HFTWG, responded to the Inter-ministerial Steering Committee (ISC) on issues related to specific policy options that will feed into the HFS, collaborated with private sector and NGOs that support the HFS, and built the capacity of UDSM staff to institutionalize and sustain health resources tracking in the country.

**Imparting resource tracking tools and methodologies:** To sustain the project's impact in the long term, the SCHFT project worked with the GoT to build its capacity to conduct PERs and ensure that financial data are available for more effective health governance and eventual HFS implementation. The project also trained health economists from the UDSM on NHA and the revised System of Health Accounts (SHA) 2011. An important tool that the staff learned was the Health Accounts Production Tool (HAPT), which streamlines and simplifies the NHA estimation process, thereby reducing the need for technical assistance and facilitating institutionalization of NHA as a regular part of the country's efforts to monitor and improve its health system performance.

### *1.4 PROJECT RESULTS FRAMEWORK*

The results presented in this report are organized according to the three IRs in the project results framework as illustrated in Figure 1.

## Figure 1: Results Framework



# 2. SCHFT ACHIEVEMENTS AND CHALLENGES

This section provides a summary of project achievements and challenges under each of the project intermediate results (IR).

### *2.1 IR 1: INCREASED EFFECTIVENESS THROUGH HEALTH GOVERNANCE*

**Component 1: Develop MOHSW's capacity to provide ongoing management oversight of health financing, specifically by monitoring resource allocation through PERs and NHAs.**

The SCHFT project viewed governance as a cross-cutting health system issue directly related to strengthening the rules, regulations, and institutions that hold governments and health providers accountable to citizens for the decisions they make and the services they deliver. Thus, as the project assisted the GoT to design and develop its HFS, SCHFT focused on the relationship between governance and health financing to achieve a transparent, accountable, and data-driven health system. The project focused on building GoT capacity to conduct PERs and NHAs for two main reasons. First, both exercises provide valuable data on where and how health expenditures are allocated, which can be used to inform annual planning and budgeting. Second, the PER and NHA help increase transparency and accountability by producing data on public spending for stakeholders.

In recent years, Tanzania has made progress in increasing the effectiveness of its health system governance. GoT currently implements the PER annually and has developed NHA estimates for fiscal years (FY)1999–2000, 2002–03, 2005–06, and 2009–10. Currently, the GoT is completing the NHA estimate for FY2012-13. The estimation results have already led to GoT's improved management of health sector funds, as described in Box 1. Furthermore, the PERs consistently show that GoT funding of the health sector is declining, which triggered the government to increase funding to the health sector in FY 2013-14. To continue this momentum, the SCHFT project focused on the production and institutionalization of routine health resource tracking data.

**Box 1: Policy Use of NHA data**
The GoT examined Tanzania's sources of health funds in FY1999–2000 and realized that donors were financing a significant portion of the health sector, while bypassing the government. To increase its stewardship of health funds and provide more oversight of health spending, the GoT used NHA findings to advocate internally for the revision of donor coordination mechanisms and the adoption of the SWAp. This initiative encouraged many bilateral donors to channel their contributions into basket funds that are managed by the government.

### *2.1.1 SCHFT PROJECT ACHIEVEMENTS FOR IR1*

**Development of a resource tracking institutionalization plan:** SCHFT's work with the MOHSW HFU to develop a resource tracking institutionalization plan is important in the drive for sustainability. Resource tracking institutionalization means that activities such as collecting, analyzing and reporting data on health care budgets and spending is systemized within a designated department in the MOHSW, completed on a routine basis, and follow predetermined standards and protocols. The SCHFT project worked with the MOHSW to develop an institutionalization plan, building on a draft that the World Health Organization funded previously. The plan highlights specific activities that will help resource tracking to become a core activity within the Ministry. Once resource tracking becomes institutionalized, the government will be able to use the data to develop policies, such as the HFS. The project submitted the resource tracking institutionalization plan to the MOHSW HFU, which examined the current status of resource tracking in Tanzania according to eight dimensions (see Box 2), and then proposed next steps for the GoT to consider. Throughout the life of the SCHFT project, MOHSW initiated several of the required actions recommended in the plan, including increased resources for production of NHA and PER estimates, harmonizing data collection tools for NHA and NASA, and working with the UDSM to develop a resource tracking module for Master's degree students. Each of these initiatives is described in more detail below.

**Box 2: Resource Tracking Institutionalization Plan**

SCHFT assessed resource tracking in Tanzania according to eight dimensions, and then provided recommendations for moving forward. The eight dimensions include:

- Demand
- Resources
- Enabling environment
- Financing indicators
- Data sources for resource tracking
- Data management
- Health expenditure information products
- Dissemination and use

**Institutionalizing the PER:** To ensure that SCHFT's resource tracking training had an impact beyond the life of the project, all PER trainings delivered used a capacity building approach that allowed trainees to take a leadership role. The table below summarizes the objectives of each of the trainings provided by the SCHFT project for PER.

### Table 1: Objectives of Resource Tracking Trainings

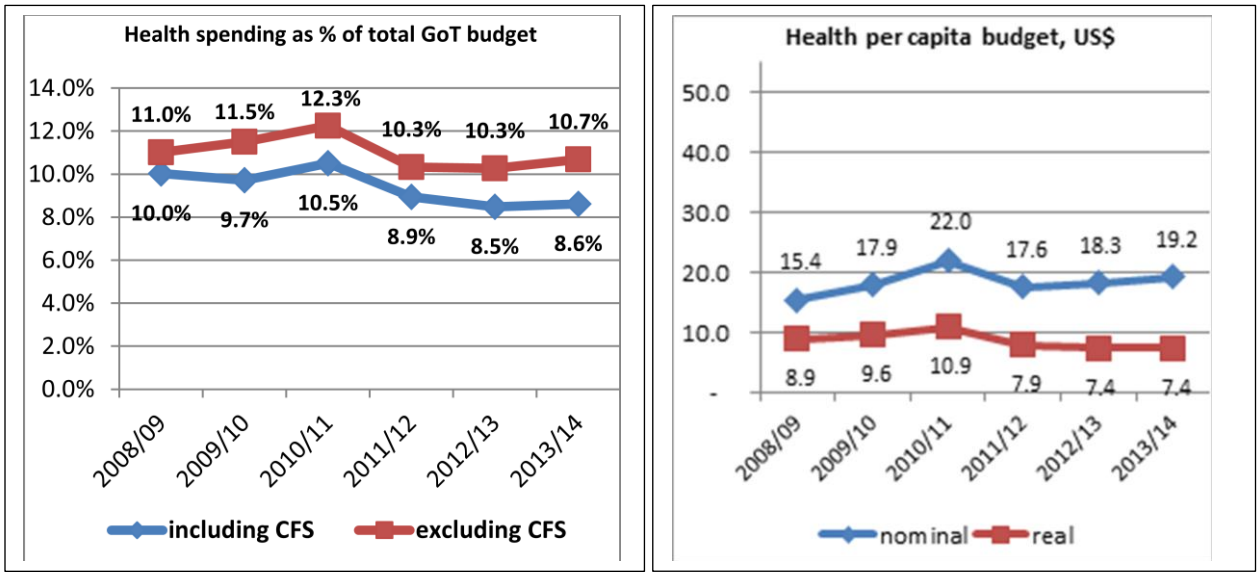
| PER Training 1: March 4 – 13, 2013 | PER Training 2: February 17-26, 2014 | PER Training 3: February 28 – March 9, 2014 |
|---|---|---|
| • Understand the objectives and scope of PERs;<br>• Develop task budgets and time frame analysis;<br>• Identify sources of data and data needs to undertake the PER in health;<br>• Complete a comparative analysis and indicator assessment;<br>• Implement a performance assessment that examines spending vs. outcomes, analysis of equity and efficiency, etc;<br>• Improve financial management and spending patterns at central and local levels;<br>• Understand tradeoffs within and across sectors to improve equity, efficiency or impact;<br>• Develop relevant conclusions and recommendations from PER data;<br>• Use sampling techniques to select statistically viable population samples for PER field work;<br>• Develop data collection instruments;<br>• Conduct field work;<br>• Analyze field data;<br>• Prepare a PER report; and<br>• Disseminate PER findings. | • Examine trends in health sector spending;<br>• Complete health expenditure analysis by financing source, including donors, government and households;<br>• Analyze recurrent and development health spending according to the National Strategy for Growth and Poverty Reduction (MKUKUTA) strategy objectives;<br>• Review local government health spending and council resource allocations;<br>• Analyze spending on human resources, reproductive and child health;<br>• Develop recommendations for the HFS, including recommendations for improving coverage of health funds; and<br>• Determine steps for developing the final PER report. | • Assess the sources of public spending on health, public expenditure on health by level (primary, secondary and tertiary), public spending on health across functional classification, and capital and recurrent expenditure on health;<br>• Examine the distribution of public expenditure on health across age group, geographical setting and regions;<br>• Assess the PER data according to burden of diseases;<br>• Understand the absorptive capacity of resource in the health sector;<br>• Compare public expenditure on health to reform outputs and priorities;<br>• Assess the compliance of financial discipline in the health sector;<br>• Assess the fiduciary risks of public expenditure on health;<br>• Compare public expenditure on health with health benefits; and<br>• Provide tips on writing PER reports, including tables and graphics. |

