

Analysis of Health Budget and Financing for MNCH in Tanzania

Final Report

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LIST OF ACRONYMS/ ABBREVIATIONS

CARMMA	Campaign for Accelerated Reduction of Maternal Mortality
CCHP	Comprehensive Council Health Plan
CCPH	Comprehensive Council Health Plan
DHS	Demographic and Health Survey
DMO	District Medical Officer
GDP	Gross Domestic Product
HSSP	Health Sector Strategic Plan
IMS	Information Management System
MDGS	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MNCH	Maternal, Newborn and Child Health
MoHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NSGRP	National Strategy for Growth and Reduction of Poverty
OPD	Outpatients Department
PER	Public Expenditure Review
PHSDP	Primary Health Services Development Programme
PMNCH	Partnership for Maternal, Newborn and Child Health
PMORALG	Prime Ministers Office Regional Administration and Local Government
RCH	Reproductive and Child Health
SCiT	Save the Children in Tanzania
TPMNCH	Tanzania Partnership for Maternal, Newborn and Child Health

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1. Introduction

This report is set to analyze financial resource allocation from the public sector and Development Partners for addressing maternal, newborns and child health in Tanzania. It includes a critical review of the progress made with regard to mother and child health indicators in Tanzania towards the attainment of the Millennium Development Goals (MDGs) and the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA) targets for Africa.

Separately from the introduction, the report has six sections: A review of the country's plans and strategies for attaining MDGs 4&5; Comparing budgetary allocations to the health sector and actual expenditures; Comparing budgetary allocations to MNCH relative to other selected subsectors; Allocation of off budget donor funds to MNCH; Analysis of expenditures on MNCH in relation to the strategic national plans and priorities in the health sector; and Emerging issues and recommendations toward the attainment of the MDGs 4&5.

1.1 Background

The targets set by the World Leaders in 2000 for Millennium Development Goals indicate that MDG4 aims to reduce the death rate for children aged under five by two-thirds between 1990 and 2015. MDG5 states an ambition to cut deaths among pregnant women and new mothers by three-quarters during the same timescale. The Lancet ([Countdown Report](#) 2010) updates on previous estimates of progress on these Goals predict that no country in sub-Saharan Africa will meet the goals to dramatically reduce deaths by 2015 (UNICEF, 2011). Researchers say just nine of 137 developing countries will achieve their ambitious targets to improve the health of women and children, although progress is speeding up in most countries.

The Global Strategy was launched at the time of the UN Leaders' Summit for the Millennium Development Goals (MDGs) in 2010, with some US \$ 40 billion pledged towards women's and children's health and the achievement of MDGs 4 & 5 – to reduce child mortality and improve maternal health. A very recent report by the Partnership for Maternal, Newborn and Child Health (WHO: Global Strategy for Women and Children's Health) says that some of the world's poorest countries have pledged £7bn of their own resources to try to reduce the death rates towards accomplishing the MDGs 4&5 by 2015. For example, Bangladesh has committed to train 3,000 midwives by 2015, while Congo has promised to provide free obstetric care, including Caesarean sections.

Notwithstanding the efforts, the financing gap to achieve the health-related Millennium Development Goals remains huge in developing countries. Clearly, more resources for the health sector, and in particular for the MNHC subsector, are needed from the respective governments, their citizens and the donor institutions. The WHO Report (2010) recommends a minimum per capita health spending of \$60 by 2015.

However, increasing resource allocation to the health sector is necessary, but alone is not sufficiently capable of attaining the objectives of the health sector; we need to address accountability, effectiveness, efficiency and equity in health expenditures. And in addition, for meeting MGD 4 and 5 in particular, there have to be in place effective national strategies for tackling maternal and child mortality.

[Save the Children](#) in Tanzania (SCiT) is working closely with the Ministry of Health and Social Welfare (MoHSW) to reduce the morbidity and mortality rate of mothers, newborns, and children under five. The latest Demographic and Health Survey Report (DHS 2009/10) for Tanzania shows that substantial progress has been made between 2006 and 2010 under-five mortality rate dropped from 112 to 81 (i.e. by 28% percent). Infant mortality rate decreased from 88 to 51 deaths per 1,000 births (42%) between 2006 and 2010. And maternal mortality has also decreased, but it is still high at 454 deaths /100,000 live births. The observed decrease of about forty percent in mortality rates for infants and 28% for under-fives for a period of five years is obviously an outstanding achievement; it is close to the desired MDG target of a decrease of 66% in the mortality rates by the year 2015

The results of the 2010 Demographic and Health Survey Report for Tanzania point to high possibility of attaining the MDG 4 provided that the efforts will be sustained, including allocation of more resources and efficient use of the same in the subsector of MNCH.

However, the attainment of MDG 5 remains rather a challenge. With a marginal decrease of about 14% in a period of ten years; it is clearly plausible that unless the current efforts are scaled up, and both supply and demand side barriers addressed, Tanzania will not be able to meet the MDG 5 even by fifty percent. Thus, there is an argent need to scale up the current effort in the form of increased financial resources, and more efficient, equitable and effective use of resources, to accelerate progress towards meeting MDGs 4 and 5.

Thus, the need for scaled up efforts towards the attainment of the MDG 4&5 is clear. The entry point is to review the national strategic plans and targets with regard to the MNCH in terms of their comprehensiveness, effectiveness and equity. Thereafter, analysis of financial resources going to the MNCH subsector in relation to the plans and targets will provide insights towards improving the performance of the subsector. Against this backdrop, this report has been prepared to set a basis for a dialogue on scaling up flow of resources and effectiveness in the MNCH subsector to achieve MGDs 4&5 in Tanzania.

1.2 Objectives of the Study

The study on MNCH financing in Tanzania set out with the following specific objectives.

- i. Review the comprehensiveness and effectiveness of the current national plans/strategies in addressing MNCH.
- ii. Track budgetary allocation to health (2005-2010) as well as expenditure data for health to reveal the discrepancy between allocations and expenditures.
- iii. Estimate allocation of MoHSW health budget to MNCH (disaggregated) for 2005-2010, relative to other sub-sectors e.g. HIV/AIDS and malaria. Estimate allocation of off-budget donor funds to MNCH (disaggregated) for 2005-2010; relative to other sub-sectors; including a comparison across regions and between MN and CH.
- iv. Analyze the consistency of MoHSW MNCH allocations and actual spending with the key strategic national plans and priorities.
- v. Provide recommendations on MNCH financing in Tanzania towards the attainment of the MDGs 4 and 5.

1.3 Approach and Methodology

The analysis of financial resources for the MNCH seeks to establish trends in budgetary allocations and actual expenditure for the sub sector. This is done with a view to identify gaps in MNCH financing between the national plans and targets on MNCH and trends of financial resources allocated for the same. In particular, the Road Map for Accelerated Reduction of Maternal and Child Deaths indicates the planned targets, interventions and financial resources needed to achieve MDG 4&5 in Tanzania.

Review of Documents

Preparation of this report involved review of the National Strategy for Growth and Reduction of Poverty (NSGRP), key MoHSW documents on MNCH plans and budget, and the annual reports on Council Comprehensive Health Plans (CCHP) which are submitted to the MoHSW every year. Specifically, the review sought to outline the national strategies and interventions on MNCH to determine their focus, comprehensiveness and consistency, and implication on resource availability and set priorities where data are available.

The CCPH have information on itemized councils' budgets and expenditure on maternal and child health though they are available for only the latest two – three years. We accessed these documents from the MoHSW and extracted information on planned and actual expenditure for 110 councils (out of 132) with easily traceable and detailed consistent financial data on quality maternal health care and Quality Child Health Care. We then computed percentage budget share of each item of expenditure and compare it with its respective actual expenditure for each given financial year. This is done to work out deviations and priorities between budgets and actual expenditure on MNCH.

In-depth Interviews

In addition to the discussions with the MoHSW, Prime Minister's Office-Regional Administration and Local Government, and the Ministry of Finance and Economic Affairs, field visits were carried out in two selected councils for further in-depth interviews on MNCH financing. This was intended for assessing the way the Health Plans are prepared and executed at the council level to determine reliability of the annual expenditure reports submitted to the MoHSW. Selection of the two councils reflected a mix of three variants: rural versus urban, maternal versus infant mortality rates, and lowest versus highest rate in mortality. Accordingly, Shinyanga District Council (highest rate in infant mortality rate) and Morogoro Municipal Council (lowest maternal mortality rate) were selected for in-depth interviews. Needless is to say that the selection of the two councils did not need to take on board representation of all the 132 councils in Tanzania because there is not any quantitative analysis in this report that is based on the two councils alone. The visits were rather intended to assess how budgets are made and executed at the council level including itemization of budget and actual expenditure. It was realized that all councils use the same format of reporting on budget and expenditure with regard to MNCH.

Sources of Financial Data

Budget and expenditure data for MNCH were compiled from MoHSW documents including the annual public expenditure review reports (PER) for 2007/08-2010/2011, local authorities, Development Partners' institutions, Ministry of Finance and Economic affairs, and the Prime Minister's Office Local Governments and Regional Administration.

Right away from the onset of our analysis we distinguish between two levels of spending: Central (MoHSW) and local (council) level; and two categories of expenditure: Maternal and Newborns (MN) and Child Health (CH). We will first explain the two levels of expenditure.

The Ministry responsible for health (MoHSW) prepares and presents its budget estimates and expenditure separately from local authorities (about 132 of them). The ministry's expenditure estimates show itemized budget by the spending departments and units including details by activities. Included in the estimates is budget for Maternal and Newborns which falls under the reproductive health and child health unit. This is

direct expenditure by the MoHSW on MN. It clearly excludes expenditure on purely on family planning and earmarks expenditure on MN for the last three years. There are several Development Partners who make spending on MN through the ministry. This is particularly the case for earmarked (medical) supplies for MN which are paid or directly supplied by Development Partners – an example here is WHO support for MN in Tanzania.

The second level of expenditure is councils' expenditure on health. Local Authorities (LGAs) prepare their budget estimates and present them under the ministry responsible for Regional Administration and Local Authorities under the Prime Minister's Office (PMO-RALG). Included in their estimates is itemized expenditure on MN which includes financial data on maternal health care i.e. capital expenditure, training, Immunization and Vitamin "A" Supplements, Surveillance and Monitoring, Procurement of Medical Equipments/Drugs (Medical Supplies), Administration, Outreach/Mobile Clinic, Antenatal and Postnatal Care, PMTCT Activities, and other activities. Also, included in the council budget and expenditure are details on child health itemized as follows: Development activities, Training of Health Workers, Immunization and Vitamin "A" Supplement, Monitoring and Surveillance, Procurement of Medical Equipments/ Drugs, Administration, Outreach and Mobile Clinic, Community Mobilization, Antenatal and post natal Care, PMTCT Activities, and Other Activities. Every financial year, councils prepare and submit expenditure reports on CCHP to the MoHSW. The reports shows approved budget versus actual expenditure every item of MN and child expenditure and by the respective spending unit at the council level. That is to say, the main source for expenditure on MNCH at both the central and local level is the MoHSW.

