The Second Module TSED Seminar
Theme: Health

Livingstone Club, Bagamoyo, 5-7 April, 2004

Background and Rationale

The Tanzania Socio-Economic Database (TSED) was jointly initiated by the National Bureau of Statistics (NBS), the United Nations Children's Fund (UNICEF) and the United Nations Development Programme (UNDP) as a tool to assist the Government and its development partners in the use of information technology to accelerate sustainable human development, focusing on key indicators to monitor socio-economic development, including poverty. The ability of both government and non-government bodies at all levels to design and implement policy measures and strategies aimed at achieving economic growth and poverty reduction depends heavily on their capacity to analyze and interpret the data that is available. For those involved in policy analysis it is imperative to strengthen their capacity to manipulate such data in the most efficient and effective way.

REPOA, in collaboration with UNDP, the Vice President's Office and the NBS, has organised a two-year training programme to support the use of the TSED. The mission of this training programme is to enhance the capacity to make the best use of available data for policy analysis. The specific objective is to promote awareness of the availability of the TSED database, to encourage its use, and to enable policy makers, planners, and researchers to retrieve and analyse various data contained in the TSED in making informed policy choices.

The theme of the 2 ½ day seminar being reported here is Health as it relates to poverty alleviation; specifically through an analysis of trends in the key indicators for the health sector. Accordingly, the training covered technical (i.e. computer) knowledge, the process of data retrieval (TSED knowledge), analysis of key indicators and methods to draw policy implications. The first seminar in the series focused on Education.

Participants were strategically selected. They comprised policy analysts, planners, statisticians and researchers from the Central Government and other relevant research and civil society organizations that are actively involved in research. There was a good mix of experiences from specialists in community health, health education, nutrition, reproductive health, behaviour change communication, community development, rural development, management information systems, population studies, research and surveillance studies, medicine and public health. The Facilitator of the seminar was a seasoned Health Economist working with the World Health Organization (WHO). See Annex A for a detailed list of participants.

The seminar was designed as follows: The first day was set aside for a general introduction to the Poverty Reduction Strategy (PRS), its monitoring framework, and how it links to the Public Expenditure Review (PER). This was followed by a brief training session on the use of TSED. On the second day, participants had an opportunity to get hands-on experience on data retrieval and carry out some basic analysis using TSED software. Using a set of pre-designed questions they were required to use the data

available in the database to respond to these questions. The third day was used to fuse everything together. The group work assignments which formed the basis for drawing conclusions and recommending amendments towards the improvement of the TSED were presented and discussed in plenary. The discussions focused on on-going processes making useful contributions to these processes.

The seminar was officially opened by Mr. Pim van den Male from UNDP on behalf of REPOA's Executive Director, Prof. Joseph Semboja.

About TSED

A wealth of socio-economic data from different sources exists in Tanzania. Access, however to that data is not easy because information is scattered in different Ministries and other Organizations with no overview of which data exists or where to find it. Furthermore, although comprehensive data is collected e.g. in the area of education and health, only a small portion is published in annual publications with much data remaining in the ministry difficult to access by others.

To address this problem the National Bureau of Statistics (NBS), in collaboration with Government Ministries and other Government Institutions and supported by UNDP, UNICEF and DFID established the Tanzania Socio-Economic Database (TSED). The main purpose of TSED is to allow an overall, up-to-date view of the socio-economic situation in Tanzania and to facilitate use of data for analysis by policy makers and other users. The National Bureau of Statistics (NBS) is responsible for the general administration of the system including overseeing the day to day operations of TSED, data provision and management, quality control and release of data. The data is provided by participating Ministries and other Institutions (academic and research), while development partners together with NBS provide financial assistance for the project

In 2001, TSED was identified to serve as repository and dissemination tool of all quantitative data coming out of the Poverty Monitoring System, established in the context of the Poverty Reduction Strategy Paper (PRSP). Since the Poverty Monitoring System is under the Vice President's Office, the National Bureau of Statistics works closely with VPO to ensure that the training programme for TSED is implemented. Through the Poverty Monitoring System, REPOA has been identified to provide technical assistance and coordinate capacity building during the thematic seminars.

The TSED database has been developed on an incremental basis as improvements have been made on a continuous basis. A total of 330 indicators covering nine sectoral areas was identified for the database. This was as a result of a long consultative process with small working groups of relevant stakeholders established for each module. In order to provide an overview of the content of the database, a matrix was created which serves as a dictionary to the database. The matrix indicates not only the breakdown of indicators within each module, but for each indicator it also provides information on the relevant level of disaggregation (female/male, rural/urban, national/regional/district level, the source(s) of information, how often the data is updated, how far back in time data can be provide (to enable analysis of changes over time), and the definition of the indicators. After reaching a consensus of what the database should include, the first attempt at developing a database using oracle started in 1996. In due course the University of Dar es Salaam Computing Centre did an analysis of the programming work, and advised that the quality of the work was poor and that reprogramming would take a

longer time. It was therefore recommended to customise an existing software package designed for UNICEF (Child Info) to suit the needs for TSED. This tool was reprogrammed and by May 2000, a first prototype was reviewed and presented to selected stakeholders.

In 2001 the first version of TSED with 67 indicators was formally launched. The launch was preceded by the development of promotional materials to raise awareness among the stakeholders. This list has now been expanded and updated, and the database currently contain over 400 indicators from various sources, including the Population and Housing Census, Household Budget Surveys (HBS), Integrated Labour Force Surveys, Demographic and Health Surveys and other data collected through the routine data systems.

TSED has two tracks: The Administrative Module to ensure quality control and manage the whole process of data collection, data entry, etc. and the User Module component which consists of various components. It is a comprehensive and up-to-date socio-economic database system that aims to expand access, use and dissemination of data on a wide range of socio-economic indicators in a user-friendly manner with a view to promote use of data in policy making. In other words, it facilitates evidence-based policy formulation and implementation.