The SCHFT project trained a total of 28 MOHSW staff on the PER methodology (16 female, 12 male) throughout the life of the project. The MOHSW PER team included experts in public financial management, economics and policy disciplines. This multidisciplinary team now has adequate internal capacity to conduct PER in the future without external technical assistance. SCHFT ensured that each of the sessions was developed in tandem and delivered by MOHSW staff. The project worked with the PER team within the MOHSW to conduct Tanzania's PER

for FY 2011-12 and FY2012-13. The project also supported two 10-day external[1] data analysis and report writing workshops. The project served as a quality advisor for the PER in FY 2011-12, and as a testament to the MOHSW's capacity, the project significantly reduced the technical assistance during the FY 2012-23 round.

As a result of the project's collaboration with MOHSW, Tanzania now has consecutive PER data since FY2008-09. Tanzania can track whether the country is making progress over time towards achieving the Abuja declaration to allocate 15% of total government budget to health, or to meet guidance provided by the WHO to allocate of at least US$34 per capita to health. As figure 2 displays, the GoT has not met either the Abuja or WHO commitments. As of FY 2013-14, health spending was 10.7% of the total budget and about US$19.2 per capita. This vital information has enabled various stakeholders, including the donor community, to implore the government to re-examine its priorities and increase funding for the health sector in the next round of the 'Big Results Now' (BRN) review and resource allocation.[2] This PER finding was cited in several of the HFS options papers to lobby for increased government commitment to health to finance the HFS implementation.

**Figure 2: Health spending in Tanzania (2008/09 -2013/14)**




Source: Health Sector Public Expenditure Review (PER) 2013-14

[1] The PER workshops were held in Bagamoyo, the first included 10 attendees, of whom 6 were women and 4 were men. The second workshop included 18 attendees, of whom 10 women and 8 men.

[2] Tanzania's priority investments are reflected in the 'Big Results Now' programme built on the Malaysian mode whose priorities are: energy, transport, agriculture, water, education, and resource mobilisation. Health is not among Tanzania's priorities, even under the country's Five Year Development Plan: 2009/10-2015/16.

**Institutionalizing the NHA:** The SCHFT project provided intensive training to six UDSM Health Economics Department professors (1 female, 5 male). The training focused on the following:

- Purpose of resource tracking
- Overview of resource tracking methodologies
- History of resource tracking implementation in Tanzania
- Policy use of resource tracking data in Tanzania
- Defining expenditures and boundaries of NHA/SHA
- Similarities and differences between the SHA 1.0 and SHA 2011 frameworks
- NHA/SHA classifications
- Three interfaces of the NHA/SHA framework
- Reading NHA/SHA tables
- Overview of key stages of the NHA/SHA
- Introduction to the Production Tool

On the last day of training, the UDSM participants developed a Resource Tracking and SHA Action Plan that outlined the key steps to incorporate resource tracking and SHA content into their existing health economics course. The project provided technical assistance for staff to develop a detailed resource tracking module. This module reflects the skills that department staff learned during the training, and includes training materials that can be used by new professors who were not involved in the intensive course. The university expects that future graduates who learn the material within the new module will be better positioned to contribute to decision making and long-term capacity building efforts in the health sector. UDSM will deliver the new module to a group of up to 22 students in April 2014.

**Harmonizing resource tracking tools:** The SCHFT project supported MOHSW and other stakeholders to harmonize resource tracking tools that were originally designed for three different methodologies: NHA, NASA and RCH[3]. While each of the studies captures relevant and complementary information for policymakers, the use of multiple instruments to collect similar data is duplicative and inefficient. Harmonizing the tools into one instrument reduces the administrative and reporting burden on government and Development Partners and increases data quality. SCHFT's harmonized tool has now been used by the MOHSW to collect relevant data from stakeholders working in the health sector.

### *2.1.2 IR1 CHALLENGES AND LESSONS LEARNED*

The SCHFT project worked intensively with the University of Dar es Salaam and the MOHSW to build capacity in NHA and PER. However, given the eighteen month duration of the project, the impact will not be visible until after the life of the project. For example, the UDSM will be rolling out the new resource tracking module during the month of April 2014. During this time, the project will not be providing technical assistance. If time had allowed, observing UDSM

[3] NASA – National AIDS Spending Assessment,
RCH – Reproductive and Child Health

delivering this module for the first time would have offered a unique opportunity for the project to identify areas where the university might need more technical support.

The SCHFT project worked at the central government level to facilitate the production of resource tracking data. However, experience in other countries demonstrates that for resource tracking data to be used once it is produced, policy relevant results need to be disseminated to decentralized levels of government and civil society. In theory, the dissemination of relevant information will lead to more demand for such data. While MOHSW would like to disseminate the results further, they may not have the resources to do so.

## *SUCCESS STORY: INSTITUTIONALIZING RESOURCE TRACKING IN TANZANIA*

Tanzania is a leader in Africa for conducting routine health resource tracking estimations. The country completed four rounds of National Health Accounts (NHA) for fiscal years (FY) 1999-2000, 2002-03, 2005-06 and 2009-10; six rounds of Public Expenditure Reviews (PER) for health for every year since FY2008-09; two rounds of Public Expenditure Tracking in Health in 1999 and 2001; one National AIDS Spending Assessment in FY 2005-06, and two rounds of PER for HIV/AIDS (2010 and 2011).

*MOHW participants analyze PER data during SCHFT sponsored training.*

During the 18-month USAID funded Strengthening Capacity in Health Financing Tanzania Project, the project team worked with the Ministry of Health and Social Welfare (MOHSW) and University of Dar es Salaam to continue the institutionalizing resource tracking process. The project provided a "status update" to the World Health Organization funded resource tracking institutionalization plan developed in 2010, and recommended new activities for the government to consider as it takes the lead role in producing routine and timely health budget and expenditure data. Throughout the life of the project, the SCHFT team worked with stakeholders in Tanzania to begin implementing several of the plan's recommendations. Specifically, the SCHFT team worked to harmonize three data collection tools into one instrument that facilitates data reporting, and to develop more human resources with relevant technical skills to complete PER and NHA estimations.