Thus, our approach to the compilation of budget and expenditure data on MN involved a visit to the Directorate of Policy and Planning at the MoHSW to hold discussions and get access to the budget and expenditure data on MNCH. Additionally, a few gaps in the data were filled in by contacting the office of the Commissioner for budget at the Ministry of Finance and Economic affairs. This required a special permission which was sought and obtained at each respective ministry. Thanks to the Director of Policy Planning- MoHSW.

Now we explain the two categories of spending on MNCH in Tanzania as indicated earlier. Expenditure on MNCH falls into two major categories: Specifically earmarked budget and expenditure on maternal and newborns health (MN), and expenditure on curative services in the general departments for which under-fives are part of beneficiaries (CH). The analysis of MNCH budget and expenditure carried out in this report observed the two categories and made estimations for CH separately from MN. As explained earlier, financial data on MN were obtainable from the MoHSW and the Ministry of Finance, but not so directly for CH. In fact data on MN expenditure at council level were compiled by going through each hard copy of annual report submitted to the MoHSW for councils for the last three years available reports. We accessed these

documents from the MoHSW and extracted information on planned and actual expenditure for 110 councils for which reports were consistently available (out of 132 councils). Thus, the proportion of the total number of councils covered is 83% which is sufficiently large to include all the basic variations.

What did we do to get expenditure on CH? The system of keeping and generating information (IMS) at the MoHSW shows data on patients attending public facilities by age and type of disease/medical problem attended. Expenditure at any health facility includes wages and salaries, implying that though we have data on expenditure for some diseases, they do not include costs on the medical personnel and other centrally incurred costs. Therefore, in order to work out the proportion of the total expenditure going to under-five in the general health services departments, we first computed the average proportion of under-five (who seek medical services in public health facilities) from the total number of patients in the outpatients department (OPD) in public health facilities in Tanzania. This information on attendance in OPD by age and medical problem attended is compiled and published by the MoHSW. We then multiplied it by the total budget going to the general health services departments - to get the spending on under-fives.

From the compiled data on ODP attendance, we found that on average, 44% of ODP patients in public health facilities in Tanzania are under-fives. We then worked with an assumption that proportionally public health facilities spend 44% of their funds (net of those going to maternal and newborns) on under-fives. And further to that, we assume that about 44% (average) of the central spending on the Health Sector (MoHSW) also goes to under-fives. It is thus conclusive to estimate that 44% of the public expenditure in the Health Sector (excluding expenditure on MN) is for under-fives. This is an estimate rather than actual expenditure because the health system has many overlapping services including those which are purely administrative and centrally administered services. In short the formula we applied is:

$$EUF = \frac{\text{Average total annual UF OPD patients}}{\text{Average annual total number of OPD Patients}} (\text{Public spending on Health excluding MN}).$$

Where, *EUF* is annual public spending on under-fives and *UFOPD* is under-five patients reporting at the outpatients department. It should be noted that this formula provides just general estimates of expenditure on CH.

2. National Health Policy, Targets and Strategies on MNCH

2.1 Objectives of the National Health Policy on MNCH

The vision of the Government of Tanzania is to have a healthy society, with improved social well being that will contribute effectively to personal and national development. The mission is to provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable.

The National Health Policy states that maternal and child mortality will be reduced in line with the MDGs 4&5. To this effect, the Government has formulated and adopted several strategy documents for implementing the National Health Policy.

2.2 National Targets and Strategies on MNCH

Tanzania is one of the 137 developing countries determined to achieve MDGs 4&5. Since the inception of the MDGs by the World Leaders in the year 2000, the country has prepared several policy and strategy documents in which targets and specific interventions for MNCH are set. These include revision of the 1990 Health Policy, preparation and adoption of the national strategy for poverty reduction (PRSP 2001 – 2005), and consecutively prepared and adopted two more comprehensive National Strategies for Growth and Reduction of Poverty (NSGRP I&II). The latter two strategies have broadly focused on three clusters namely growth and reduction of poverty, quality of life and social well being, and good governance and accountability. The NSGRP is a five year strategy that indicates the milestones to be achieved and the strategies thereof for the components of each cluster. The health sector under which MNCH is a sub sector falls under cluster two of the NSGRP II.

Box 1: NSGRP I Targets on MNCH and Strategies

Under the subsector MNCH, the **2005 – 2010 NSGRP** determined to achieve the following **Targets:**

- Reduce infant mortality rate from 95 per 1,000 live births to 50
- Reduce under-five mortality rate from 154 to 79 per 1,000 live births
- Reduce maternal mortality rate from 529 to 265 per 100,000

Sub strategies:

- Increasing coverage of births attended by trained personnel from 50% to 80%
- Emphasis on public health and primary preventive strategies, and implementation of universal and cost-effective basic services
- Increased financial, technical and human resource to target the underserved and vulnerable groups.

By 2007, it was realized that the pace of the achievement of the targets of the **NSGRP 1** on the sub sector MNCH was not in line with the strategy timeframe and the timeline for the realization of the MDGs 4&5. The critical challenges comprised two categories according to the Road Map for Accelerated Reduction of Maternal and Child Deaths (2007) for Tanzania:

- I. *Health system factors:* Inadequate implementation of pro-poor policies, weak health infrastructure, limited access to quality health services, inadequate of human resource, shortage of skilled health providers, weak referral systems, low utilization of modern family planning services, lack of equipment and supplies, weak health management at all levels and inadequate coordination between public and private facilities.
- II. *Non health system factors:* Inadequate community involvement and participation in planning, implementation, monitoring and evaluation of health services, some social cultural beliefs and practices, gender inequality, weak educational sector and poor health seeking behaviour.

In response, the MoHSW prepared the **National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania**, covering the period 2008 – 2015. The purpose of the road map is twofold: To put in place 'one integrated maternal, newborn and child health strategic plan' to ensure to

improved coordination of interventions and delivery of services for the MNCH subsector; and second is guide implementation across operational levels of the health system so that policy drawn at national level will be carried out at the district and community levels. The Road Map operationalized the tenets of the New Delhi Declaration 2005 of developing one national MNCH plan for accelerating the reduction of maternal, newborn

Box 2: Targets and Strategies of the Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths

Operational targets of the Road Map to be achieved by 2015 are:

1. Increased coverage of births attended by skilled attendants from 46% to 80%.
2. Increased immunization coverage of DTP-HB 3 and Measles vaccine to above 90% in 90% of the districts.
3. New EPI vaccines introduced (Hib, Pneumococcal, Human Papilloma Virus (HPV) and Rota Virus vaccines).
4. Reduced stunting and underweight status among under-fives from 38% and 22% to 22% and 14%, respectively.
5. Increased exclusive breast feeding coverage from 41% to 80 %
6. PMTCT services provided to at least 80% of pregnant women, their babies and families.
7. 90% of sick children seeking care at health facilities appropriately managed.
8. Increased coverage of under-fives sleeping under ITNs from 47% to 80%.
9. Ensuring 75% of villages have community health workers offering MNCH services at community level.
10. Increased modern contraceptive prevalence rate from 20% to 60%
11. Increased coverage of CEmOC from 64% of hospitals to 100% and of BEmOC from 5% of health centres and dispensaries to 70%
12. Increased proportion of health facilities offering Essential Newborn Care to 75%.
13. Increased antenatal care attendance for at least 4 visits from 64% to 90%
14. Increased number of health facilities providing Adolescent friendly reproductive health services to 80%

Strategies

- Advocacy and resource mobilization for MNCH
- Health System strengthening and capacity development
- Community mobilization and participation
- Fostering partnerships

and child deaths, in order to improve coordination, align resources and standardize monitoring and evaluation. This was also in line with the voice from the Tanzania Partnership for Maternal, Newborn and Child Health (TPMNCH) launched in 2007.

In 2008, the Government updated the 2003 Health Sector Strategic Plan (HSSP II) and prepared and adopted the HSSP III 2009 – 2015, which among other objectives seeks to increase access to Maternal, Newborn and Child Health (MNCH) services; and strengthening the health systems to provide quality MNCH services, among others. Increasing access to MNCH interventions is part of the Primary Health Services

Box 3: Objectives of the HSSP III and MAMM on MNCH

- Increase coverage of primary health care in remote areas
- Increase proportion of skilled attended deliveries
- Provide Emergency Obstetric Care (EmOC) and Family Planning.
- Provide youth-friendly reproductive health services and increase availability of family planning methods and child health interventions.
- To strengthen the health system to provide quality MNCH services.
- Review regulations, guidelines and standards, and improve standardized supervision, at all levels of the health services.

Development Programme (MMAM 2007 - 2017) – country wide programme of expanding basic health services in Tanzania.

In 2010, the Government adopted the **NSGRP II 2011 - 2015**, which among other things sets targets and strategies for the subsector MNCH. The strategy takes into account the results of the Demographic and Health Survey of 2010 which shows significant achievements in child mortality rates but a marginal improvement in maternal mortality rate since 1990. The new strategy sets targets for the year 2015 and interventions deemed necessary for implementing the strategy.

Box 4: Targets and Strategies of MKUKUTA II (NSGRP II) on MNCH

Targets include:

- Reducing maternal mortality rate from 454 in 2010 to 265 per 100,000 in 2015
- Reducing infant mortality rate (MMR) from 51 to 38 per 1000 in 2015
- Reducing under-five mortality from 81 in 2010 to 54 per 1000 in 2015
- Reducing under-five underweight from 21 to 14 percent
- Reducing stunting for under-five from 35 to 22 percent
- Neonatal mortality (NMR) reduced from 26 per 1,000 live births (2010) to 19 per 1,000 live births in 2015
- Increasing the breast feeding of less than six months from 50 to 60%.