All government agencies involved in the process have appointed two focal persons who have been trained on the basic features of the TSED and how to retrieve data, draw maps and carry out different analyses. The most important part of the process is the thematic seminars, which are organised around themes, based on key sector priorities. The objective of these seminars is to raise awareness about the existence of the Database and train participants to start using data to influence policy change and facilitate informed decision making at higher levels of government.

TSED is not replacing other information systems rather complementing the efforts by putting basic statistics in one pool.

Highlights of Presentations and Discussions

The Poverty Reduction Strategy, its monitoring framework, and link to the Public Expenditure Review – *Presented by Servus Sagday, Vice President's Office*

This presentation was based on the assumption that participants were familiar with the PER process and the monitoring aspect of it. The presentation had three major parts: the background which included all that had taken place since 2000 to date, the PER, and the Poverty Monitoring System (PMS) as it is linked with the PRS and PER.

Background to the PRSP

Tanzania became eligible for the HIPC initiative at the end of 1999 due to its impressive macroeconomic performance. This signaled the preparation for the Poverty Reduction Strategy Paper (PRSP) that was finalized in October 2000. The PRSP is an instrument

that channels national efforts towards agreed poverty reduction objectives. It is part and parcel of the on-going macro economic and structural reforms process. It clearly distinguishes the role of the government and contains milestones on macro economic level that focus on 3 dimensions of poverty:

- *Income poverty reduction* (i.e. maintaining sound macroeconomic policies and intensifying the implementation of reforms to raise factor productivity;
- *Improving human capabilities, survival and well-being* (i.e. rehabilitation of existing structures in the social services); and
- *Containing extreme vulnerability*

The preparation of the PRSP was done concurrently with the preparation for the PMS in 2001. The process was consultative, participatory and multi-level. The first level was at the technical level where the discussion focused on the process itself including who to consult and how to do it. It involved consultations within Government, between Government and development partners and between government and local institutions. The second level was at zonal level where issues for poverty reduction and priorities were identified and the third level was the drafting process itself which entailed national consultations and approval.

As is normal in all development initiatives, strengths and weaknesses were inevitable. The process was rushed and there was limited consultation resulting into a number of shortcomings particularly with regard to target setting. Targets were over ambitious and did not look into the existing capacity of institutions to meet those targets. In the judiciary for example, the targets exceeded capacity by a long shot. The Government initiated a mechanism to get views of the people on vulnerability in order to recommend appropriate measures in the plans that were being drawn. However, it was not clear what measures to put in place to contain extreme vulnerability.

A number of other national processes were set in motion to complement the PRSP: The national development vision, national Performance Expenditure Survey (PES), the TAS and the PER.

The National Development Vision (Vision 2025)

This is a broad description of what Tanzania would look like in 2025. The vision's objectives are clustered around three major pillars: High quality livelihood, Good governance and the rule of law, and Strong and competitive economy.

The National Poverty Eradication Strategy (NPES)

This is a medium term strategy aimed at reducing poverty by 50%. Three areas for strategic intervention have been identified. These include: creation of an enabling environment (policy and legal framework) for poverty eradication; building capacity for poverty eradication (investment in pro-poor sectors) and the promotion of social and economic services.

The Tanzania Assistance Strategy

The PRSP anchored on this framework that aimed at promoting national ownership, improving the predictability of aid flows and integrating donor funds into the budge. The Strategy also built capacity for donor coordination, facilitated the harmonization and rationalization of development processes and reduced transaction costs on aid delivery and management.

The Public Expenditure Review

There are different levels of understanding of the process of this tool that is used to assess and analyze expenditure against set government PRS objectives. The PER ensures fiscal discipline and accountability-effectiveness in the control of public resources and adherence to rules and institutional roles. It is a government led process but is also open enough to allow other stakeholders to participate in managing the government budget through working committees and other implementation mechanisms. The PER facilitates the budget process by providing inputs to the budget guideline which sectors use to define priorities to be financed through the government budget (i.e. MTEF). It is a very useful process as it addresses the problems arising out of the budget execution. Issues such as delays in disbursement and other problems arising from the budgetary limitations are also addressed and feedback on budget execution provided. The PRS process informs the PER which in turn informs the MTEF and national budgets.

Implementation of the PRS

The PRSP is also an accountability document as it has to report on progress on an annual basis. The PRS uses existing macro and sectoral mechanisms for implementation. The World Bank (WB) and International Monetary Fund (IMF) votes are relevant in this case as agreed benchmarks are being monitored and performance of priority sectors assessed. So far, three progress reports (2001, 2002 and 2003) that explain the performance of the aforementioned areas in detail have been prepared.

PRS Review Process

The first PRSP is in its final year. A comprehensive review is done after every three years. The review process itself was launched during the Poverty Policy Week in October last year and is ongoing at various levels. PRSP II will be available after a year. The main objectives of the review are to:

- Draw lessons learnt in previous years into the current PRSP to make it more comprehensive and pro-poor
- Expand and enhance interventions to reduce poverty
- Design improvements to the whole approach by analyzing gaps

- Raise awareness among stakeholders at grassroots level to ensure national ownership of the process.

The process makes use of existing frameworks and mechanisms, is driven by national interests and is based on realistic and achievable content. The timeframe is set in the context of on-going long-term strategies, to ensure that development process is following a pre-determined route. It goes hand in hand with the harmonization of process and capacity building to address constraints in the PRS and PMS.

The review process timetable is as summarized in the calendar below:

Activity	**Schedule**											
	J	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
1. Stakeholder consultations	x	x	x									
2. Studies and reviews		x	x	x								
3. Drafting				x	x							
4. Consultation on first draft						x	x					
5. Preparation of second draft								x				
6. Consultation on second draft								x	x			
7. Preparation of final draft									x	x		
8. Presentation of draft PSRP II (Poverty Policy Week)										x		
9. Approval and Endorsement										x	x	
10. Publication and Dissemination												x

The review process aims to bring about increased grassroots participation in the PRS and greater ownership of PRS across government. The macro-micro linkages between growth and poverty reduction will be re-examined and priority sectors or priority outcomes for all sectors reviewed. Cross-cutting issues such as HIV/AIDS, environment, gender and others will be integrated and more attention will be paid to governance, security and peace as fundamentals for poverty reduction.