PER data in Tanzania has been a powerful tool for the government and Civil Society to analyze public sector spending against policy, efficiency, equity, and sustainability parameters, especially because data has been produced for each year since FY 2008-09. To continue the exercise on a routine basis, the project worked with a multidisciplinary team within the MOHSW to host four trainings and to complete two rounds of the PER for FY2012-13 and FY2013-14. The MOHSW team now has internal capacity to complete the PER without external assistance.

*"The SCHF has worked with the Ministry of Health and Social Welfare Tanzania to move resource tracking institutionalization forward. Without this project, we would not have been able to train the University of Dar es Salaam to become an external resource in the System of Health Accounts methodology. The new expertise housed within the University will enable Tanzania to train a new generation of resource tracking practitioners."**--Mr. Charles Pallangyo, Permanent Secretary, Ministry of Health and Social Welfare***

*UDSM reviews new resource tracking module.*

Tanzania has also used NHA data to analyze the flow of funds from public and private sectors and donors throughout the health system. To institutionalize the production of NHA data in Tanzania, the project provided an intensive training session on the revised System of Health Accounts 2011 methodology[4] to a group of six professors from the Health Economics Unit at the University of Dar es Salaam. The training focused on the theory behind the SHA 2011 methodology, as well as use of the Health Accounts Production Tool software to complete an estimation. After the training, the university developed a training module so that resource tracking skills could be built into an existing health economics course. The course will be delivered in March 2014 to approximately 22 Master's level students. According to Dr. Otieno Osoro, Assistant Lecturer in the Health Economics Department, "*A significant output of our engagement with the SCHFT Project was the development of the resource tracking module for our health economics course. This module will help to guide existing and future instructors within our department, and provide students with new skills that have high market demand.*"

[4] OECD, EUROSTAT and WHO collaborated to revise the System of Health Accounts 2000 methodology, which was the basis for the NHA. The new framework, released in 2011, has a new conceptual frameworks and an extended set of classifications.

## *2.2 IR 2: IMPROVED PLANNING FOR FINANCIAL HEALTH SERVICES*

**Component 2: Assist with completion of a GoT Health Financing Strategy.**

Tanzania is currently implementing its HSSP III (2008-2015). The plan prioritizes developing a national HFS. As such, the MOHSW dedicated a SWAp milestone for 2012 to the strategy. Although the GoT initially intended to achieve the milestone by June 2012, MOHSW recognized the complexity of developing a comprehensive HFS and that further stakeholder engagement and technical assistance was required. Because the strategy is cross-sectorial, MOHSW established an ISC to provide political guidance to the HFS development process, as well as endorsement to the final strategy. The HFS will ultimately provide much needed harmonization and coherence in financing of the health sector.

The most recent NHA estimated that donors were the major financiers of total health expenditures in FY2009–10, contributing 40 percent to the health sector. The MOF contributed 26 percent, and the private sector (including household out-of-pocket spending) accounted for 34 percent. These sources are not sustainable. To ensure sustainability of health financing, Tanzania needs to find innovative ways to raise additional revenue for the health sector while increasing spending efficiencies, improving the equity of financing and better aligning country and donor priorities. MOHSW HFTWG commissioned 11 HFS options papers that were designed to provide recommendations for Tanzania's most pressing health financing challenges. The paper topics include:

1. **Minimum Benefit Package (MBP):** provides options to sustainably structure access to health benefits;
2. **Insurance Market Structure:** provides options for the social and private health insurance architecture;
3. **Performance Financing:** provides options for linking payment to performance of service providers;
4. **Equity-Based Financing:** provides options for improving equity targeting of resources;
5. **Inclusion of Poor and Vulnerable:** provides options for identification and financing of services for the most resource limited populations;
6. **CHF Reforms:** provides options for the re-design of the CHF system;
7. **Private Sector Resources:** provides options for strengthening equitable funding from the private sector;
8. **Financial Management and Reporting (FMR):** provides options for improving accountability and timely funds;
9. **Innovative Financing and Fiscal Space:** provides options for increasing public financing for health;
10. **Provider Autonomy:** develop scenarios for provider autonomy within the different options presented in the Health Insurance Market Structure and Public Financial Management papers.
11. **Health Insurance Institutional Arrangements:** provides options to increase Social Health Insurance System capacity and reforms of the health insurance market as means to achieve UHC.

### *2.2.1 SCHFT PROJECT ACHIEVEMENTS FOR IR2*

SCHFT worked with the MOHSW and the entire HFTWG to facilitate developing the HFS. The project assisted the Ministry to develop terms of reference for nine options papers and the HFS development roadmap. MOHSW and the HFTWG requested the SCHFT project to lead or collaborate on three of the 11 options papers including: MBP, Private Sector Resources and FMR. Lastly, the project Chief of Party participated in writing initial draft sections of the HFS. Further information on the private sector and financial management papers is presented below.[5]

**Options for expanding private sector contribution to health:** In recent years, the GoT has recognized the need to expand the role of private investors, employers, and faith-based organizations as financiers of health care. Specific initiatives to reach this goal are described in Box 3.

**Box 3: Expanding the Role of the Private Sector in Tanzania**

In recent years, the GoT has increased the role of the private sector through:

- Developing a National PPP Policy in November 2009: Within the health sector, the objective of this policy is to improve participation of the private sector in resource provision, capital investment, managerial skills and technology through efficient and sustainable PPP arrangements. These arrangements will then improve delivery of reliable, affordable and accessible health and social welfare services for Tanzanians.
- Establishing a National PPP Steering Committee for health in 2008: The mandate of the Steering Committee is to guide PPP development in Tanzania. The committee is currently being re-launched as a Public-Private Health Forum to engage with wider health stakeholders.
- Developing a PPP Technical Working Group (PPP TWG) in 2009: The TWG was formed as part of the SWAp governance structure to coordinate the implementation of the HSSP III.
- Developing a PPP strategic plan for 2010–2015: The strategic plan guides implementation of PPP strategic objective of the HSSP III.

To contribute to the GoT's efforts, MOHSW and the ISC requested the SCHFT project to undertake a study to evaluate options to leverage PPPs for inclusion in the ministry's HFS. To achieve Tanzania's overall goal of Universal Health Coverage, the GoT is seeking to effectively leverage domestic resources and spurs buy-in from private health insurance schemes. The approach to the study included a review of relevant documents related to health financing in Tanzania; review of best practices on health financing and service provision PPPs (from international and local experience); purposeful interviews with public and private sector officials to inform the PPP options; and discussions with the office of the National PPP Commissioner and MOF.

[5] Detailed information on the MPB paper is described under IR3.

SCHFT successfully completed the PPP options paper and both the MOHSW and the HFTWG welcomed the recommendations in the report as important input to feed into the HFS. The paper concludes that despite a conducive health sector private sector policy environment, policy implementation remains a challenge. Common challenges to public and private sector collaboration in the health sector include:

- Private providers are undercapitalized and have limited access to finance, which restricts their ability to initiate partnership dialogue or make capital developments for expanded service provision;
- Limited public funds are already stretched to meet existing public demand, and the formula and regulations for the provision of donor basket funding to private sector subcontractors is unclear;
- Limited use and traction of public health insurance options has restricted the number of private providers engaged in the provision of public health services; and
- National PPP strategies and policies for health have not effectively trickled down to the local level.

In an effort to address the above challenges, the paper developed options to improve implementation of policies to enhance private sector contributions to health care. These options include:

- Increasing the private sector's access to finance for capital investment by increasing private provider knowledge on access to finance and commodities, and promoting and investing in private sector credit mechanisms;
- Expanding corporate contributions to health through employer subsidized premiums to the National Health Insurance Fund, National Social Security Fund, Private Health Insurance, and Community Health Funds; contracting with health providers; delivering care through on-site clinics; and investing in workforce wellness programs;
- Identifying greater resources to finance Service Level Agreements (SLAs) and working with SLAs to attain greater efficiency;
- Exploring co-location or intramural private practice to provide private or fast-track services; and
- Exploring contracts between private health providers and government to renting public facilities, investing in the maintenance of public facilities, and be reimbursed by the public sector for providing public goods.