Stated strategies:

On MMR and NMR:

- i.
 - I. Ensuring appropriate number and mix of health professional is trained and deployed;
 - II. Improving access to quality maternal and antenatal care; basic and comprehensive emergency obstetric care, and post-natal care;
 - III. Addressing disparities in health outcomes and services delivery by socioeconomic groups and by urban/rural and districts;
 - IV. Strengthening Public Private Partnerships (PPP) in health care delivery;
 - V. Providing nutrition education and micronutrient supplements to women of reproductive age, especially pregnant and breastfeeding women;
 - VI. Promoting adequate child spacing by enhancing access to modern contraceptive use for all sexually active persons, particularly targeting women and their spouses, adolescent girls and boys;
 - VII. Ensuring access to primary and secondary education to reduce early pregnancy and promote child spacing;
 - VIII. Increase Intermittent Presumptive Treatment in pregnancy (IPTp) coverage;
 - IX. Improving access and quality of obstetric care; strengthening referral systems; and preventing malaria incidences;
 - X. Improving accessibility/attendance and quality of antenatal care services;
 - XI. Strengthening community care and involvement in the health of expecting mothers to ensure accessibility to basic services;
 - XII. Preventing chronic diseases (malaria, TB, HIV and AIDS) which are major causes of death);
 - XIII. Systematically build up the capacity for procurement and supply management for timely and adequate provision of medical supplies and pharmaceuticals.

On Child Health:

- I. Improving quality of facility, and community-based Integrated Management of Childhood Illnesses (IMCI);
- II. Strengthen health promotion and engagement with communities on proper management of childhood illnesses;
- III. Ensuring universal Vitamin A coverage of under-five children and post partum women
- IV. Scaling up implementation of public health and primary preventive strategies such as use of safe and clean water;
- V. Promoting personal hygiene and sanitary measures, implementation of environmental health programs;
- VI. Increasing immunization coverage and introducing new options for Expanded Program in Immunization (EPI) vaccines;
- VII. Promoting optimal breastfeeding and complementary feeding practices;
- VIII. Combating malaria through strategies such as universal distribution of long-lasting nets; implementation of Rapid Malaria Test (RDT) for malaria country-wide; and introducing additional malaria control strategies including indoor residual spraying;
- IX. Regulating and promoting food fortification with vitamins and minerals;
- X. Responding rapidly to health and nutritional challenges that especially affect children due to adverse conditions such as climate change;
- XI. Engaging in partnerships with organizations and sectors outside health sector at national, regional and international levels in order to adapt and mitigate impacts of adverse weather conditions.

2.3 Emerging Issues on National Policies and Plans on MNCH

We have multiple strategy documents for the MNCH sub sector which complicate prioritization in financing

The National Health Policy stipulates that the general policy objective of the MNCH is to achieve MDGs 4&5. Towards its implementation, the government has prepared and adopted four major strategy documents under which sub strategies and targets for improving MNCH are identified as indicated earlier in Boxes 1 – 4. MMAM begun in 2007; the Road Map begun in 2008, the HSSP begun in 2009; and NSGRP II begun in 2011; all are under implementation until 2015 or 2017. Each of these requires a financing strategy though of course they lead into a common end. For example, the Road Map for Accelerated Reduction in Maternal and Child Mortality Rates alone requires total additional funding of about US\$674,030,000 for about seven years according to the financial cost estimates of the Road Map. This amounts to about TZS 144.44 billion increase per year net of inflation; or about 25% increase in the health sector budget for 2008/09 alone. This is separate from the costing of MMAM, NSGRP, etc. The issue is how to come up with a unified costed strategy for MNCH so that there is prioritization and effective budgeting and monitoring of expenditure for MNCH. This would also serve as a basis for an effective monitoring and evaluation of interventions in the sub sector MNCH. As it is now, there are several strategy documents to deal with, making it difficult to make evaluation and prioritize expenditure for improved outcomes.

Despite the Multiple Strategy Documents for the MNCH Sub-sector, Attainment of MDG 5 Remains a Challenge

Although the government and development partners have continued to commit resources for MNCH, there is not yet matching results with regard to the reduction of maternal mortality rate. The constraining factors have been identified by the Road Map document as enlisted earlier in this document. The major issue however is whether there can be an effective monitoring mechanism over time to determine impact of financial resources allocated for the subsector.

Sequencing Interventions is Necessary for Setting Priorities in Health Expenditure

MKUKUTA II shows a 65% shortage of human resource in the health sector in Tanzania. In view of addressing the gap, there are two overlapping planned interventions across the four strategy documents: Increasing coverage of birth attended by skilled health personnel (from around 40's to 80%), and improvement in the provision of primary health services. These are by large the underlying factors for deaths during pregnancy, and early childhood in Tanzania. However, we need to identify sequential interventions for addressing MNCH. For example, how do we increase the number of births attended by skilled health personnel and distribution of services without addressing availability

cum access to health facilities? Couldn't we introduce mobile services in the short run to save lives? Also, as indicated in the strategy documents, the observed disparities in the distribution of the available health personnel works in favour of urban and non remote rural areas leaving remote areas underserved and thus vulnerable to premature deaths. Couldn't introduction of conditional incentive package redress the imbalance – at least in the immediate future? This could be combined with other initiatives eg increased intake and production of midwives and nurses, and possibly also mid-level obstetric workers.

The NSGRP II and other national strategies on MNCH could distinguish between immediate, short and long term interventions so that expenditure can be prioritized at every point of time. This would also make monitoring and evaluation relatively easier. In fact, unlike the other strategy documents, the Road Map for Accelerated Reduction in Maternal and Child Deaths is very detailed on the timing, involvement and costing.

Align Preparation of Strategies and Interventions for MNCH with Resource Capacities

Preparation of the national targets and strategies on improving MNCH seems to identify and enlist a set of interventions for addressing the sub sector without effective reference to resource capacities; and thus makes their achievement far from reality. For example, the NSGRP I envisaged to increase coverage of births attended by trained personnel from 50% to 80% by 2010; which, among other factors, was expected to reduce maternal mortality rate to 265 per 100000. But five years down the road, NSGRP II indicated a 65% shortage of human resource, and maternal mortality rate is still high at 454. Thus, the intended impact was not realized despite the efforts made in the sub sector.

Therefore, the plans should be more realistic and cost-based interventions within the resources and time limits. The Medium Term Expenditure Framework (MTEF) has been a useful tool in planning and forecasting and sequencing expenditure in the public sector; but not so useful in addressing resource constraints and financing of the NSGRP in the long term. Thus, forecasting resource inflow in the public sector for the planning horizon is essentially needed in order to align targets, planned interventions and strategic financing. This would allow an effective distinction between constraints emanating from lack of financial resources from the pure issues of effectiveness and efficiency in the implementation of interventions. Though the forecasting is done every year, it has not been effectively been able to predict resource inflow in the long term because of dependency to external financing.

Fragmented Approach at National Level versus a Consolidated Strategy at Council Level

It is observed that at the national level there are four operational strategy documents with regard to the improvement of MNCH: NSGRP II, HSSP, MMAM and the Road Map for Reduced Mortality Rates for maternal cases, newborns and children. These are translated into one document at council level: Comprehensive Council Health Plan

(CCHP), which is the guiding document for implementation at that level. Much as this makes implementation easier to councils, monitoring and evaluation of each national strategy and of each sub strategy, and therein attribution, becomes complex and difficult; and so with decision on financing by components of the MNCH by the respective strategies. Councils which constitute the implementing authorities at the grassroots level find it difficult to distinguish spending and outcomes by the different sub strategies on MNCH; rather they just work with one consolidated strategy document - CCHP which combines all the national level strategies/interventions into one single operational document. Councils receive earmarked funds from the central government to implement their CCHP. It becomes difficult to monitor, evaluate and draw lessons and experiences for each of the strategies prepared and adopted at the national level. Thus, MNCH strategy documents that are prepared after the adoption of a main national strategy, say NSGRP II, should be clearly linked to the latter including alignment in financing and monitoring by components. These will make resource allocation more focused and reach where they are needed most.

The NSGRP II Lacks Emphasis on Community Roles on MNCH

Needless is to emphasize the role of people and their communities in health interventions particularly on MNCH. However, this is not well articulated in the NSGRP II and thus may be overlooked in resource allocation. For example, community health committees have played an outstanding role in the outcomes of health interventions and programmes in Zanzibar; the use of peer educators at the community level is definitely instrumental in achieving the objectives of health interventions (Rahaleo Community Health Initiative, Aga Khan Foundation, 2011).

The Community Health Fund (CHF) is still infant in Tanzania as it contributes less than 1% of the total health sector financing. At the community level there is not earmarked funds for the subsector MNCH; rather, the funds are mainly used for development projects at the community level.

Need to Strengthen Monitoring and Evaluation for MNCH Interventions

The national strategy documents on MNCH indicate desired outcome indicators and targets but lacks details on performance indicators for annual monitoring and evaluation. The Road Map document, for accelerated reduction of maternal and child deaths, is a more comprehensive document relative to the rest. It indicates components to be financed every year and the total amount required for each particular year so that it is easier to monitor levels of financing. The need to make one consolidated document that will guide formulation of annual budgets and actual expenditures is important.

3. Trends of Health-care Financing Indicators in Tanzania

The financing strategy for the health sector is in principle based on the vision and objectives of the Tanzania Health Policy and the adopted implementation strategies as indicated earlier. The HSSP III indicates the following financing strategies:

- I. Reduce the budget gap in the health sector by mobilizing adequate and sustainable financial resources
- II. Enhance complementary financing for provision of health services, increasing the share in the total health budget to 10% by 2015
- III. Improve equity of access to health services
- IV. Improve management of complementary funds raised at local level
- V. Increase efficiency and effectiveness in use of financial resources

In line with the trends in the national resource base (GDP), the health sector strategy documents and the financing strategies, we make an assessment of the financing trend by sources in the health sector before we embark on a more specific analysis with regard to the financing of the MNCH sub sector in Section 4.

3.1 Macro Economic Performance and Budgetary Allocations to the Health Sector

Health sector budgetary allocations are drawn from the MTEF and annual national budgets. The national budget in turn depends on the size of the national cake (GDP) and therein revenue collection for the public sector and other sources particularly Development Partners. Thus, analysis of financing for the health sector has to begin with an assessment of the macro performance of the economy and revenue collection. This is precisely the presentation we make in Table 1 and Figure 1.

The table shows that, on average, gross nominal domestic product (GDP) has been growing at 15.4% since 2005/06. Tax revenue collection averaged 14% of GDP – which is below the regional average (sub Sahara) of 18%, and grew at an average rate of 19% per annum. At the same time, the national nominal budget grew at an average rate of 24.9%, which is much higher than the GDP growth, and constituted about 25.9% of the GDP on average during the period.