Monitoring of the PRS process

The monitoring system for the PRS became operational in 2001. It aimed at providing evidence on achievement of poverty reduction targets (using a set of indicators) and was a result of a long discussion to identify what is missing. Before the system was put in place, a lot of data was being collected by different institutions using different methodologies but it was scattered and not being utilized. A decision had to be made on how to make use of all this and perfect the system. This led to the development of an integrated system that puts together the different sources including routine data, surveillance data, etc. and the dissemination of information so that it is used for decision making at various levels.

The PRS monitoring system has a number of very rich and distinct characteristics including an elaborate institutional framework and a set of indicators on multi-

dimensions of poverty. The system outlines information needs and allows for choice of data collection instruments. Research priorities on poverty are clearly outlined, dissemination plans are in place with annual work plans and budgets and capacity building plans to ensure efficiency and effectiveness of the system.

The PMS institutional framework, Indicators and Outputs

The institutional framework is divided into four different levels: The National Poverty Monitoring Steering Committee which provides guidance, the PRS Technical committee that links evidence on poverty back to policies, the Poverty Monitoring Secretariat for general support to the system and Technical Working Groups that focus on four different aspects, namely: Survey and Census, Routine Data System, Research and Analysis and Dissemination, Sensitization, and Advocacy.

Some initial steps have been put in place to review the PMS to reflect what is emerging from the PRS process. Currently, the indicators focus on income poverty, human capabilities and PRS indicators linked to the poverty monitoring master plan. At the beginning there were 39 but were later added to 60 indicators. The PMS review is within the context of the PRS review.

Three specific outputs are envisaged from the process: The Poverty and Human Development Report which is an annual analytic report, the PRS annual progress report and a series of Policy briefs.

Highlights of Discussion

The PRS is an evolving process that links to different on-going processes. It has its shortcomings but it is being improved on an incremental basis through lessons learnt. For instance, it is now evident that the involvement and participation of the health sector was not adequate during PRSP I and efforts are being made to make amends on this. The contributions from different organizations, including the REPOA training seminars, will inform the review process and generate ideas on how to deal with some of the shortcomings that have been identified in the process.

PRS Implementation and Monitoring in the context of the health sector –
Presented by Dr. Faustin Njau, Ministry of Health

PRS Implementation

The Health Sector Strategy Policy (HSSP I) preceded the PRSP. However, it was later reviewed to harmonize it with the PRS. The latter was oriented to the revised policy, highlighting gender and HIV/AIDS mainstreaming and enhancing private-public partnership. HSSP I laid a foundation for PRSP implementation.

The MOH has developed HSSP II which runs from 2003-2008. It consolidates HSSP I and emphasizes the improvement of the quality of health services. Under the primary health care concept the importance of devolving authority to local authorities was identified but

not harmonized and integrated in the process. The main link to the PRS is availability of health services and easier access by the majority. This is crucial for poverty reduction.

In the HSSP, the PRS is translated into the health strategy. There is a set of indicators that focuses on making services available and accessible. Strategy 1 focuses on district level facilities and Strategy 2 focuses on the regional level service delivery points. The voice of the poor is respected and captured through health boards and various committees. Communities are empowered to monitor the quality and availability of services in the interest of equity and access. Currently, service provision suffers because of staff shortages as there is a serious shortage of key providers who as a result are overworked hence not very efficient.

The HSSP was also translated into the MTEF in line with the Sector Wide Approach. There needs to be a good link between national policies (e.g. Vision 2025) and the implementation tool – i.e. the Investment Plan. The MTEF is formulated to cater for the pro-poor and the ministry has been able to allocate resources to serve the poor.

Another link is through joint review and analysis even though this is hindered by serious under funding. The GOT is investing only $ 5 per capita which is not sufficient to operationalize all the plans in place. Even though development partners have agreed to work with the government to address the resource gap it is not clear which gap they are going to address. There is a serious financial gap that impacts on the operationalization of the all the plans and frameworks in place.

PRS Monitoring

The MTEF is implemented and monitored internally in terms of financial performance, PRS and gender links. However, internal evaluation is not very objective as it may be influenced by successes and/or shortcomings. There is need for an external evaluation and should be done with national goals in mind.

There are 19 indicators to monitor district health services. These are not in the data system; they are mostly for improving clinical performance. There are also input indicators which are very important in monitoring financial inputs. A number of practical links exist between health care provision and poverty. These include poor transport and lack of food at household level and how the two impact on access to health care.

The Health Management Information System (HMIS) is being revamped by a task force that was formed 10 years ago. This team has come up with a total of 22 recommendations have been made which will be discussed with the government and other stakeholders to determine the way forward. The rationale behind the selection of indicators is based on the fact that not all health indicators can be used to analyse poverty levels. It is more important to monitor trends in various areas, e.g. reduction in mortality rates, improved access to health care, etc.

It is 10 years since the initiation of health sector reforms. Efforts are now underway to harmonize and link the process with Millennium Development Goals (MDGs). The MDG

goals and targets have been observed in the formulation of HSSP II. The health sector PRS targets and indicators are in harmony with the MDGs except for the protracted MDGs time line of 11½ years. The MOH's MTEF is for 3 years and the HSSP for 5 years.

Intersectoral collaboration is extremely essential for implementing the PRS for health related MDGs as well as for monitoring and evaluating the sector. The process of jointly reviewing the health sector since five years ago has helped to further shape the refinement of the linkages to the MDGs, strategic planning, and the monitoring of the sector performance and information systems. However, of utmost importance is the need to harmonize sector financing mechanisms and putting in place skilled human resources at service delivery points, without which, the realization of the MDGs will remain a dream.