GoT implementation of these suggested private sector options for financing the health sector should go a long way in improving health service delivery in Tanzania.

**Financial management options for improving accountability and timely availability of funds:** Tanzania has made great strides in public financial management (PFM) at both the national and local level through implementation of integrated financial management systems, as described in Box 4. Overall, the system and institutional framework for management and reporting of health funds is improving, although much remains to be done to ensure cost effective, efficient and accountable management of resources.

The MOHSW and the ISC requested SCHFT to undertake a study on the state of PFM in the public health sector and to provide feasible options for strengthening that can be included in the HFS. The paper focused on how to improve value for money, accountability and timely

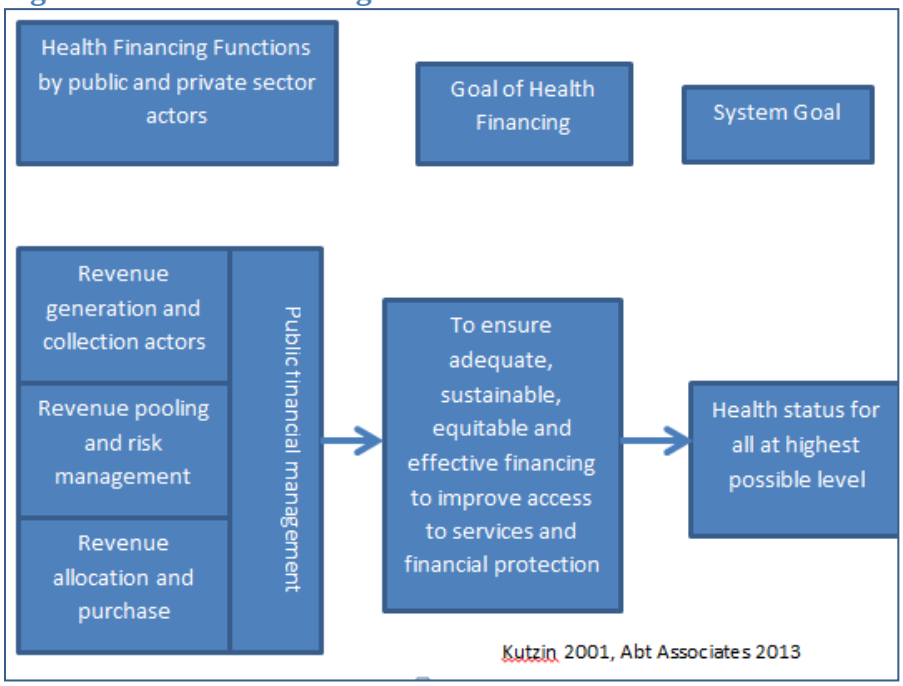
availability of funds within the health system. The project undertook the study using both secondary and primary data.

The paper clearly demonstrated how PFM (planning, budgeting, monitoring, organizing, controlling, and reporting of public financial resources) aligns with the objectives of a health financing strategy. It cuts across the three components of health financing (resource mobilization, resource pooling and purchasing) as depicted in Figure 3 below. Strengthening financial management systems that underpin health service delivery is therefore critical to a successful HFS.

**Box 4: Government Initiatives to Improve PFM in Tanzania**

In the mid-nineties, the government embarked on Public Financial Management (PFM) Reforms in which an Integrated Financial Management System (IFMS) was introduced to capture approved budgets and track expenditure transactions both at Central and Local Governments, as well as strengthening procurement and accountability processes in all sectors At the local level PlanRep was introduced as a tool to assist~~s~~ local authorities in planning and budgeting. More recently, the central and local government~~s~~ with support from Development Partners are working to update management and reporting tools, the accounting and planning software packages Epicor and PlanRep, and to introduce the Strategic Budget Allocation System.

**Figure 3: Health financing framework and PFM**



Effective PFM systems maximize financial efficiency, improve transparency and accountability, and contribute to long-term economic success. The paper identified several challenges to effective PFM in Tanzania:

- While computerization of the financial management and reporting systems has improved resource management and accountability, the mingling of Basket Funds, Block Grant Funds and funds from other sources has proved to be a big management challenge for all Councils;
- Management structures to ensure value for money in resource use are inadequate;
- Autonomy at decentralized levels for priority-setting is limited;
- Accounting and planning systems are still not sufficiently linked; and
- Audit and other reports continue to identify weaknesses in a number of Councils' financial management and reporting, including: inappropriate allocation of resources, inefficient revenue systems, inequity and inefficiency in the use of health resources as well as weak delivery of vital public health care services.

The SCHFT project recognized that a strong PFM system is essential to improved health service delivery, poverty reduction and to achieve the health-related MDGs. Based on the challenges identified, the paper therefore recommended:

- Development of a PFM strengthening plan for the MOHSW;
- Establishment of a small central team at MOHSW to provide corporate oversight and monitoring of institutions that receive budgetary transfers from the ministry, and ensuring that transfers to health institutions include service agreements;
- Strengthened internal controls, including functioning of Internal Audit;
- Building procurement capacity beyond the Procurement Management Units at LGA to include heads of departments and councilors;
- Strengthened Regional Health Management Teams financial management capacity to supervise LGAs by adding to the team Regional Technical Advisors with financial management experience;
- Resolving Controller and Auditor General's recommendations both at central and LGA levels; and
- Fixing critical functionalities of Epicor, e.g. reporting and bank reconciliations and including qualified accountants in the Information and Communications Technology design team in Dodoma.

### *2.2.2 IR2 CHALLENGES AND LESSONS LEARNED*

The HFTWG and the ISC put forward an extensive competitive process to select consultants who would develop option papers and provide technical assistance in developing the HFS. At times, the project faced challenges because this process moved quickly and the HFTWG requested the project to lead activities that were not within the approved annual work plan. To achieve country ownership, SCHFT needed to be flexible to the Ministry's changing needs while still completing the deliverables set forth within the project's work plan. Striking a balance between the two

involved having open conversations with both the USAID/Tanzania Mission and MOHSW to set expectations and to determine an appropriate course of action to meet the needs of both stakeholders.

The HFTWG is under much pressure to develop the HFS. As a result, they have many technical papers to review and have the responsibility to provide feedback to the consultants preparing those papers. This has tended to create delays in the finalization of the papers. For example, The FMR paper suffered from delays in obtaining feedback from the TWG, particularly because the technical content could only be reviewed in detail by a few of the members with expertise in PFM.

## *SUCCESS STORY: DEVELOPING TANZANIA'S HEALTH FINANCING STRATEGY*

With oversight from the Inter-Ministerial Steering Committee (ISC), the Government of Tanzania (GoT) is in the process of developing a new Health Financing Strategy (HFS) to guide more efficient resource mobilization, allocation, and use in the health sector. This strategy will require options that address user fees and equity, accountability and transparency through effective regulation, quality and Value for Money. To analyze Tanzania's most pertinent health financing issues, the ISC identified key areas for reform and commissioned nine studies to inform the HFS. The USAID funded Strengthening Health Capacity in Finance, Tanzania (SCHFT) project took the lead for two of these studies, titled *Options for Expanding Private Sector Contribution to Health* and *Options for Financial Management and Reporting*. The project also provided support for the development of a third GIZ- led study on Tanzania's *Minimum Benefits Package*.