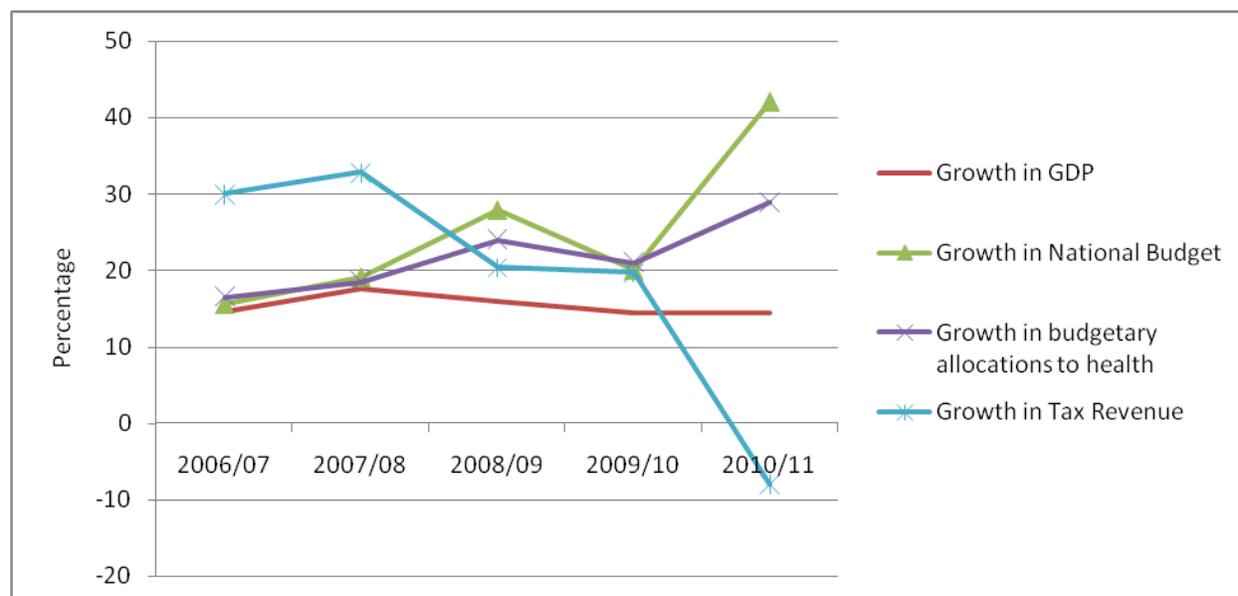
In real terms, i.e. taking into account inflation, per capita GDP grew by 4.5% on average, which was significantly lower than real per capita national budget growth (13.2%) during the period.

Table 1: Basic Macroeconomic Indicators

	Particulars	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	Average
1	GDP in TZS (billions TZS)	16,953.30	19,444.80	22,865.00	26,497.20	30,338.10	34,749.80	
	% growth		14.70	17.59	15.89	14.50	14.54	15.44
2	National Budget in TZS (billions TZS)	3,873.30	4,474.70	5,327.80	6,811.80	8,173.70	11,609.60	
	% growth		15.53	19.06	27.85	19.99	42.04	24.89
3	National Budget as % of GDP	22.8	23	23.3	25.7	26.9	33.4	25.85
4	Tax revenue (in billions)	1,946.40	2,529.40	3,359.20	4,043.70	4,840.90	4,454.05	
	% growth		29.95	32.81	20.38	19.71	-7.99	18.97
5	Tax revenue as a % of GDP	11.5	13	14.7	15.3	16	12.82	13.89
6	Nominal Growth of GDP		14.7	17.6	15.9	14.5	14.5	15.44
7	Nominal Growth of national budget		15.5	19.1	27.9	20	42	24.9
	Nominal	449.63	500.28	570.68	641.54	712.56	793.85	
8	Per capita GDP (in thousands TZS)							
	Nominal Growth		11.26	14.07	12.42	11.07	11.41	12.05
	Real	331.1	343.8	357.9	370.2	383.8	412.7	
	Real Growth		3.8	4.1	3.4	3.7	7.5	4.5
	Nominal	102,725.60	115,125.60	132,973.10	164,925.80	191,979.20	265,215.80	
9	Per capita national budget (TZS)							
	Nominal Growth		12.07	15.50	24.03	16.40	38.15	21.23
	Real	75,651.30	79,107.30	83,394.20	95,173.70	103,394.80	137,862.40	
	Real Growth		4.6	5.4	14.1	8.6	33.3	13.2
10	Population (millions)	37.7	39	40	41	43	44	
	% growth		3.5	2.6	2.5	4.9	2.3	3.16
11	Deflator*	1.36	1.46	1.59	1.73	1.86	1.92	

*Calculated as Nominal GDP divided by Real GDP with 2001 as the base year. **Source:** Various official documents

Figure 1: Trends in the Growth of GDP, Fiscal Performance and Allocation to the Health Sector



What do the trends tell us?

- Tax revenue collection has been improving, except for 2010/11
- The growth of the national budget has been much higher than the growth of the economy and tax revenue in Tanzania
- Non tax sources of revenue including donor funding are the main drivers of the fast-increasing national budget
- Growth of the Health Sector budgetary allocations are below the national budget growth

Therefore: Improve tax revenue collection to reach at least the regional average (18%) to increase further the national budget; and at the same time potential for mobilizing more non tax revenue can be negotiated. This could lead to more resource allocation to the health sector.

What are the implications of the trends on the Health Sector Financing?

Table 2 shows trends in budget allocations to the health sector since 2005/06. It is observed that budgetary allocations to the health sector have been growing at an average rate of 21.8%. This has been below the average growth rate (24.9%) of the national budget during the period. The share of the health sector in the national budget has remained rather constant at around 11% over the past five years, mainly because expenditures in other sectors have also been growing. As indicated later Health comes third in budget priorities.

Table 2: Selected Health Budget Indicators

Particulars	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	Average
1 Budgetary allocations to Health (Billions of TZS)	446.2	520	616	764	925	1,193	
% growth		16.5	18.5	24	21	28.90	21.78
2 Health sector allocations (% of National Budget)	11.5	11.6	11.6	11.2	11.3	10.3	11.25
3 % growth of nominal allocations to Health		16.5	18.5	24	21.1	29	21.82
4 Real allocations to the Health sector (Billions TZS)	328.58	357.3	386.3	440.9	498.2	620.1	
5 % growth in Real allocations to Health sector		8.7	8.1	14.1	13	24.5	13.68
6 Per capita nominal allocations to Health (TZS)	11,833.40	13,379.00	15,374.00	17,771.00	21,726.00	27,254.00	
7 Per capita Real allocations to Health (TZS)	8,714.60	9,193.20	9,641.80	10,255.10	11,701.00	14,167.00	
8 % growth in nominal per capita allocations		13.1	14.9	15.6	22.3	25.4	18.26
9 % growth in Real per capita allocations		5.5	4.9	6.4	14.1	21.1	10.4

Source: Various official documents

Table 3: Health Expenditure Per Capita (PPP International \$) Selected Countries

S/N	Country	Health per capita spending in 2008 (International I PPP \$)	Regional Average
1	Uganda	112	
2	Rwanda	102	
3	Zambia	80	
4	Kenya	66	
5	Tanzania	57	69.4
6	Burundi	50	
7	Malawi	49	
8	Mozambique	39	

Source: Who, World Health Statistics 2011

Table 3 shows per capita international PPP US dollars for Tanzania and the neighbouring countries. Tanzania spends less than the average of the region on health – less by 18% of the average spending. It lies below Kenya, Zambia, Rwanda and Uganda. Clearly, more effort is needed to raise health spending and thus health outcomes therein.

However, the nominal and real per capita allocations in the health sector have been growing at an average rate of 18.3% and 10.4%, respectively. *Implications:*

- Growth in the national spending has not been in favour of the Health Sector
- Budgetary Allocations to the Health Sector have generally been below the Abuja declaration by 4%

Therefore:

- Increasing budgetary allocation to the Health Sector to reach the target of 15% set by the Abuja Declaration would be adequate for full implementation of the Road Map for Accelerate Mother and Child Mortality Rates in Tanzania.
- Urge local and external resources to increase expenditure on health to match at least the neighbouring countries (by International dollar spending)

3.2 Trends in actual expenditure on the Health Sector

Actual expenditure on the health sector has been growing by 20.7% in 2006/07 to 31.4% in 2011 – growth rate (Table 4). This is higher than the rate of growth in the budgetary allocations in the sector; and thus indicates a collapsing gap between budgetary allocations and actual expenditure in the sector. Actual expenditure as a proportion of budgetary allocation has improved from the lowest of 91.8% in 2008/09 to 98.2% in 2009/10.

Per capita public expenditure on health has increased in both nominal and real terms. In nominal terms, per capita public expenditure on health increased by 141.2% between 2005/06 and 2010/2011. In real terms, the per capita spending increased by 70% in a period of five years (Figure 2). This is a remarkable achievement though it is incredibly dependent on external financing and comparably low in per capita international dollar spending relative to the neighbouring countries as indicated earlier.

Observations:

- Real growth in per capita expenditure in the sector is lower than the real growth in per capita national budget

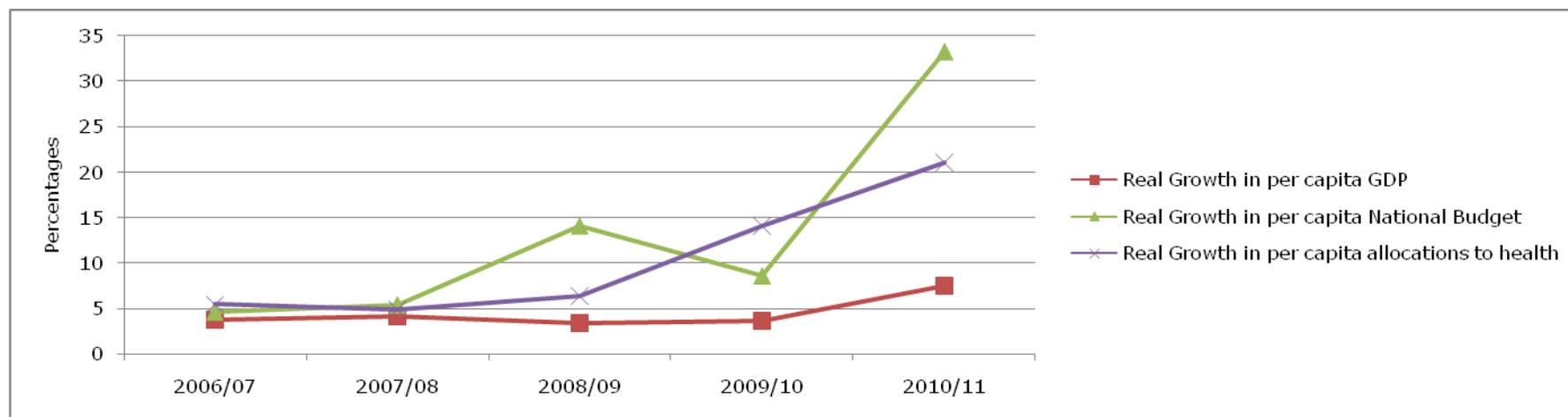
Implication: Tanzania needs more capita health spending at least to match growth in the national budget and the neighbouring countries

Table 4: Selected Health Expenditure Indicators

Particulars	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	Average
1 Actual health budget expenditure (Billions TZS)	426	514	571	701	908	1193	
% growth		20.66	11.09	22.77	29.53	31.39	23.09
2 Actual health Budget Expenditure as % of National Budget	11	11.5	10.7	10.3	11.1	10.3	10.82
3 Actual Expenditure in the Health sector as % of the budgetary allocations	95.5	98.8	92.7	91.8	98.2		
4 Nominal Per capita health expenditure (TZS)	11,298.00	13,224.00	14,251.00	17,118.00	21,327.00	27,254.00	
5 Real per capita health expenditure (TZS)	8,320.30	9,086.70	8,937.50	9,878.30	11,486.10	14,167.00	
6 Growth in real per capita health expenditure		9.2	-1.6	10.5	16.3	23.3	11.54
7 Growth in nominal per capita health expenditure		17	7.8	20.1	24.6	27.8	19.46

Source: Various official documents

Figure 2: Comparing Growth and Allocations to the Health Sector



3.3 Sources of Financing for the Health Sector

The composition of the Health Sector financing by the various sources of funds is analyzed in Tables 5&6. The results show that the main source of fund for the health sector is the government who's budgetary and actual expenditure shares have averaged 62.38% and 66.1%, for the past five years, respectively. This reflects an improved trend in the financing gap between budgetary allocations and actual release of funds. In fact over the past two years expenditure on the health sector has surpassed budgetary allocations for the same.