Highlights of Discussion

Poverty reduction is our war and a number of strategies have been designed to fight poverty at different levels. The question to be addressed is how all these are being directed towards the poor of the poorest? While the primary health care system was an excellent idea and designed to cater for this group, most of the outreach programs are hindered by lack of adequate personnel and transport. The move towards comprehensive district planning is an attempt to correct the shortcomings of the initial primary health care concept. The health sector is facing serious shortages in terms of financing as a result; there are not many initiatives to address poverty as far as health indicators are concerned. The private-public partnership (PPP) is important to fill this financial gap and mainstream activities across all other sectors. The ministry of health has tried to incorporate PRS issues in the HSSP even though the latter was developed prior to the PRS. It is important to review the list of health indicators and see how they can be incorporated into the database (TSED)

Introduction to the software component: data retrieval and data manipulations, etc – *by Jane Mwangi National Bureau of Statistics*

Giving a brief background on why the TSED software was developed the Presenter informed the workshop that TSED is an indicator and databank administration system. It is a data bank that stores information and facilitates systematization for analysis of performance indicators, it contains tools for the generation of tables, graphs, reports and maps and allows grouping of indicators in different frameworks.

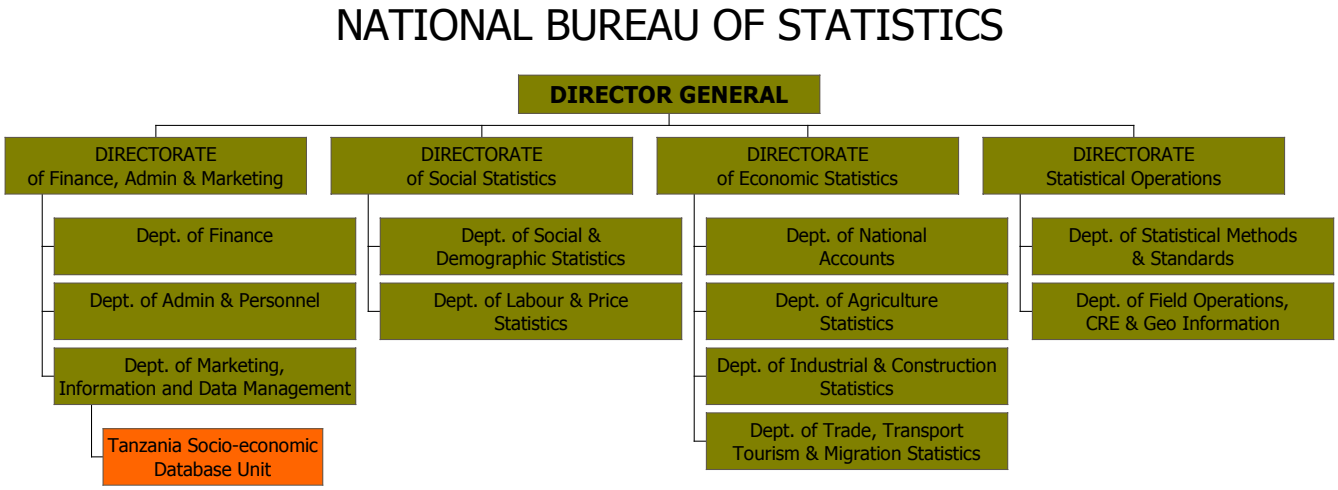
Explaining the importance of developing the database she informed participants about the need for a common database and unified dissemination mechanism for national statistics. Different organizations generate different data e.g. line ministries – DSS, MTUHA, etc. but there was no central unit to disseminate common statistics. There was also limited access to basic data. TSED will make basic data available to as a wide an audience as possible. Before TSED there was relative difficulty among statisticians to manage data and to reconcile information on different indicators.

Objectives of TSED

TSED seeks to achieve four main objectives, namely:

- To enhance availability and timely dissemination of socio-economic data in order to support policy analysis and decision making
- To strengthen the capacity of database management in NBS and supports NBS in its role as executing agency
- To provide users with a comprehensive set of indicators that help Govt., donors and other interested people to analyze the situation in Tanzania, and
- Facilitate the monitoring of international, regional and national goals and commitments

TSED also ensures quality control of data collected. Data quality cannot be compromised – it is important to have as reliable data as possible for it to be credible. Having the TSED at the NBS was a strategic decision to ensure quality. It has been integrated into the national statistics and is placed within the marketing of the NBS.



The Role of TSED in poverty monitoring

TSED was identified as a tool for storage and dissemination of quantitative information from different surveys, routine data, census and other relevant research on specific areas. The database contains a theme that highlights monitoring indicators. During the household survey a special CD was developed that contained specific data in that area and contributes to the poverty alleviation process by providing relevant information that will help to determine poverty levels and trends in alleviation.

Participants were shown examples of the goals and poverty monitoring indicators and how they are highlighted in TSED as well as health indicators that are available on the database. Even though there are some indicators that are missing in the database either because data is not available at source or have not been incorporated in the database, most of the indicators that help in poverty monitoring are available on the database. The database also generates tables and graphs that easily and quickly provide basic data at a glance, e.g. distance from a health facility, individuals seeking health care, difference between rural and urban areas.

Challenges

A number of challenges are being faced to ensure sustainability of the current momentum. These include provision of incentives to focal point institutions to ensure that they will continue to be motivated to work for the project, strengthening the link with the local government particularly now that the Local Government Reform (LGR) database is in place and see how to link the two to simplify and facilitate exchange of information. Another challenge is how to ensure more participation from other stakeholders (CSOs, NGOs, and local government authorities) can be encouraged through conscientious capacity building. It does not make sense to have a database that is not being used, yet the promotion of use of the evidence produced by the PMS in decision making at all levels is a challenge. The training seminars for civil servants, researchers and planners on how to use the database and localize it for their individual organizations, is a step in the right direction.