*The MOHSW HFTWG meets to discuss the national HFS*

The SCHFT team used similar methodologies to develop each study. The project team collected primary data through key informant interviews as well as observation of practice; completed a comprehensive review of existing literature, which included both published documents as well as other reports that stakeholders made available; and consulted with projects engaged in relevant activities at the central and Local Government Authority levels.

The Financial Management and Reporting study assesses processes and tools for management and reporting of health resources and makes recommendations for improving accountability and value for money in the use of financial resources. It also presents a series of options that aim to strengthen financial management systems, to ensure budgets are fully executed, financial controls are in place, audits reports are acted upon, and information is transparent and available to stakeholders. Implementing the options through the HFS will increase the effectiveness and efficiency of resources, and also build confidence among citizens that the health sector is accountable with minimal corruption or misuse of public funds.

The study on Expanding Private Sector Contribution to Health provides new strategies that leverage technical and financial assets from the private sector. The paper explores partnership options with the private sector that vary in terms of the cost, degree of private sector involvement, risk to both parties, and relative use of private and public financing. The recommendations include establishing and strengthening institutions and processes for PPP dialogue, involving the PMO-RALG in key Ministry of Health and Social Welfare (MOHSW) initiatives, strengthening the capacity of the MOHSW PPP unit and PPP-TWG, focusing efforts to improve communication of PPP strategies and priorities to all levels of the health system.

After the SCHFT project completed these two papers, they were presented to the HFTWG, which reviews and approves all options papers. As the nine options papers were being finalized, the project Chief of Party (CoP) and the HFTWG wrote the HFS outline. The project COP also actively participated as a member of a small HFS writing team – completing four sections of the HFS (situation analysis, social determinants of health and burden of disease in Tanzania, health services delivery, and governance/stewardship) – and serving as a member of the HFTWG. According to Mr. Charles Pallangyo, Permanent Secretary, Ministry of Health and Social Welfare, *"The SCHFT led options papers provide innovative recommendations for the Ministry to consider when developing the Health Financing Strategy. The project's work will contribute to an evidenced based strategy that expands access to health services, decreases barriers to health care, and protects families from financial catastrophe."*

### *2.3 IR3: SUSTAINABLE OPERATIONS CAPACITY*

**Component 3: Provide technical assistance to MOHSW to evaluate/assess/model some of the agreed-upon approaches to expanding pooled-risk systems.**

The *Tanzanian National Health Policy of 2003,* as updated in 2007, sets out a policy vision to improve the health and well-being of all Tanzanians with a focus on those most at risk and to encourage the health system to be more responsive to the needs of Tanzanians. The Health Policy also emphasizes that health services should be "available and accessible to all the people in the country (urban and rural areas)." In this regard, Tanzania is committed to the principle of Universal Health Coverage to reach the goals of the Health Policy.

To achieve Universal Health Coverage, GoT has been developing risk-pooling initiatives through various health insurance and prepaid health products and redirecting the government's contribution to help improve social health protection for the poor. Development partners have also made a strong commitment to improving social health protection. In this regard, SCHFT supported the development of a minimum benefits package (MBP) options paper, as one of the 11 technical background papers informing the health financing strategy. One of the main objectives of this paper is to define the MBP of health care services that can be guaranteed to all Tanzanians as a next step towards Universal Health Coverage.

#### *2.3.1 SCHFT PROJECT ACHIEVEMENTS FOR IR3*

**Development of the MBP Options Paper:** The MOHSW and the ISC requested that GIZ lead the MBP options paper, with the SCHFT project taking a supportive role. GIZ and the SCHFT project worked together to determine effective MBP interventions based on the following criteria:

- Potential contribution to reducing the burden of morbidity and mortality in Tanzania (considering not only their epidemiological burden, but also the social and economic burden as well);
- Interventions that have been demonstrated to be safe and effective;
- Interventions supported by cost-effectiveness analysis; and
- Affordability and medium and long-term sustainability in financing as well as equity considerations.

Based on those criteria, a minimum set of health care outpatient and inpatient services were determined and costed under several options. Box 5 provides details on the MBP package recommended in the options paper.

**Box 5: Minimum health care package (MBP) for Tanzania**

1. Outpatient service: general and specialist consultations and reviews, general and specialist diagnostic testing including laboratory investigation, X-rays, ultrasound scanning, medicines on the essential drug list, surgical operations such as hernia repair, and physiotherapy.
2. Inpatient services: general and specialist services in patient care, diagnostic tests, medication-prescribed medicines on the essential drug list, blood and blood products, surgical operations, inpatient physiotherapy, accommodation in the general ward, and feeding (where available).
3. Maternity, new born and child health: Adolescent sexual & reproductive health including PMTCT, IMCI, EPI, Nutrition.
4. Communicable diseases: Malaria, TB, STI, Lymphatic filariasis, Schistosomiasis and soil-transmitted helminthes, Leprosy.
5. Non communicable diseases: Diabetes, Injuries and disabilities, Eye care, oral health.
6. Emergencies: health situations which require urgent attention such as road traffic accidents, medical, surgical, pediatric, and obstetric and gynecological emergencies.

The MBP was estimated to cost a minimum of TZS 620 billion per annum (USD 388 million), which translates to about TZS 55,146 (USD 34) per capita. The paper proposed several possible sources of financing for consideration by the government including: increasing the health budget to 15% of total government budget to meet the commitment made under the Abuja agreement; establishing MBP-dedicated taxes to defray the cost of the package to the poor; review health insurance and harmonize the various social insurance schemes; and fostering PPPs in health financing.

### *2.3.2 IR3 CHALLENGES AND LESSONS LEARNED*

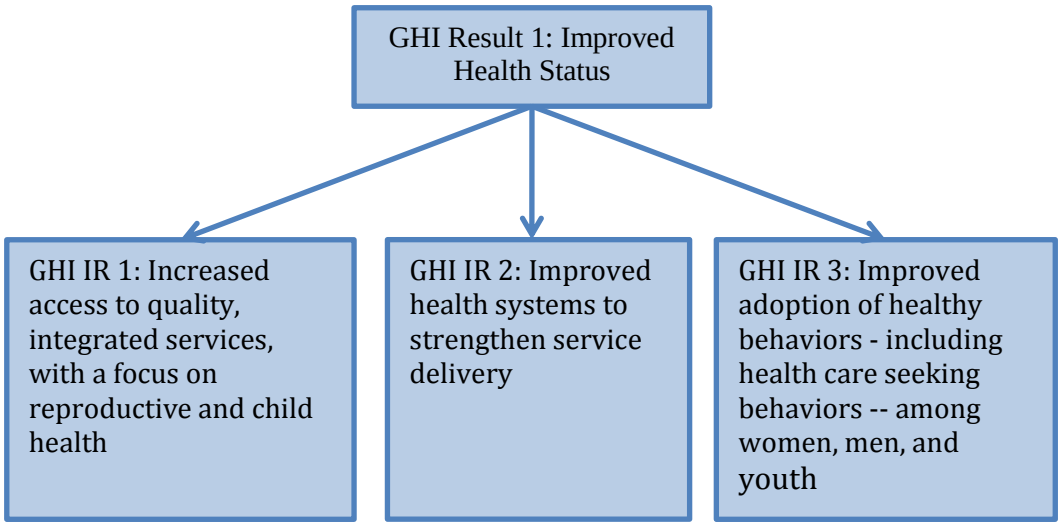
The team developed the MBP options paper using their knowledge of best practices from international experience, as well as from one-on-one discussions with stakeholders. There was initially insufficient engagement with the HFTWG and the group did not contribute to the paper until the team presented the first draft. During the presentation to the TWGHF, the team realized that some relevant technical information was missing and additional data had to be collected, analyzed and presented in the format that stakeholders requested. This experience reinforced the importance of active dialogue with stakeholders throughout the drafting process to ensure that all expectations were known, and that stakeholder inputs were sufficiently incorporated into the paper.