Foreign expenditure in terms of actual release of funds has averaged 33% of the total expenditure of the sector since 2005/06. This is less than budgetary commitments for the same which have averaged 37.62% (Table 6). Clearly, release of funds from foreign sources has generally been less than budget commitments. For example, in 2009/2010, the actual fund release was 87.4 of the budget, creating a financing gap of TZS 47.6 billion. The amount would have constituted 33% of the respective annual expenditure required for the on-going implementation of the Road Map for Accelerated Reduction of Maternal and Child deaths.

Further in Figures 3&4 we observe that the share of foreign sources of funds in the budget estimates for the health sector has increased from 28.6% in 2006/07 to 46.1% in 2010/2011. In terms of actual expenditure, the share increased from 30.1% in 2005/06 to 35.8% in 2009/2010.

Implications:

- Actual flow of funds for the Health Sector has on average surpassed budgetary allocations
- Both local and foreign sources of funds have been growing overtime, but the latter has grown faster than the former.
- Actual funds from foreign sources have on average been less than the corresponding budget estimates
- Off budget sources of funds have been marginally small

Therefore:

- Urge Development Partners to honour their budget Commitments to the Health Sector
- Urge local sources to increase their expenditure on Health

Table 5: Sources of Funds for the Health Sector (Million TZS)

DESCRIPTION	2005/06	2006/07		2007/08		2008/09		2009/10		2010/11
	Actual Exp	Approved estimates	Actual Exp	Estimates						
Government Funds	296,819	370,991	348,890	413,258	378,113	459,496	461,504	548,658	578,682	643,011
Foreign	129,555	148,880	164,715	202,490	192,959	304,098	239,569	376,441	328,845	549,712
O/W										
Basket	68,299	99,911	103,204	80,956	80,956	99,730	85,401	121,640	128,796	161,804
Non Basket	61,257	48,969	61,512	121,534	112,003	204,368	154,168	254,801	200,049	387,908
Off-Budget	3,363	-	2,964	-	5,696	-	5,858	-	10,784	-
Total	429,738	519,871	516,570	615,748	576,769	763,594	706,931	925,099	918,311	#####

Table 6: Source of Funds for the Public Health Sector (%)

DESCRIPTION	2005/06	2006/07		2007/08		2008/09		2009/10		2010/11
	Actual Exp	Approved estimates	Actual Exp	Estimates						
Government Funds	69.1	71.4	67.5	67.1	65.6	60.2	65.3	59.3	63.0	53.9
Foreign	30.1	28.6	31.9	32.9	33.5	39.8	33.9	40.7	35.8	46.1
O/W										
Basket	15.9	19.2	20.0	13.1	14.0	13.1	12.1	13.1	14.0	13.6
Non Basket	14.3	9.4	11.9	19.7	19.4	26.8	21.8	27.5	21.8	32.5
Off-Budget	0.8		0.6		1.0		0.8		1.2	
Total	100	100	100	100	100	100	100	100	100	100

Source: MoHSW: Public Expenditure Report 2010/2011

Figure 3: Percentage composition of sources of funds for the Health Sector (Budget estimates)

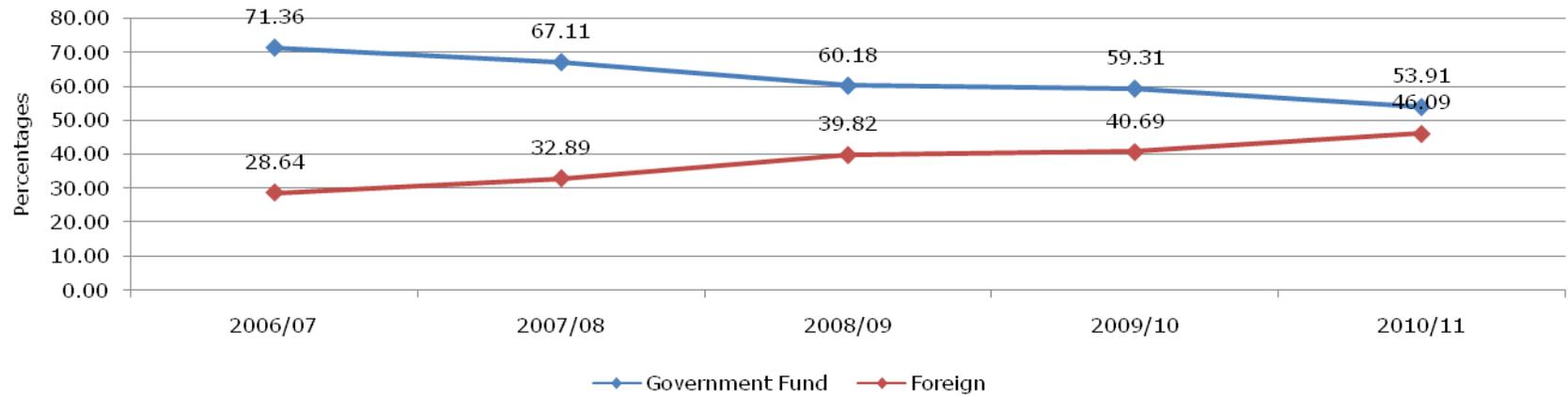
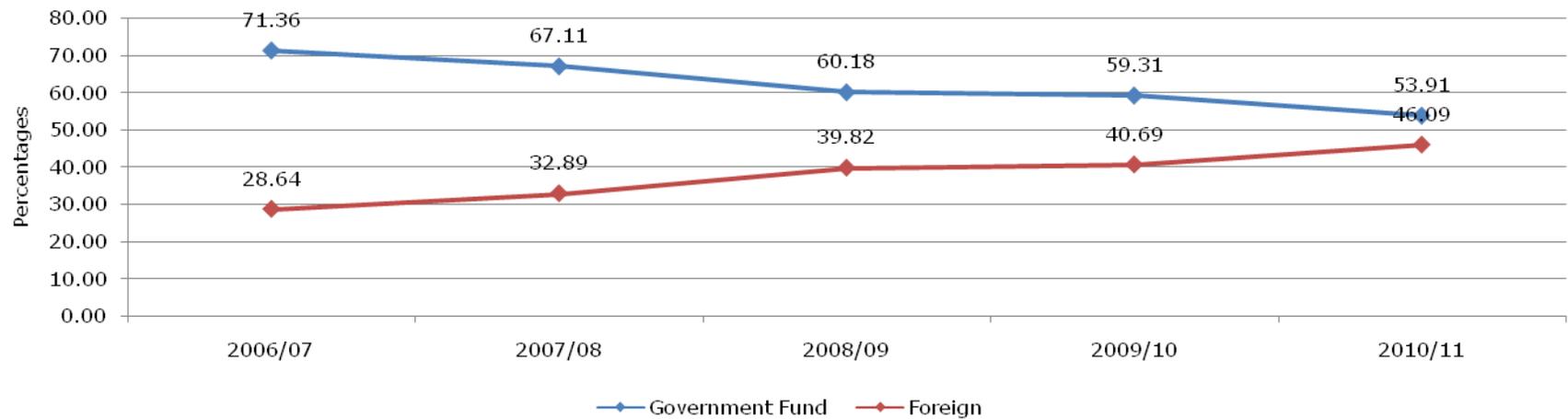


Figure 4: Percentage composition of sources of funds for the Health Sector (Actual Expenditure)



3.4 Health Sector Budgetary Allocations Relative to other Sectors

Table 7&8 is a summary of the government expenditure by the major sectors for the last ten years. It is observed that health has never been at the top up as a priority in budgetary allocations for the last ten years. Since 2005/06, the Health Sector has ranked third in priority in the allocations. In general there have been three priority sectors in the government budgetary allocations with the Health Sector taking the third position with an average allocation of 9.5% of the total budget. Allocations to the Education sector which has persistently ranked first have been 18.1% on average; and the Infrastructure sector comes second with an average allocation of 11.7%.