Usefulness of TSED

TSED is user friendly, it involves many stakeholders and ensures that poverty alleviation indicators are updated regularly and disseminated to lower levels. Toward the end of 2001 the tool was endorsed by the UN for the monitoring of MDGs at global and country level. Tanzania is ahead because it already has TSED and all that needs to be done is to revise it to suit the needs. Tanzania is the first country to come up with a common tool for sharing information. A number of countries have come to learn from Tanzania, including Malawi, Ghana Uganda, Lesotho, Burundi and others. TSED is also useful because it allows for capacity building and will benefit from new technological advancements. Having a web-enabled version ensures that updates of the data can be shared easily. This is in the pipeline and will be out very shortly. Currently the TSED is available on CD.

In addition, data is organized in different ways including by sector and sub-sector. For example, agriculture is sub-divided into agriculture and fishery. The health sector is sub-divided into 8 categories including health care, health services, immunization, morbidity, mortality reproductive health, safe motherhood and service delivery. Each sub-division is divided into indicator categories and with the right click on any of the indicators you get more information including definition, unit of measurement, source and a link to the actual publications (if available electronically).

Last but not least, TSED is very adaptable. Even though it is developed in English it can be translated into whatever language that will make it more accessible. For example in Burundi it is in French and in Mozambique it is in Portuguese.

Highlights of Discussion

Currently, the smallest unit of data in the database is for district level for specific sectors, but it can go even lower. Certain data is available up to ward level. Anything is possible as long as there is credible data. However, indicators are very limited because NBS works with only a few government ministries. Participants noted that there are

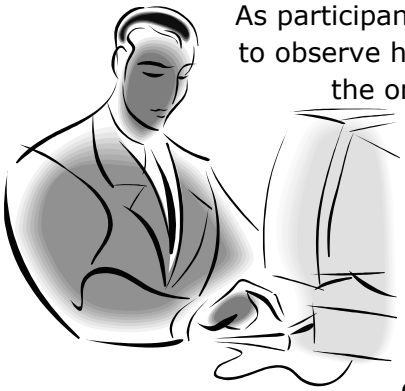
some indicators for which NBS says there is no data while it is available, e.g. data on diarrhea. Caution was also expressed on the danger of using national aggregates because they don't portray specific characteristics that could make a difference in terms of decision making and strategic planning.

TSED does not collect information; it relies on other departments and institutions for its data. One of the objectives of the training seminars is to find out what data is available where so as to update the current version of TSED and make it more informative and useful.

Participants also expressed the need to harmonize indicators for which there are different sources of information, e.g. HIV/AIDS, and to be careful about data on specific indicators that differs from one source to another or data whose calculation is not known, e.g. life expectancy. The discussion also went as far as identifying other problems related to routine data collection, e.g. the MTUHA forms whereby it was observed that very few government facilities complete these forms.

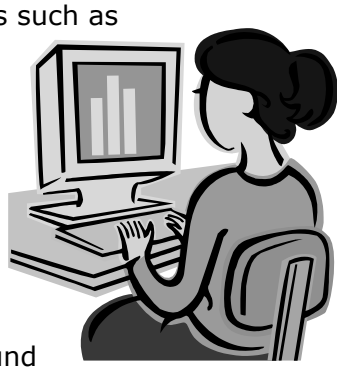
The NBS is trying to bring institutions together to discuss data and methodology and see how to improve reliability of data. The NBS has been given this mandate. The process will take time but something is being done by way of revising some data sets. The presenter assured participants that once the web-enabled version is available it will be easier to download updated versions of the data.

From Theory to Practice: Familiarization with the database



As participants were orienting themselves with the TSED they were requested to observe how the data was organized as well as anything that was out of the ordinary.

They noted that data is organized in different themes such as poverty monitoring, local government M&E system, etc. and when you right click on any of these themes it links you to another document that contains the relevant indicators. Data is also be organized by organization/institution, e.g. AMMP, TEHIP, etc. Again, available data for each indicator is indicated in terms of time (i.e. the years for which data is available), **area** (Africa, Tanzania – mainland and Zanzibar) and other classifications. In short, as you browse around through the database you can get different kinds of information including the source, a link to the report in PDF format, and even calculate for indexes.



One of the things they noted that was out of the ordinary was that the unit of measurement for infant mortality was indicated as a percentage instead of per 1000 live births. Participants were encouraged to note any other inconsistencies so that they can be worked on.

Elaborating further on how information can be used the Presenter informed the seminar that the different features, e.g. the Map wizard can be used to get even more information about the different indicators being analyzed. For example, you can customize a map to include features like health facilities available that will show the distance from different locations. The map can be cut and pasted in any document.

Data manipulation and interpretations – *Presented by Richard Mkumbo, Ministry of Health*

The measurement of health sector performance is a fundamental aspect in assessing the progress of the sector in the ongoing reforms. The MOH has introduced a monitoring tool -- the Public Expenditure Review -- which is carried out on an annual basis to monitor and evaluate performance of the sector. The PER is used to trace how funds are being utilized. In addition to the PER, the MOH has also developed a set of indicators that help to assess the performance of the sector. It is organized by the Ministry of Finance (MOF) that has this mandate. The role of the MOH is limited to dissemination of key findings on performance indicators, particularly the input indicators from the health sector.

Allocation to the health sector is divided into three categories: central, regional, and district level. The chunk goes to the central level. Indicators 1, 2, 3 and 7 are input indicators while indicator 12 is an output indicator.

- Indicator 1 monitors the GOT commitment to health sector spending at each level of the health system.
- Indicator 2 measures total resources per capita for health spending, including off-budget funds.
- Indicator 3 monitors the recurrent expenditure
- Indicator 7 shows the level of government commitment to health service implementation at the LGA level, monitoring the share of overall GOT allocations to the council level which is assigned to health.
- Indicator 12 monitors cost sharing fees collected by the public health facility

The PER provides an opportunity to update selected performance indicators for the health sector as a whole. The table below shows the updated figures, in Tanzania shillings (current prices), for four indicators, and the percentage share of LGA allocations budgeted for health in the coming year. The cost-sharing indicator has not been updated.