# 3. PROJECT IMPLICATIONS FOR PRIORITY HEALTH PROGRAMS

### *3.1 PROJECT RESULTS IN THE CONTEXT OF USG GHI, PEPFAR AND MISSION CORE OPERATING PRINCIPLES*

The SCHFT project supports Tanzania's health systems strengthening (HSS) efforts, which are also central tenets of the USG's Global Health Initiative (GHI), the strategy that aligns all U.S. agencies' work to support a country's national health system. Figure 3 below illustrates the Results Framework from the Tanzania Global Health Initiative Strategy 2010 – 2015. The SCHFT project supports IR2: Improved health systems to strengthen service delivery. IR2 includes two sub-IRs that are relevant to the SCHFT project: strengthened governance, management, financing and accountability in advancement of national policies and systems; and improved health support systems.

**Figure 3: GHI Results Framework, Tanzania**




In addition to the above, USAID/Tanzania developed an HSS strategy (2013-2018) that incorporates principles and goals from PEPFAR, PMI, Stop TB, and the broader USG initiatives for 'A Promise Renewed' to end preventable maternal and child deaths and achievement of an 'AIDS-Free Generation'. The HSS strategy contributes to these higher level outcomes by assisting Tanzania to accelerate coverage of high impact interventions, while simultaneously building a strong health system, which can sustainably provide positive health impact across health programs for HIV/AIDS, malaria, family planning, maternal and child health and tuberculosis. SCHFT supports this HSS strategy, in particular IR 1: Increased, effective, and

efficient domestic financing for health; and IR 4: Health Information Systems and Data Use Strengthened.

According to the HSS strategy, HSS support is a "means of ensuring that any improvement in Tanzania's health system must be sustainable after donor support ends, and that there is institutionalized capacity for ongoing improvement. In doing so, the country increasingly relies on its own financial resources and has the human resource and institutional capacity to sustain and improve health services for all its citizens"[6]. Below are examples of how the project has incorporated principles of GHI, PEPFAR and mission core operating principles into day to day activities:

**Promote sustainable financing:** The SCHFT project worked closely with the MOHSW and the HFTWG in the development of Tanzania's HFS. In particular, as the SCHFT results framework shows, the project assisted in developing policy options papers to feed into the HFS; facilitated in writing the HFS document outline and situation analysis sections; and actively participated both as a member of a small HFS writing team and a member of the HFTWG. The HFS will give direction and coherence to the MOHSW's efforts to harness and expand the base of sustainable health financing in Tanzania, specifically targeting sources that are not donor dependent. The SCHFT project also supported the MOHSW to develop a resource tracking institutionalization plan that will progressively put in place the systems, institutions and human resources needed to sustainably ensure collection of routine health data, analysis and use for decision-making, which will help the ministry make a case for itself for greater government resources to flow to health.

**Strengthened governance and management:** Accountability and transparency are pillars to strong health system governance. The SCHFT project worked to improve both pillars by supporting the completion of two PER estimations with the MOHSW. These PER studies provide all stakeholders with important information concerning the government's investment in health. Furthermore, the FMR options paper also outlined multiple options to improve financial management in the public health sector.

**Focus on women, girls, and gender equality:** More than Fifty percent of the SCHFT project's trainees were female.

**Encourage country ownership and invest in country-led plans:** The SCHFT project has worked closely with MOHSW key staff on resource NHA and the PER. The project also built the capacity of the UDSM to be a training institution for SHA/NHA and to be a technical resource to the MOHSW. As a result of the project's training and capacity building, the MOHSW has now the capacity to undertake PERs internally without reliance on external support as in previous years. The UDSM will offer a resource tracking module to its health economics students.

**Promote learning and accountability through monitoring and evaluation:** The SCHFT

[6] USAID/Tanzania Health Systems Strengthening Strategy, 2013-2018; September 30th, 2013

project submitted quarterly reports that reported on progress against the projects approved Performance Management Report. On a quarterly basis, the project reflected and reported on reasons goals, objectives and or targets were not met; lessons learned; and best practices/creative implementation.

### *3.2 SCHFT PROJECT SUPPORT FOR PRIORITY HEALTH PROGRAMS*

The project's primary impact has been in the domain of health financing. Health financing is a critical component of the health system, essential for ensuring expanded access to basic essential health care, such as family planning services, obstetric and newborn care, malaria prevention and treatment, and HIV care and treatment.

As textbox 6 demonstrates, building local resource tracking capacity has enabled the government to track revenue collection, financial risk protection and resource allocation. As the government implements the HFS, monitoring each of these indicators is critical to tracking its progress. For revenue collection, these indicators help to measure the level of dependency on non-domestic sources of financing; the level of government financial support to the health sector relative to other financial commitments; and the availability of resources for providing health services to the population. For financial risk protection, these indicators can be used to track the effectiveness of interventions to protect households form out of pocket expenditures. Lastly, in terms of resource allocation, disease specific data can provide insight regarding whether funds are appropriately targeted to major burdens of disease.

The MBP and Private Sector Resource papers provided concrete examples that could expand access to basic essential health care. As previously discussed in section 2.3, the MBP paper proposes and costs basic services that could be offered to the general population. The Private Sector Resources paper provides examples of contracting-out for clinical or specialist services or the use of corporate social responsibility to expand access to these essential services.

**Box 6: Tracking Revenue Collection, Financial Risk Protection and Resource Allocation**

Revenue collection

- General government health expenditure as a proportion of general government budget
- Donor spending on health as a percent of total health expenditure (THE)
- Total Health Expenditure (THE) per capita
- THE as a percentage of gross domestic product
- Government spending on health as a percent of THE

Financial risk protection

- OOP spending on health as a percent of total expenditure on health (THE)

Resource allocation

- Percent of THE spent on country priority health services (e.g. HIV, FP, MCH)

# 4. RECOMMENDATIONS FOR FUTURE ASSISTANCE

To continue the momentum created by the SCHFT project to sustainably institutionalize health resource tracking and support Tanzania's HFS, the project recommends the following future assistance:

**Support to MOHSW 5-year resource tracking institutionalization plan:** The project recommends continued support to the MOHSW to implement its 5-year resource tracking institutionalization plan, with a focus on building human resource capacity at the national and sub-national level, supporting harmonization, integrating different resource tracking efforts, and updating equipment and technologies to facilitate efficient data production.

**Support additional local institutions to acquire knowledge and skills in resource tracking:** The project made strides to strengthen skills of UDSM teaching staff on resource tracking through a firm fixed price sub-award. This is the first step to ensure that MOHSW and eventually LGAs have a pool of trained resource tracking experts to tap for their data needs, which is a critical step towards regular production and use of health accounting information to inform policy and planning. Given the experience with UDSM, the project recommends considering a similar intervention where curriculum is developed within other Tanzanian tertiary level institutions and LGA financial management training programs. Through the partnership with the university and/or MOHSW, development partners could explore possibilities of introducing resource tracking courses for existing professionals in the health sector (e.g. short-certificate courses) to accelerate the availability of resource tracking experts.

**Support Harmonization and Integration of Health Resource Tracking Exercises in Tanzania:** As part of the institutionalizing resource tracking, the project worked with the MOHSW to harmonize data collection instruments for the recent NHA exercise with instruments for the concurrent NASA and RMNCH efforts. The lessons from the project's exercise should be documented and used to strengthen other harmonization activities moving forward. In the future, this will enable the MOHSW and other stakeholders to systematically approach their resource tracking information needs. Given the level of traction, both nationally and internationally, and the broad scope of the NHA/SHA, making this methodology the base platform for integration may be beneficial.