Observations:

- Health has never topped up as a priority in budgetary allocations for the last ten years
- Health comes third in terms of priority sectors in budgetary allocations after Education and Infrastructure

Implication:

The Health Sector gets disproportionately less budgetary allocations compared to the budget growth capita health spending at least to match growth in the national budget and the neighbouring countries

Table 7: Government Expenditure on Major Sectors

Billions of TZS	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Education										1,743.9	2,045.4
Health	254.9	344.9	436.2	428.4	707.5	669.5	891.2	1,086.0	1,430.0	800.4	1,181.7
Water	100.7	142.1	186.7	216.2	315.6	365.8	427.4	589.9	803.8	347.3	397.9
Agriculture	18.3	32.5	51.9	61.0	143.6	159.9	189.9	309.1	231.6	669.9	903.8
Lands	19.1	31.9	60.2	117.3	123.1	168.7	195.5	379.0	513.0	33.5	53.8
Infrastructures	5.1	8.1	20.1	6.5	6.4	13.8	18.3	26.3	27.3	1,096.6	1,505.1
Judiciary	92.5	179.6	190.2	231.0	309.3	375.6	497.8	777.2	974.3	103.4	139.4
HIV/AIDS	9.2	18.8	23.1	32.7	27.7	51.3	72.6	69.9	83.2	162.6	24.2
Total	1,272.8	1,462.8	1,989.5	2,516.9	3,527.6	4,035.1	4,850.6	6,066.8	7,271.1	9,532.7	11,609.6

Table 8: Percentage Composition

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	Average (2005/06-2010/11)
Education	20.0	23.6	21.9	17.0	20.1	16.6	18.4	17.9	19.7	18.3	17.6	18.1
Health	7.9	9.7	9.4	8.6	8.9	9.1	8.8	9.7	11.1	8.4	10.2	9.5
Water	1.4	2.2	2.6	2.4	4.1	4.0	3.9	5.1	3.2	3.6	3.4	3.9
Agriculture	1.5	2.2	3.0	4.7	3.5	4.2	4.0	6.2	7.1	7.0	7.8	6.1
Lands	0.4	0.6	1.0	0.3	0.2	0.3	0.4	0.4	0.4	0.4	0.5	0.4
Infrastructures	7.3	12.3	9.6	9.2	8.8	9.3	10.3	12.8	13.4	11.5	13.0	11.7
Judiciary	0.7	1.3	1.2	1.3	0.8	1.3	1.5	1.2	1.1	1.1	1.2	1.2
HIV/AIDS		0.3	0.3	0.8	1.7	3.0	2.4	1.8	1.5	1.7	0.2	1.8
Others	60.7	47.9	51.1	55.8	52.0	52.3	50.3	44.9	42.6	48.0	46.2	47.4
Expenditures	100											

Source: Ministry of Finance and Economic Affairs

4. Trends of the MNCH Sub-sector Financing and Emerging Issues

4.1 MNCH Spending at the National Level

The subsector MNCH has two major components; maternal and newborns – MN, and child health - CH. At the MoHSW, MN falls under the Department of Reproductive and Child Health (RCH), and CH falls under the general expenditure on health services other than MN. Accordingly, the analysis in this report distinguishes between the two. Expenditures on MN were directly obtainable from the spending units which include the RCH Department at the MoHSW, District and Urban Councils, and Development Partners. This information is categorically available from the spending units at the various sources. At the MoHSW, there is a distinction between expenditure on reproductive health and maternal and newborns. Immunization and PMTCT are components of MN. But financial information on CH has been computed from the general data as we explain next.

The information management system (IMS) at the MoHSW shows data on patients attending public facilities by age and type of disease/medical problem diagnosed. Expenditure at any health facility includes wages and salaries, implying that though we have data on expenditure for some interventions, they do not include costs on the medical personnel and other centrally incurred costs. Therefore, in order to work out the proportion of the total expenditure going to under-five in the general health services departments, we first computed the average proportion of under-five (who seek medical services in public health facilities) from the total number of patients in the outpatients department (OPD) in public health facilities in Tanzania. We then multiplied it by the total budget going to the general health services departments - to get the spending on under-fives. This is to say that about 44% of ODP patients in public health facilities in Tanzania are under-fives; assuming that proportionally public health facilities spend 44% of their funds (net of those going to maternal and newborns) on under-fives. And further to that, we assume that about 44% (average) of the central spending on the Health Sector (MoHSW) also goes to under-fives. It is thus conclusive to estimate that 44% of the public expenditure in the Health Sector (excluding expenditure on MN) is for under-fives. This is an estimate rather than actual expenditure because the health system has many overlapping services including those which are purely administrative and centrally administered services.

Table 9 shows expenditure on the sub sector MNCH and its major components – MN and CH for the period 2005/06 – 2010/2011. Further in Table 10, it is the proportionate shares of the MNCH and its components in the total Health Sector expenditure. On average, the subsector MNCH received 47.6% of the total spending in the Health Sector. Expenditure on MN averaged 4.6% of the total spending in the health sector with the peak in 2007/08. The component CH received about 43.8% (estimates) of the expenditure on the health sector during the period.

It is observed further from Table 10 and Figure 5 that the share of the MNCH in the Health Sector expenditure has marginally decreased from 46.4% in 2005/06 to 45.6 in

2010/2011. More alarming is the declining share of the MN from 4.3% in 2005/06 to 2.8% in 2010/2011. The growth rate of MN has also decreased significantly (Figure 5). This is particularly a concern because despite the fact that maternal mortality rate has remained persistently high in Tanzania; there are not clear deliberate efforts to increase the share of the MN in the health spending. However, the share of the CH in the total spending on health has remained fairly constant during the period. It should be noted that basket funding and budget support approaches do not permit breakdown of spending on MNCH by the sources of the funds (Development Partners).

Table 9: Actual Expenditure on Maternal New Born (MN) and Child Health (CH) (Millions of TZS)

MN Sub-sector	18,405.12	18,298.8	22,171.9	37,191.9	30,287.0	33,460.3
CH-Sub sector	179,506.31	220,691.32	261,173.48	319,616.50	393,717.26	510,075.60
MNCH Sub-sector	197,911.4	238,990.1	283,345.4	356,808.4	424,004.3	543,535.9
Health Sector	426,374.00	513,606.00	571,073.00	701,073.00	907,527.00	1,192,723.00

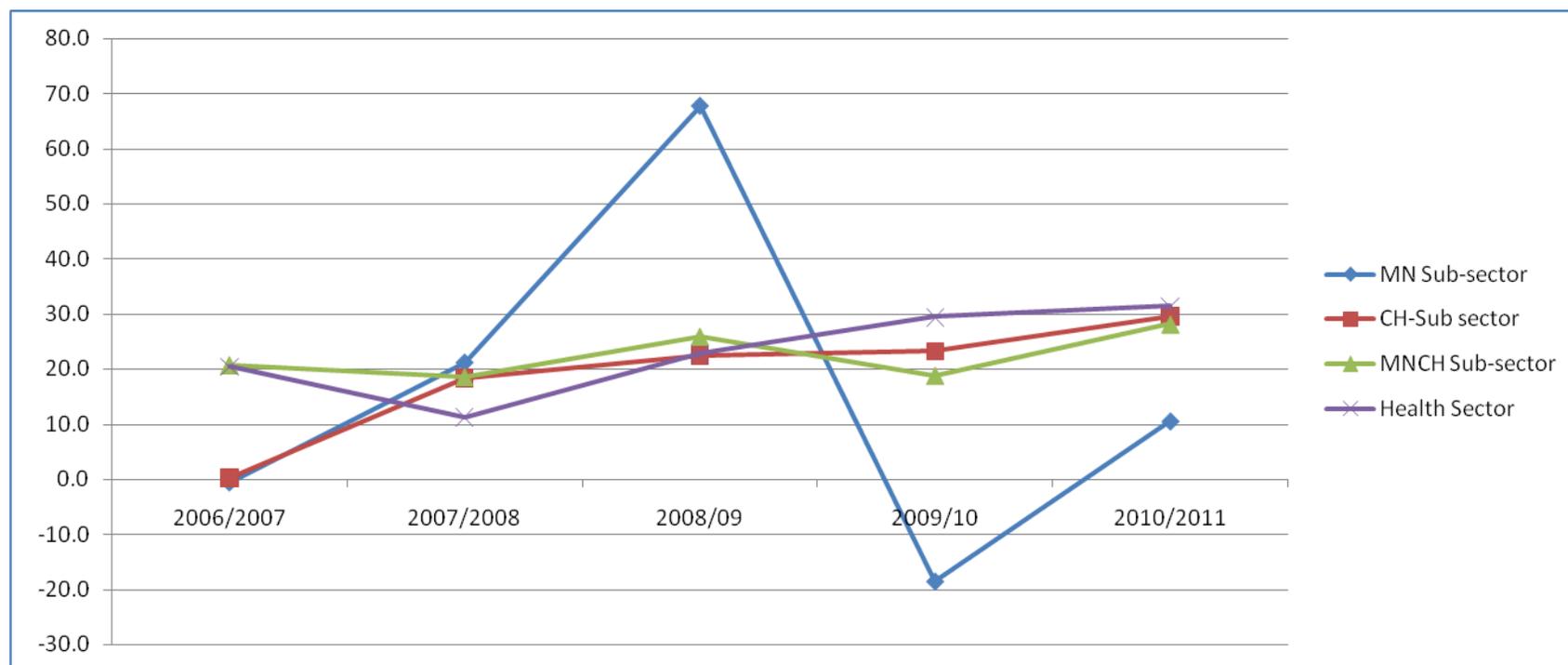
Source: URT, Ministry of Health and Social Welfare

Table 10: Relative Shares of the Sub Sector MNCH in the Actual Public Expenditure

MN Sub-sector	4.3	3.6	8.5	5.3	3.3	2.8	4.6
CH-Sub sector	42.1	43.0	45.7	45.6	43.4	42.8	43.8
MNCH Sub-sector	46.4	46.5	49.6	50.9	46.7	45.6	47.6

Source: URT, Ministry of Health and Social Welfare

Figure 3: Growth Rates of Expenditure on Mother and Child Health



Source: URT, Ministry of Health and Social Welfare

Table 11 shows expenditure by the major interventions at the MoHSW in 2009/2010. The sub sector MNCH received the lion share of the spending in the Health Sector. However, the share of the sub sector MN is relatively very small – about 3.3%.

Table 11: Comparing the Share of MNCH with other sub Sectors in 2009/10

Malaria	3.8
TB/Leprosy	3.8
HIV & AIDS	11.2
CH	42.9
MN	3.3
Others including administration	35.0
Total Health Budget (Actual)	100

Source: Public Expenditure Reports, MoHSW

Summary:

- The share of the MNCH in the total health expenditure is 47% on average
- The share of the CH has remained fairly constant over the last five years
- The MN share, however, is only 4.6% and declining
- MN share is also the smallest in the total funds used to finance interventions in the HEALTH SECTOR IN 2009/2010.

Thus, MN has not received the due priority in the public health expenditures

4.2 Off-budget Donor Financing of MNCH

Off-budget donor financing includes expenditure made on MNCH outside the national budget framework. This information which is not reflected in the national budget has been very difficult to get from the sources. Based on the available information, the analysis of off-budget donor financing of MNCH in Table 12 shows an increase from 0.2% of the total expenditure on MNCH in 2006/07 to 2.4% in 2010/11. Most of donor financing of the sub sector is through basket funding, which is not earmarked for specific expenditure.

Table 12: Budgetary and Off-budget Financing of MNCH in Tanzania

Source of funds	2006/07	2007/08	2008/09	2009/10	2010/11
Budgetary source	99.8	99.9	98.2	96.1	97.6
Off budget	0.2	0.1	1.8	3.9	2.4
Total MNCH	100.0	100.0	100.0	100.0	100.0

Source: Public Expenditure Reports, MoHSW

4.3 Spending at the LGAs Level

Councils prepare one comprehensive document for planning and budget at that level. The document is commonly known as Comprehensive Council Health Plan (CCPH). This is the document which shows actual expenditure by health interventions for the outgoing year and planned expenditure and activities for the coming year. We accessed these documents from the MoHSW and extracted information on planned and actual expenditure for 110 councils (out of 132 in total).