Finance-related health sector performance indicators

	Indicator	Level	Baseline	FY03		FY04
				Budget	Actual	Budget
1	Total GOT public allocation to health per capita (central, regional, and district)	Central	1,245	2,139	1,782	2,721
		Regional	172	244	242	270
		District	848	1,320	1,334	1,443
2	GOT and donor allocation (budget and off-budget) to health per capita	National average	5,100	7,108	6,868	7,656
3	Per capita GOT recurrent expenditure broken down by level (central, hospital services, preventive services)	Central	190		423	
		Hospital	1,077		1,270	
		Preventive	894		1,397	
7	% of GOT funds available for budgeted and actual district health activities against the total overall funds available for district activities	Budget	18%	17.7%		16.6%
		Actual	15%			
12	Cost-sharing fees collected by public health facilities in year x as a proportion of the 1998 targets	National average	0.46		n/a	

Note: Figures in Tanzania shillings unless otherwise indicated.

There are some positive improvements that have been observed. The first studies including National Health Accounts indicated that health expenditure constitutes 4.5% of GDP (Draft NHA Report 2000). Per capita health expenditure currently stands at US$ 7.6 (Draft PER 04 Report) leaving a financing gap of US$ 4.4 per capita if we take the World Development Report recommended per capita of US$ 12 for developing countries. In terms of cost sharing, figures for the national level stood at 0.46 per cent. Improvements were also recorded at facility level.

When one looks at health service funding and the corresponding indicators for cost sharing (table below), the revenues generated from cost sharing can make a substantial contribution to the daily running expenses with substantial variation in both revenue-generation and absorption.

Potential HSF cost-sharing indicators, FY03

DESCRIPTION	Expd/ (Balance BF + Rev)	Rev/ Drug expd	Bal CF/ Drug expd	pc Revenues (TSh)
Muhimbili National Hospital	13%	54%	75%	97
Mbeya referral hospital	0%	7%	68%	15
Mirembe referral hospital	0%	0%	6%	-
Kibongoto referral hospital	34%	7%	10%	16
Arusha regional hospital	11%	53%	98%	113
Mbulu district hospital	39%	33%	48%	74
Monduli district hospital	8%	14%	90%	32
Babati district hospital	108%	12%	-1%	25
Kiteto district hospital	0%	0%	5%	-
Arumeru district hospital	66%	24%	12%	50
Karatu district hospital	0%	0%	3%	1

Highlights of Discussion

Indicator # 1 shows expenditure by levels – central government, regions and districts and the reason for higher allocation to the central level was explained to be because a

big portion of this was spent on drugs. Given that these drugs are eventually distributed to regions and districts, the expenditure for regional and district level should reflect the cost of these drugs otherwise the picture being portrayed is far from reality.

At the same time, tracking expenditure in this manner is quite challenging because what is reported is actual expenditure. The amount that goes to the Medical Stores Department (MSD) is not reflected. Efforts are underway to harmonize the reporting system to be able to establish how much was allocated to each facility at lower levels. The process becomes even more complicated because most of the drugs are not available from MSD and have to be sought from other sources. The issue of equity also becomes complicated because of the presence of national vertical programs like TB, Malaria and others that cover the whole country. There are some figures that show how much funds are allocated to the central level and how much go to lower levels but in most cases it is not easy to establish specifics.

When monitoring performance it is important to go beyond finance. For example, it would be interesting to show to what extent those contributions have been in relation to equity – taking into consideration that the more efficient we get in revenue collection the poorer communities get.

There is also need to capture other financing sources e.g. MDGs and other non-monetary contributions at community level, e.g. building materials and manpower. If all these are taken into consideration it will change the picture slightly.

By way of conclusion, it is important to note that economic theories have some trade offs in that to achieve growth and efficiency is sometimes contradictory. There is need to have mitigating factors such as exemptions and the like to be able to achieve both growth and equity. Also, if one reviews the PERs that have been taking place over the years, figures on inflation are rarely provided even though there is a strong effect on the performance of the health sector when there is a downward trend.

While it is important to talk about additional resources to the sector, it is equally important to be mindful of the fact that doing so could be similar to refueling an inefficient vehicle that would not produce any more power. The health sector has to be able to show how more funds can make a difference in terms of performance in order to make a case to the MOF.

The Place of Health in the PRSP – *Presented by Max Mapunda, WHO Country Office*

In this session, the Presenter gave an overview of the health sector content in terms of pro-poor interventions, priorities and the missing links. He singled out issues of equity and efficiency that surfaced in the discussions on the first day reiterating the need to think twice about continuing to fuel a car that is no longer efficient and look towards achieving maximum output from invested resources.

The PRS Process

The process was dominated by a small group from the Ministry of Economic Affairs, Finance and Planning Commission with a limited degree of consultations. Sectoral ministries including health were not optimally involved. Even local government participation was limited. The MOH is trying to change its mindset to embrace the poverty alleviation concept and some modest improvements have been realized in as far as PRSP is concerned.

However, the path in and out of poverty is not discussed in-depth. It is limited to "poverty snap shots" that need to be built in and be part and parcel of the plan of action. Also, when we talk about health, ill-health is described as a consequence of poverty and not a cause. The Presenter drew participant's attention to the vicious circle between poverty and health explaining that poverty affects health and that if you address poverty you will be dealing with ill health. Also the out of pocket health spending is not calculated. Some initiatives that have been started in Tanzania to mobilize resources for the betterment of health but these efforts have increased the out of pocket spending. Analysis on the actual impact has not been done yet. The whole issue of health as an investment is slowly unfolding.