**Support mechanisms to institutionalize data collection platforms:** To maximize the efficiency of data collection and reduce the associated cost, there is a need to incorporate resource tracking data needs into existing data management platforms, such as HMIS. In addition, MOHSW can capitalize on existing and regular household surveys, such as DHS, as vehicles for capturing out of pocket expenditures. Lastly, it will be beneficial to support MOHSW in exploring possibilities of using the Ministry of Finance's existing platform for donor reporting to obtain granular data related to their health portfolios.

**Continue support to the developing HFS**: The SCHFT project has provided support to the development of Tanzania's HFS. However, this task is not yet complete. Future assistance is needed to finalize the strategy. A crucial next step is to work with the MOHSW and ISC to analyze the information presented and identify the options that are appropriate for inclusion in the strategy and implementation.

**Support evidence generation for the HFS:** Based on the findings of both SCHFT-led options papers, USAID should continue to support studies and approaches that facilitate gathering evidence that will inform the HFS development and implementation. Further data-driven analysis may be required as Tanzania selects options to implement through the HFS.

**Provide long term support to MOHSW requests related to achieving the HFS goals:** Implementation of the HFS is a long term commitment. USAID assistance will be required throughout this time to identify and obtain resources that can be dedicated to preventive, promotion, curative, and rehabilitative health services; increase absolute resources to the health sector; increase efficiency in the use of available resources; and promote sustainability of health care financing and improve the quality and coverage of health services.

**Improve Monitoring and Evaluation of the HFS:** USAID should work with MOHSW to develop a robust M&E system for the HFS. The system should be aligned with country health information platforms, and enable policymakers to track progress towards goals and make changes as needed.

# 5. MONITORING AND EVALUATION (M&E)

### *5.1 PERFORMANCE MONITORING PLAN*

The SCHFT project M&E framework set targets for governance and financing system improvements, and served as a management tool to keep the project focused on its ultimate objective of improved governance, financing, and operations in Tanzania's health sector. At the same time, the M&E framework was intended, where appropriate, to provide valuable, actionable information to key MOHSW personnel who are responsible for finalizing, implementing, and monitoring Tanzania's HFS. The indicators for measuring project performance were carefully crafted and selected to respond to each objective and intermediate result. The project adopted a structured, project- wide process for documenting quantitative and qualitative information on results achieved or lessons learned that facilitated knowledge exchange within the project and across the wider stakeholder community. The performance monitoring plan is presented in Table 2 below.

**Table 2: SCHFT Project Monitoring Plan**

| Activity | Indicator | Data Source | End of Project Result | Explanation/Next Steps |
|---|---|---|---|---|
| **Intermediate Result 1: Increased effectiveness in health governance** | | | | |
| **Component 1: Develop capacity to provide ongoing management oversight of health financing in MOHSW, specifically monitoring resource allocation through PERs and NHA** | | | | |
| **Year One Indicators** | | | | |
| 1.1 | 1.1: MOHSW formally approves an institutionalization plan for resource tracking and initiates implementation of at least 2 planned activities before the end of project | Institutionalization plan | Draft institutionalization plan developed and submitted to HFU, MOHSW. The ministry now has a 5-year resource institutionalization plan. SCHFT has contributed to institutionalization of resource tracking as outlined in the plan by: (1) harmonizing resource tracking data reporting tools, and (2) working with the UDSM to develop a resource tracking course. | To implement the resource tracking institutionalization plan, the MOHSW will need to continue building capacity at the national and LGAs' levels, and harmonizing various resource tracking tools currently in use. In addition, further donor support may be required to support the ministry's e-Health plan to ensure routine data is analyzed, disseminated and used for decision-making. |
| 1.2 | 1.2: MOHSW-led PER completed with support from local technical/academic institution | PER report | The SCHFT project provided technical assistance to MOHSW HFU on the PER and supported the analysis and report writing PER workshops. The Ministry has adequate internal capacity to conduct PER internally in the future. | The MOHSW does not require further support in conducting PER. However, as discussed in Section 4 above, PER and other resource tracking tools need to be harmonized to reduce duplication and improve efficiency. |
| 1.3 | 1.3.1: Number of relevant technical staff from MOHSW and local technical institutions trained in NHA, PER, and/or NHA Production Tool (disaggregated by gender) | Project records | 16 technical staff trained (7 female, 9 male) on PER and NHA/SHA.<br>• 10 participants attended PER data analysis training – 6 (F), 4 (M)<br>• 6 UDSM participants attended NHA/SHA training – 1 (F), 5 (M) | Capacity building within the MOHSW and UDSM contributed to resource tracking institutionalization by building internal resources. |

| Activity | Indicator | Data Source | End of Project Result | Explanation/Next Steps |
|---|---|---|---|---|
| | 1.3.2: % of relevant technical staff from MOHSW and local technical institutions that received training in NHA, PER, and/or NHA Production Tool who say they are using new skills on the job and can provide examples (disaggregated by gender) | Project records, Post training assessment | Training was completed at the end of Year One. On average, prior to the training the UDSM staff reported their resource tracking skills at 2.0/5.0. After the training, they rated their skills as 4.5/5.0. Skills include use of SHA data, understanding the SHA 2011 methodology, knowledge of the key stages of the SHA process and use of the production tool. | The new skills acquired by UDSM staff will be used to train the next generation of health economists in the semester that begins in May 2014. PER skills have been used by the MOHSW HFU to conduct the 2013 PER whose data analysis and report preparation is underway. |
| 1.4 | 1.4: NHA course content adapted to fit the TZ context and incorporated into the teaching curriculum. | Project records | The UDSM has completed development of a resource tracking module and its contents have been incorporated into the existing Health Economics course. | The resource tracking module will enable new University professors who were not participants in the training to learn the material. The module aims to institutionalize the course within the department. |
| **Year Two Indicators** | | | | |
| 1.1 | Course content for NHA/SHA component of health economics course completed. | Project records | UDSM resource tracking course will be delivered in March 2014. | After the course is complete, the UDSM intends to assess whether the department should a) continue to provide the same course b) develop a full-fledged resource tracking course or c) develop a resource tracking night course geared for professionals. |
| 1.2 | Number of meetings/workshops held for stakeholders as part of the implementation of MoHSW institutionalization plan. | Project records | The SCHFT project provided two PER workshops for MOHSW. The first workshop focused on data entry for the FY2013 PER (10M; 8 F) and the second focused on report writing (1M; 5 F). | After the report writing workshop, the MOHSW plans to disseminate the FY2013 PER results. |
| **Intermediate Result 2: Improved planning for financing health services** | | | | |
| **Component 2: Assist with completion of GOT health financing strategy** | | | | |
| **Year One Indicators** | | | | |
| 2.1 | 2.1.1: MOHSW drafts HFS document that (1) outlines key system bottlenecks; (2) describes various policy options, including the benefits | HFS document | Draft FMR, PPP and MBP options papers completed and submitted to MOHSW for input into the HFS. | During year one, the project received detailed comments on each of the drafts submitted. |