Actual versus Planned Expenditure

The CCHP documents show two major categories of expenditure on MNCH: Quality Maternal Health Care and Quality Child Health Care. In Figures 6a-c, we analyze council expenditure and compare between planned and actual expenditure by the two major categories for three years – 2007/08 – 2009/10. It is shown that generally in all the three years, councils spend less than the planned expenditure. At most they spent 77.6% of the planned expenditure – which was in 2008/09. The category of Quality Child Health Care suffered most in all the three years.

Further in Table 13 is analysis of councils' expenditure on MNC by the cost centres which include DMO (District Medical Officer), District Hospital, Health Centres, Dispensary, and Community. The table indicates shares of each cost centre in planned expenditure and actual expenditure, respectively. We observe significant variations between planned and actual expenditures – which suggest that reallocation of funds at the council level is common; the final spending deviates from the planned spending.

Figure 4: Actual Versus Planned Expenditure 2007/08

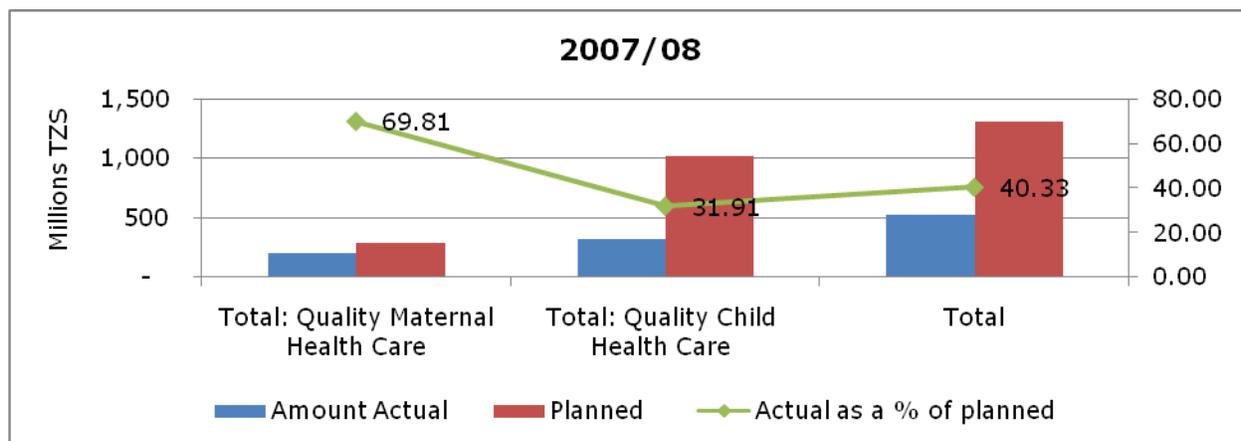


Figure 5: Actual Versus Planned Expenditure 2008/09

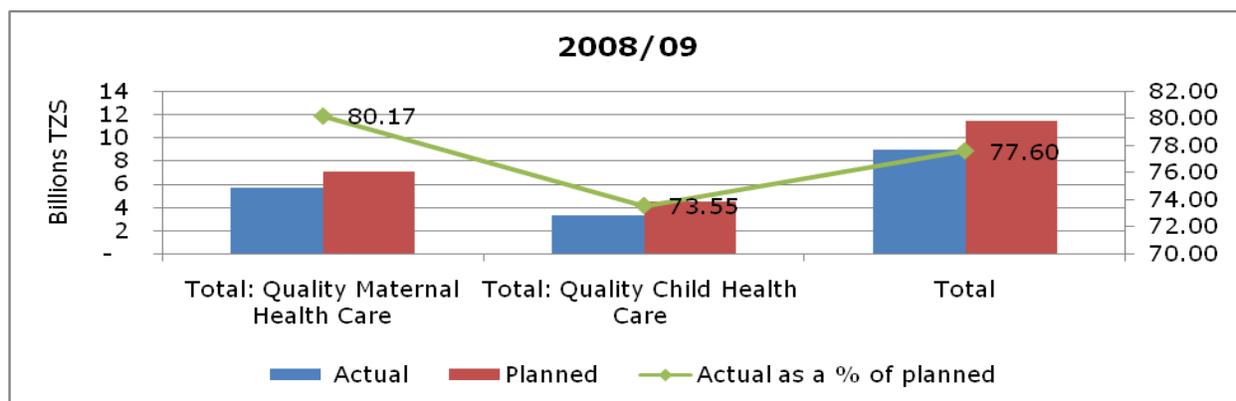
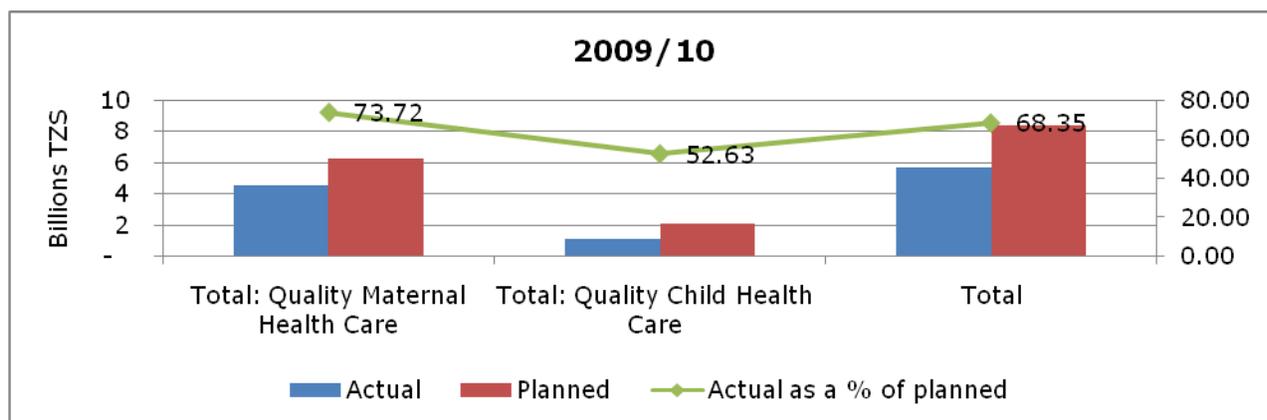


Figure 6: Actual Versus Planned Expenditure 2009/10



Source: Comprehensive Council Health Plans (CCHP) Annual Reports

Table 13: Relatives Shares of the Spending Units at the LGAs Level (Cost Centres)

		2007/08		2008/09		2009/10	
		% Share in:		% Share in:		% Share in:	
		Planned Expenditure	Actual Expenditure	Planned Expenditure	Actual Expenditure	Planned Expenditure	Actual Expenditure
1	Sub Total DMO	15.71	18.70	18.27	17.07	16.26	17.01
2	Sub Total Hospital	17.48	27.09	22.53	20.07	24.42	25.74
3	Sub Total Health Centre	21.36	23.51	21.39	24.60	19.83	17.08
4	Sub Total Dispensary	39.66	26.61	25.75	27.55	26.56	32.26
5	Sub Total Community	5.79	4.09	12.05	10.72	12.93	7.90
	TOTAL	100	100	100	100	100	100

Source: Comprehensive Council Health Plans (CCHP) Annual Reports

Further analysis of MNCH expenditure at council level in Table 14 shows planned versus actual spending by activities of each major category of expenditure. Again, significant deviations between planned and actual expenditure exist. For example, on average, planned expenditure on community mobilization was 8.97% of the total spending on MNCH at the council level, but actual expenditure was 25.29% - about three times of the planned expenditure. Actually, release of funds to councils may be less than budgeted for; but also, councils have many competing needs for which they are sometimes compelled to reallocate funds –even if they are specifically earmarked by activities.

Table 14: Details of Expenditure by Relative Shares at the LGAs Level

Sub Category of Expenditure	2007/08		2008/09		2009/10		Average planned	Average Actual
	% Share in:		% Share in:		% Share in:			
	Planned Expenditure	Actual Expenditure	Planned Expenditure	Actual Expenditure	Planned Expenditure	Actual Expenditure		
Quality Maternal Health Care:								
Development of Maternal Ward	3.61	8.95	2.92	1.98	6.59	4.39	4.37	2.12
Training of Health Workers	3.44	6.16	5.18	5.36	7.37	6.69	5.33	10.60
Immunization and Vitamin "A" Supplements	0.58	0.44	3.54	4.17	1.80	2.13	1.97	4.87
Surveillance and Monitoring	0.42	1.04	0.27	0.34	0.66	1.82	0.45	3.10
Procurement of Medical Equipments/Drugs(Medical Supplies)	6.03	6.59	29.06	32.25	33.47	42.03	22.86	41.94
Administration; Planned 2007/08	0.22	0.40	6.91	6.89	8.85	9.79	5.32	10.04
Outreach/Mobile Clinic	4.85	8.53	3.95	4.21	4.77	4.89	4.53	10.32
Community Mobilization: Planned 2007/08	0.09	0.29	0.91	1.12	0.98	0.63	0.66	2.52
Antenatal and Postnatal Care	0.85	2.00	0.61	0.79	0.82	0.47	0.76	3.13
PMTCT Activities	0.00	0.00	1.84	2.22	0.66	0.60	0.83	2.91
Other Activities	2.12	4.06	5.98	3.87	8.60	6.97	5.56	8.95
Quality Child Health Care:								
Development activities	0.21	0.21	0.10	0.10	0.02	0.26	0.11	1.79
Training of Health Workers	1.31	2.98	3.04	2.96	1.72	2.13	2.03	5.53
Immunization and Vitamin "A" Supplement	45.96	6.36	17.95	17.40	7.84	10.02	23.92	18.39
Monitoring and Surveillance	0.14	0.35	0.20	0.19	0.08	0.12	0.14	1.83
Procurement of Medical Equipments/ Drugs	2.72	3.74	6.70	6.99	11.53	1.13	6.98	7.43
Administration	0.00	0.00	0.45	0.48	0.70	0.63	0.38	2.06
Outreach and Mobile Clinic	0.83	1.65	2.46	2.30	1.02	1.44	1.44	4.19
Community Mobilization	25.68	45.98	0.94	1.12	0.30	0.49	8.97	25.29
Antenatal and post natal Care	0.00	0.00	0.34	0.35	0.16	0.40	0.17	1.88
PMTCT Activities	0.69	0.00	0.07	0.07	0.07	0.12	0.28	1.59
Other Activities	0.23	0.28	6.58	4.81	2.00	2.86	2.94	5.48
TOTAL	100	100	100	100	100	100		

Source: Comprehensive Council Health Plans (CCHP) Annual Reports

What do the trends in MNCH spending at the council level tell us?