Health Sector annual performance indicators

The MOH does not want to put something in the sector without measuring its performance and impact. The 22 annual indicators will be monitored and measured along with another 11 periodical indicators. The purpose is to monitor progress in the sector in terms of input, process, output and income. The input indicators largely look at resources which range from total government public allocation to the health sector (i.e. the commitment of the government to the sector). Recently although the PER in the health sector shows nominal increases it does not portray the share of government as per expectations. Despite the Abuja declaration whereby the government committed to allocate 15% and other advocates for increasing share of public expenditure to the health sector, the current figure still falls short. It is still around 8-12%. As an input the proportion of the government spending on the sector indicates commitment.

The process indicators on the other hand examine whether and how the system is functioning. The MOH has developed some indicators to measure the effectiveness of health delivery including the HMIS to collect routine data as well as the state of facilities in terms of repair, available medical equipment and supplies and so forth. The nature and characteristics of process indicators are centred around the efficiency and functioning of the system. All the indicators that are part of the PSRP are indicated.

Another set of indicators is the output indicator which measures the output. For efficiency the input-output ratio has to be balanced. There are two different types of efficiency: allocative and technical efficiency with the latter taking precedence. This would include number of patients attended compared to the resources inputted.

Outcome/impact indicators are much more complex because their success is not necessarily solely due to the contribution of the health sector alone. The success of these indicators can only be determined through surveys.

Recognition of the role of the health sector in poverty reduction

The health sector plays a fundamental role in directly improving the well-being of the poor. Unfortunately, the strategies reflect some constraints. There are no detailed discussions of health in the macro economic framework and various policies affect the health sector. When the health sector was conceiving the health sector proposal that was reactive because macro economic policies were affecting health and this was dealt with by reforming (overhauling) the system.

Trade liberalization allowed a list of commodities to be imported while restricting drugs. Some of the policies e.g. privatization had to engage the MOH but instead it was reacting to the policies that had already been determined. The main disadvantage that the sector is facing is the traditional division between productive and non-productive sectors and health was classified as the latter even though ill-health of the population affects productivity. This is a challenge to further be addressed in the PRSP. Investment in human capital is yet to be seen as direct investment.

Missed opportunities

Health is not limited to medical care; it is much broader than that and there are a number of missed opportunities that need to be brought on board. These include agriculture, specifically nutrition and how it impacts on human health and their consequent productivity, rural roads which accounts for accessibility to facilities, as well as school health and education and its indirect impact on improved health.

Health sector content and pro-poor checklist

In addressing pro-poor initiatives the MOH will be reducing the financial burden of health care by the poor and this does not necessarily mean free medical care. It is more financing health services through progressive taxation in that those with high income brackets would pay more and hence pay for those who cannot afford to pay. If this worked well this would have been the most ideal option. However, the policies are not pro-poor because those who can afford to pay are actually the ones who access the services and the poor continue to suffer. The pro-poor policies need to reduce the financial burden of health care for the poor.

There is also need to reallocate public resources in favour of the poorer regions. Previously the MOH was allocating resources on the basis of number of facilities. This gave more to those who have less need and it was a very unfair distribution of resources. With the element of PRSP the MOH developed criteria of resource allocation that was based on intensity of population. This also created more inequity because the urban centres still got more resources and the rural needy still suffered. The MOH has not worked out a resource allocation formula to address this issue. This formula includes four indicators: population intensity, poverty index, distance covered for supervision of facilities and infant mortality rate as an indication of poverty.

Pro-poor strategies need to combat the diseases of the poor which need to recognize epidemiological transitions. In Europe, diseases like hypertension and diabetes are now diseases of the poor unlike in Tanzania where these are diseases of the affluent. Diseases of the poor in Tanzania are such as malaria, diarrhea, cholera, etc. The well off have access to all the means to protect themselves from these diseases. They are the ones who can afford to buy insecticides, mosquito nets and repellants to protect themselves from getting malaria and even when and if they do, they can afford to seek medical care to treat the disease. To really initiate pro-poor policies in place, planning and resource allocation has to target diseases that affect the poor most.

Enhancing reproductive and child health is another pro-poor approach that facilitates life saving. Life expectancy in Tanzania currently stands at 52 years. This means that investing in saving children contributes to life years saved.

Fighting HIV/AIDS falls within the pro-poor policy. Recently the care and treatment angle is dominant in the fight against HIV/AIDS even though the cost of care and treatment is way above the cost of prevention. The Tanzanian health budget cannot manage this without heavy external assistance and the danger is that it can skew resources towards those who can afford. Billions of dollars are used to procure antiretrovirals but that is the trend. The issue is more about the severity of the situation -- death -- and that is why saving lives at any cost is seen as the only strategy. The severity of the situation is related to poverty in that those who cannot afford services are the ones who are dying from HIV-related diseases and AIDS.

Interventions that address poverty need to facilitate the targeting of resources to the deprived population groups. When planning and budgeting it would make sense to target resources towards this group. Public finance is limited and whatever is allocated to the health sector needs to be apportioned on the basis of the most effective health interventions that are cost-effective and most efficient in saving lives of the most deprived populations. Waivers and subsidies need to target this deprived population to protect them from the impoverishing costs of health care. In the same breath, staffing problems in remote areas need to be dealt with and NGOs and communities need to be involved in health care interventions. The health sector is fairing fairly well in this as it has embraced the private sector and NGOs.

A huge gap exists between analysis and strategy of programs responding to the health needs of the poor. As capacities are being built at the MOH this aspect will be taken care of. Moreover, expenditures are not directed towards the poor. Anti-poor bias in internal spending within the MOH shows that administrative costs surpass whatever investments made for actual service delivery. The focus is now on the improvement of service delivery and quality. Previously more funding was going towards improving systems. The next HSSP focuses on improvement of health delivery.

There is need to conduct an elasticity analysis to determine how we can target resources allocated to health to achieve more. Finally, if interventions are external-driven they will not be effective. We need to have pro-poor activities.