| Activity | Indicator | Data Source | End of Project Result | Explanation/Next Steps |
|---|---|---|---|---|
| | and risks of each; and (3) explains reasons for selecting the policy(ies) | | | |
| | 2.1.2: Evidence that the MOHSW effectively utilized NHA and PER results to inform the development of health policy options, including the development of the HFS | HFS documentation | Matrix comparing existing health financing indicators circulated for reference to all consultants writing HFS policy option papers. | Since the HFS is not yet complete, the project cannot determine the extent to which NHA and PER data are used. |
| 2.2 | 2.2.2 Number of Terms of Reference (TOR) documents written (with MOHSW) to facilitate the development of policy option papers for the ISC | TOR documents | 9 TORs completed successfully. | ToRs were used by various consultants who led or contributed to the HFS options papers. |
| | 2.2.1: Number of project-generated policy options papers presented to MOHSW for potential inclusion in HFS | Policy option documents | SCHFT project successfully led and completed FMR and PPP options papers for potential inclusion in the HFS. | Synthesis of the option papers for potential inclusion into the HFS has begun and will continue beyond the life of the project. |
| **Year Two Indicators** | | | | |
| 2.1 | Finalize and submit to the TWGHF PPP and FMR papers | Project records | As previously mentioned (indicator 2.2.1) the SCHFT project successfully led and completed FMR and PPP options papers for potential inclusion in the HFS. | Due to the participatory nature of the development of Tanzania's HFS, the strategy was not completed by the end of the project. |
| 2.2 | SCHFT provides targeted technical assistance in development of the HFS | HFS document | The SCHFT project contributed to four sections of the HFS. The SCHFT CoP was a member of the HFS writing team. | The development of the HFS is still underway. |
| **Intermediate Result 3: Sustainable capacity operations** | | | | |
| Component 3: Provide technical assistance to the MOHSW to evaluate/assess/model some of the agreed upon approaches to expanding pooled risk (group social health insurance) systems | | | | |
| **Year One Indicators** | | | | |
| 3.1 | Number of health insurance related policy options papers that the project played a supportive (i.e. non-lead) role in developing. | Project records | The project has supported the GIZ team lead to complete the MBP paper, and the final draft was submitted. | At the end of year one, the project was waiting for comments from the HF TWG. |
| **Year Two Indicators** | | | | |
| 3.1 | Number of health insurance related policy options papers that the project played a supportive (i.e. non-lead) role in developing. | Project records | The SCHFT project obtained comments from the HF TWG and worked with GIZ team to finalize the MPB paper. | Final MBP paper was submitted to the HF TWG. |

# 6. PROJECT MANAGEMENT AND ADMINISTRATION

### *6.1 INTRODUCTION*

The project period of performance was September 25, 2012 to March 24, 2014.

The SCHFT project had a lean local staffing comprised of a COP and finance/ administrative manager to undertake project management and administration at the country level, with active and responsive program management support from the home office.

### *6.2 FINANCIAL ACTIVITIES*

At the time of this report, the project had been fully obligated at $ .

As of December 27, 2013, the project had invoiced total expenses of $ . The final invoice for expenses incurred through March 24, 2014 has not yet been submitted.

### *6.3 SHORT TERM TECHNICAL ASSISTANCE (STTA)*

The SCHFT project benefitted from a highly competent Abt core team with proven skills matched to each activity. STTA was provided by Abt staff who had conducted similar activities on the Health Systems 20/20 project. They applied lessons learned under that project to the Tanzania situation. Abt's technical experts were deployed to meet a variety of short-term technical assistance needs as requested by the MOHSW, the health financing technical working group and the inter-ministerial steering committee in the development of the HFS.

A list of the STTA trips taken during the project follows.

### Table 3: SCHFT Project STTA

| Name | Scope of Work | Time Line |
|---|---|---|
| | Meet with USAID/Tanzania, and other stakeholders including the Ministry of Health and Social Welfare and Prime Minister's Office – Regional Administration and Local Government; Development Partners to communicate about the new project and create a plan for working with them closely in the future, and<br><br>Assist the project Chief of Party, Daniel Ngowi, with project start-up activities including finalizing the project Work Plan and setting up the project administrative systems. | October 22-November 3, 2012 |
| | Work with the project Chief of Party and the Ministry of Health and Social Welfare to: draft a resource tracking institutionalization plan, and follow up on development of terms of reference for the Options papers for the health financing strategy development that the project has been tasked with writing. | December 1-December 13, 2012 |
| | Present the draft Financial Management and Reporting paper to the TWGHF and collect any missing data that may be required to respond to issues raised by the TWG | November 1 – November 20, 2013; Completed |
| | Meet with the MOHSW PPP TWG to receive feedback on the commissioned PPP Options paper;<br><br>Work with , the SCHFT COP, to draft the PPP options report, conduct key stakeholder interviews, visit focal organization sites, and conduct follow-up meetings with MOH. | February 24-March 15 2013 |
| | Provide training to the University of Dar es Salam staff and possibly the Ministry of Health Family Welfare's NHA team members on resource tracking with emphasis to the System of Health Accounts 2011 methodology and the production tool developed to support it.<br><br>Work with the University to develop a plan to have a resource tracking curriculum adopted into the Master of Health Economics program. | July 14 – July 25, 2013 |
| | Provide training to the University of Dar es Salam staff and possibly the Ministry of Health Family Welfare's NHA team members on resource tracking with emphasis to the System of Health Accounts 2011 methodology and the production tool developed to | July 14 – July 20, 2013 |

| Name | Scope of Work | Time Line |
|---|---|---|
| | support it.<br><br>Work with the University to develop a plan to have a resource tracking curriculum adopted into the Master of Health Economics program. | |
| | Assist the project COP to complete End of Project documentation, begin drafting final report, and debrief with USAID, MOHSW and other project partners to ensure a smooth project close out. | February 24-March 15 2014 |
| | Assist the project COP and F&A to close the financial and administrative aspects of the project, including ensuring proper disposition of inventory, closing of bank accounts, payment of staff severance, handing over of office to landlord, etc | March 10-March 21, 2014 |

### *6.4 PROJECT CLOSE OUT*

Abt has almost completed all close out activities in accordance with the close out plan submitted in the approved SCHFT Year 2 work plan.

Abt handed over the Tanzania office space to the landlord on March 21, 2014. All government property was disposed of in accordance with USAID disposition instructions as described in Section 6.4.1 below.

Over the next 90 days, Abt shall be processing final vendor, expenses and other similar financial actions and shall issue its final invoices and quarterly report (SF 425).

#### *6.4.1 Disposition of Property: After Action Report*

On March 1, 2014, Abt submitted its proposed property disposition plan. On March 11, 2014, Abt received USAID's disposition instructions for federally owned property acquired under the award.

On March 12, 2014, Abt informed USAID that two laptops purchased by the University of Dar es Salaam did not contain any sensitive information and obtained concurrence from USAID that Abt did not need to sanitize those laptops. In accordance with USAID instructions, Abt sanitized the remaining two computers of all user, system and project data and files. Abt provided USAID with certification of destructions that sanitization was completed and, on March 19, 2014, USAID instructed Abt to go ahead with transfer of the computers to the approved beneficiaries. Abt disposed of all government property in accordance with USAID instructions and obtained signed records of transfer from all three

beneficiaries. The transfer records are attached to this report as follows:

- MoHSW Equipment Transfer Memorandum
- Tanzania Mentors Association Equipment Transfer Memorandum
- University of Dar es Salaam Equipment Transfer Memorandum

### *6.4.2 Development Exchange Clearinghouse*

The following documents were uploaded to the Development Exchange Clearinghouse in accordance to the Agreement for Strengthening Capacity in Health Financing in Tanzania (SCHFT)

- Health Care Financing Strategy Options Paper: Options for Expanding Private Sector Contributions to Health
- Options for Financial Management and Reporting
- Health Care Financial Strategy Background Paper # 1~ Options for Minimum Benefits Package in Tanzania
- University of Da es Salaam Final Grant Activity Completion Report
- NHA Health Resource Tracking Module UDSM
- SCHFT Quarterly Performance Report, Quarter 1, Year 1
- SCHFT Quarterly Performance Report, Quarter 2, Year 1
- SCHFT Quarterly Performance Report Quarter 3, Year 1
- SCHFT Quarterly Performance Report Quarter 4, Year 1
- SCHFT Quarterly Performance Report Quarter 1, Year 2
- SCHFT Quarterly Performance Report Quarter 2, Year 2
- SCHFT End of Project Report