- Actual expenditure deviates significantly from planned expenditure across most of the activities under MNCH subsector.



Implications:

There are reallocations that lead to reprioritization of activities in the MNCH sub sector – potentially compromising the objectives and targets set at national level

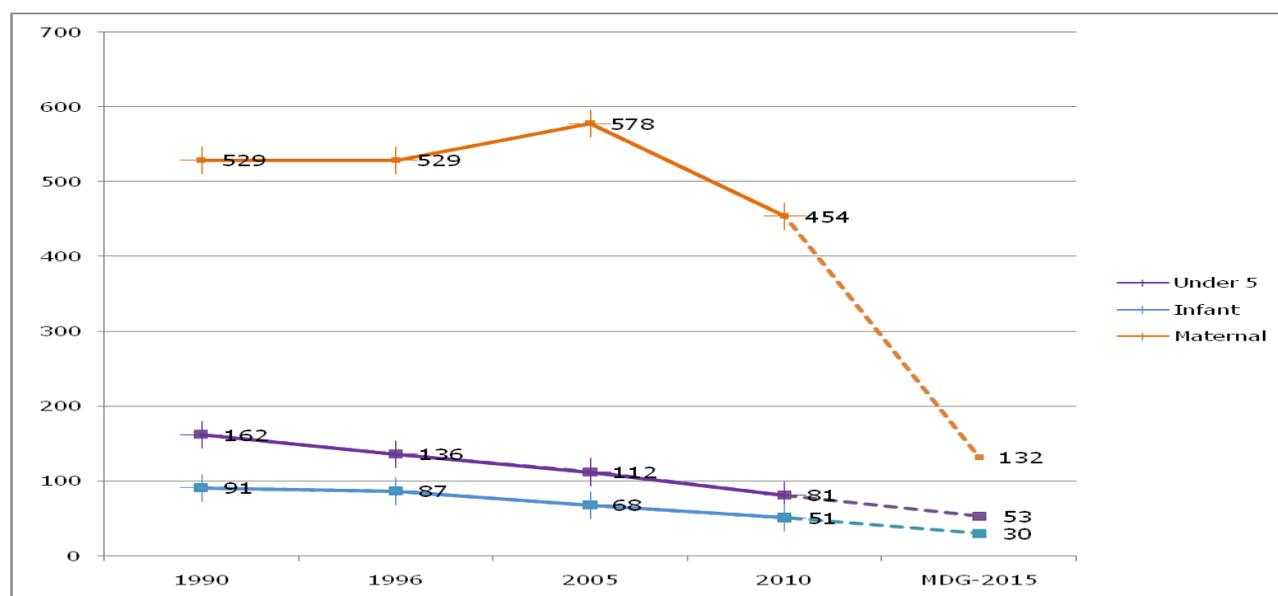
Thus, Improve management of the MNCH funds at the council level including strict auditing and monitoring.

6. Summary of Entry Points and Recommendations for Advocacy for Increased Public Expenditure on MNCH

6.1 More effort is needed to achieve the MDG 4&5

The trends in Newborns and Child Health in Tanzania point to the possibility of attaining the MDG 4, as indicated earlier, provided that the current efforts on MNCH are scaled up and sustained, including allocation of more resources and efficient use of the same in the sub sector of MNCH. However, the observed trend in Figure 8 predicts that attainment of MDG 5 remains rather a challenge; it is clearly plausible that unless the current efforts are massively scaled up, Tanzania will not be able to meet the MDG 5 even by fifty percent.

Figure 7: Trends in MNC Death Rates in Tanzania



Recommendation: Work jointly with other stakeholders in the sub sector MNCH to call for and support full implementation of the Government Road Map for Accelerated Reduction of Maternal and child Deaths. Focus the efforts in the areas of quick wins which have been identified by the Road Map as constraints. To mention the most critical ones, these are increased access to quality health services, increased medical equipments and supplies, and enhanced community involvement in MNCH services. Introducing mobile facilities with mobile personnel in the short run would give quick results as we strive to put in place long term solutions. Think of intensifying the efforts in those districts which have the highest mortality rates.

The Road Map says that there has been inadequate community involvement and participation in planning, implementing, monitoring and evaluation of MNCH services. This is rather a serious weakness which other stakeholders –i.e. Plan International have observed and initiate interventions. Save the Children Tanzania can working jointly with the on-going efforts to mobilize communities or work to support such efforts.

6.2 Arguments for Sharpening the Planning and Monitoring and Evaluation of Interventions

The national strategies on MNCH have ambitious interventions that may be difficult to implement concurrently. Thus, sequencing of interventions is necessary for setting priorities in expenditure on MNCH and effective monitoring and evaluation.

Recommendation: Align the current strategies and interventions for MNCH with resource capacities cum availability. We need to know how much resources are there for MN in each budget circle and set what can be achieved for those particular inputs by every district. Thus, councils should indicate clear targets with clear indicators in their CCPH both annually and in the medium term expenditure framework. This should be followed with an effective monitoring and evaluation system. In fact Save the Children can support efforts at council level to put in place an effective monitoring and evaluation at that level. This would then be linked up with a capable and effective same system at the national level. Lack of this will limit the achievements enlisted in the national strategies.

6.3 At the Macro Level

Improve tax revenue collection to reach at least the regional average (18%) to increase further the national budget; and at the same time potential for mobilizing more non tax revenue can be negotiated. This could lead to more resource allocation to the health sector.

- The Health Sector gets disproportionately less budgetary allocations compared to the national budget growth. Increase allocations to the health sector at least to match growth in the national budget and per capita health spending in the neighbouring countries
- Increasing budgetary allocation to the Health Sector to reach the target of 15% set by the Abuja Declaration would be adequate for full implementation of the Road Map for Accelerate Mother and Child Mortality Rates in Tanzania (as indicated earlier in 3.1). This is urgent given that maternal mortality rate is high in Tanzania and unlikely to achieve the MDG target by 2015. It is further observed that allocations in the subsector MNCH do not match the desired outcomes in the national plans.
- Urge local and external resources to increase expenditure on health as a proportion of the total government budget to match at least the per capita international US dollar spending in the neighbouring countries; and further, we should prioritize maternal and newborns in the spending.

Recommendation: Urge all stakeholders of the subsector MN to increase their spending on the subsector to reach 15% of the national budget and at least 70 international dollar spending (as per WHO) – the average of the region.

6.4 At the Sectoral Level

- Acknowledge the big effort exerted by Development Partners in the Health Sector and urge them further to honour their budget commitment to the sector
- Urge local sources of finance, the public sector in particular, to increase their expenditure on MN, and seek to reduce dependency on external sources in the long term.

Recommendation: Urge stakeholders to honour their financial commitment in the health sector and the sub sector MNCH. Encourage efforts to develop sustainable health financing mechanisms at all levels.

6.5 At the MNCH Level

- The share of the CH has remained fairly constant over the last five years
- The MN share, however, is only 4.6% and declining
- MN share is also the smallest in the total funds used to finance interventions in the health sector in the year 2009/2010.
- MN has not received the due priority in the public health expenditures

Recommendation: Strategize to ensure that the share of MNCH in the total budget increases. This can be achieved by initiating jointly financed interventions at national and community level. Civil society organizations can be urged to play their role by lobbying for increased public spending on the sub sector MNCH. In addition, more off budget spending can be mobilized through joint programmes or interventions.

6.6 At the Council Level

- Actual expenditure deviates significantly from planned expenditure across most of the activities under MNCH sub sector
- There are reallocations that lead to reprioritization of activities in the MNCH sub sector – potentially compromising the objectives and targets set at national level
- Improve management of the MNCH funds at the council level including strict auditing and monitoring.

Recommendation: Urge and support efforts to increase transparency and accountability at the council level. The role of civil society organizations should be activated. Also, urge the government and other stakeholders to put an effective monitoring and

evaluation for health expenditures and outcomes at the council level and link it with the national level. The role of communities should be clearly identified and publicized.

Some Key Documents Consulted

MoHSW, Annual Health Statistical Abstract Tanzania Mainland, 2008

MoHSW, Health Sector Performance Profile Report, various years

MoHSW, Health Sector Strategic Plan III July 2009-June 2015

MoHSW, National Road Map Strategic Plan to Accelerate Reduction of Maternal Newborn and Child Deaths in Tanzania 2008-2015

URT, Comprehensive Council Health Reports, various years

URT, Economic Survey, various years

URT, National Strategy for Growth and Reduction of Poverty I, 2005

URT, National Strategy for Growth and Reduction of Poverty II, July 2010

URT, Poverty and Human Development Report, 2009

URT, Tanzania Demographic and Health Survey (TDHS), 2010

Government Budget and Expenditure Votes Documents: Various

Annex I: Off-budget allocations to MNCH (Donor funded) Millions of TZS

Year	2006/07	2007/08	2008/09	2009/10	2010/11
MNCH off budget (foreign)	471.94	237.53	6,313.67	16,553.78	12,784.04

Annex II: Off-budget allocations to MNCH (Donor funded) by source (Millions of TZS)

	Name of Donor	AMOUNT IN TSH AND YEAR				
		2006/07	2007/08	2008/09	2009/10	2010/11
1	ADB	-	1,484,615,613.13	5,518,452,398.47	14,697,870,753.15	11,204,875,790.36
2	UNICEF					
3	WHO					
4	UNDP					
5	UNFPA					
6	WB					
7	JICA					
8	DFID	-	-	-	-	-
9	CIDA	471,936,663.35	533,053,436.50	543,107,981.65	523,905,095.00	558,340,733.60
10	SIDA	-	-	-	-	-
11	DANIDA	-	-	-	-	-
12	EU	-	-	-	1,332,000,000.00	1,020,825,000.00
13	IRISH AID	-	-	-	-	-
14	NORAD	-	-	-	-	-
15	WORLD VISION					
16	GTZ					
17	USAID					
18	CARE					
19	JHPIEGO					
20	EGPAF					
21	FHI	-	357,600,000.00	252,105,000.00	-	-
22	AED					
	GRAND TOTAL (TSHS)	471,936,663.35	2,375,269,049.63	6,313,665,380.12	16,553,775,848.15	12,784,041,523.96

Annex III: LIST OF PEOPLE CONTACTED AND THEIR ADDRESS

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20	Mary Quorro	District Executive Director, Shinyanga	DED office, Shinyanga

		DC	
21		Municipal Medical Officer, Morogoro MC	Morogoro Municipal Council
22	M.W.F. Maganga	Prime Ministers' Office-Regional Administration and Local Government	PMO-RALG Hq, Dodoma