Resources

When talking about resources, there are a number of questions that need to be dealt with. These include:

1. Whether planned increased (HIPC) reflects existing trends or whether they are additional. Is there shifting relative? The claim is that absorptive capacity is limited while ignoring the conditionalities that accompany the resource support.
2. Will HIPC resources cover additional spending in current needs?
3. What percentage of global HIPC resources will be earmarked for health?
4. What happens when the government's debts are cancelled?
5. Where does the saved amount go to health so that it can effectively contribute to poverty reduction?
6. Will HIPC incur a new expenditure framework?
7. What about the huge resource gap that has been recently identified?
8. What about the commitment gap and aid flow within OECD?

The link between health and poverty reduction is not reflected in the strategies. There are problems in the framework expressed as gaps in capacities and resources. Moreover, the gap cannot be quantified. There is heavy reliance on the WB Development report and other reports but there is no internal study that has been conducted to identify the actual gap.

The importance of health financing

The presenter reiterated the concept of equity by clarifying that it does not necessarily mean equality. In health there is horizontal equity whereby equal health needs of everyone get the same attention, regardless of income level and other categories. Vertical equity on the other hand recognizes that health needs differ according to social groups, income etc. in that those with greater health needs should be given priority.

Equity is a very useful instrument for poverty reduction. When the National Health Insurance Fund (NHIF) was being introduced there was fierce opposition by those that are contributing more. This was because proportionally those who earn more pay more than what they get from the fund but this is necessary for equity purposes.

Efficiency is how you achieve maximum output with less input. In health, efficiency is defined in terms of allocative and technical efficiency whereby the latter would address the input-output ratio while the former refers to the impact of an intervention. For the PRSP, inputs have to be used to achieve both allocative and technical efficiency and the instruments that will facilitate this process include the PER that depicts government spending, national health accounts that cover both government and private spending and the costing of the basic health packages which is based on a list of essential health package.

Highlights of Discussion

Poverty reduction requires approaches that are multidisciplinary and multidimensional including the methods of monitoring it. Most of the studies are snap shot approaches and hence very limiting. We need to be more innovative and all encompassing in our approach in defining poverty. Experts from all fields (sociologists, economists, statisticians, anthropologists, etc.) need to sit together to define poverty in order to identify the best and most effective strategies to deal with it. Areas that will be considered during resource allocation include: drugs and medical supplies, reproductive and child care, malaria prevention. The per capita expenditure for the health sector also needs to take into consideration the contribution of other sectors to identify the gap that exists in other sectors. The Resource allocation formula looks at the appropriate variables that you can use in the distribution of resources. The MOH uses the four variables to allocate resources in an equitable manner. All these variables are those that can be measured and for which information is available.

The human resource problem is also needs to be addressed both in terms of migration and shortage. While the magnitude of the problem varies from country to country, in Tanzania, the problem is more due to the employment freeze rather than due to migration. Efforts are being made to fill the gaps by finding a way around this policy. WHO/Afro region is also addressing the problem.

Summary and Conclusion

Use of the TSED for policy analysis and decision making is indeed a welcome idea. However, this database needs to incorporate data from as many sources as possible and as many socio-economic indicators as possible to serve as a central point of reference on basic country statistics. It also has to be kept up-to-date for it to continue being relevant and useful for decision making. All this requires the allocation of financial and human resources to implement this valuable system. This calls for collaborative stakeholder participation and commitment, coordinated planning and implementation, well functioning sectoral information systems and a general positive will to harness everybody's individual commitment to accomplish what needs to be done.

Significant strides have already been made in the right direction. The system is in place and there is considerable awareness on the need for accurate data for decision making not to mention keen interest in making the system work.

The Seminar was highly interactive as participants were able to learn, share and brainstorm on the most effective ways to make available information useful for policy analysis, planning and decision making. The poverty monitoring strategy was analyzed in terms of how useful and successful the current approach is and what can be done to further improve it as elaborated in specific sections above. Participants at the seminar showed a strong commitment and interest to make the system work.

It is important to mention here that the Facilitator's remarkable knowledge of the health sector and how it operates and his ability to synthesize the discussions, significantly contributed to the success of the seminar. Throughout the process he encouraged

participants to find their place in the poverty reduction process and make their mark. Participants left the workshop eager to make a difference in their places of work.

Workshop Programme

Monday April 5 – Introduction and Concepts

Time	Activity	Responsible
08:30 – 09:00	*Registration*	REPOA
09:00 – 09:30	Opening	**Pim Van der Male** UNDP on behalf of Prof. Semboja REPOA
09.30 – 10.30	Introduction to Poverty Reduction Strategy (PRS), monitoring, and link to the Public Expenditure Review (PER)	**Servus Sagday** Vice President's Office
10.30 – 11.00	*Tea/coffee break*	
11.00 – 12.30	PRS implementation and monitoring in the context of the health sector (sector indicators, sources of data, PRS and MDG targets)	**Pim Van der Male** UNDP
12.30 – 14.00	*Lunch*	
14.00 – 15.30	Introduction to the software component: data retrieval and data manipulations, etc.	**Jane Mwangi** NBS
15.30 – 16.00	*Tea/coffee break*	
16.00 – 17.00	Data manipulation and interpretations	**Richard Mkumbo** Ministry of Health

Tuesday April 6 – Analytical Work: Groups

Time	Activity	Responsible
08:45 – 0:00	*Registration*	REPOA
09.00 – 10.30	Discussion of health themes and guide to group work	**Max Mapunda** WHO
10.30 – 11.00	*Tea/coffee break*	
11.00 – 12.30	Group work	Participants
12.30 – 14.00	*Lunch*	
14.00 – 15.30	Group work (Continued)	Participants
15.30 – 16.00	*Tea/coffee break*	
16.00 – 17.00	Group work (Continued)	Participants

Wednesday April 7 – Presentations of Group Work and Discussions

Time	Activity	Responsible
08:15 – 08:30	*Registration*	REPOA
08:30 - 10.30	Presentations of group work	**Max Mapunda**

10.30 – 11.00	*Tea/coffee break*	
11.00 – 12.00	General discussions	**Max Mapunda**
12.00 – 13.00	Evaluation and Closing	
13.00 – 14.00	*Lunch*	