"All About the Health Budget!"

Training for Health Equity Group Members on
Health Budget Formulation, Implementation and Monitoring Processes
at National and District Level from a Pro-poor Gendered Perspective

Organized by, the Health Equity Group

Supported by, Women's Dignity Project

Report prepared by: Ismat Dewji Sheriff, CARE

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Final

Background:

The Health Equity Group constitutes five civil society organizations, namely CARE Tanzania, Women's Dignity Project, Save the Children Tanzania, Youth Action Volunteers and Tanzania Gender Networking Program. The group had identified a need to learn more about the health sector public budgeting, analysis and performance monitoring processes at national and district levels in Tanzania. The aim is to advance the group's budget literacy so as to be able to engage in public policy and budget advocacy for improved maternal and child health service delivery. . In addition the group wants to be trained on Budget analysis (i.e. how to read, understand, and carry out simple analyses on the National, Ministerial and District-level Health budgets) and Gender Budgeting in Health.

Overall Objective:

To enable the Health Equity Group to engage effectively in National and District level budgeting and monitoring processes in order to influence policy and decision-making for better maternal and child health outcomes.

Structure:

Three one-day training session, facilitated by experts in the area,[1]

Session 1 (July 13th): National Budgeting and Monitoring Processes facilitated by Paul Smithson
Session 2 (July 21st): District Budgeting and Monitoring Processes facilitated by Sally Lake
Session 3 (Aug 18th): Gender Budgeting facilitated by Gemma Akilimali

Participants came from all three organizations, each organization could invite up to three people. For the first session, eleven people attended, twelve at the second session and six at the last one.[2]

[1] See Annex I for Scope of Work for consultants who conducted the training sessions
[2] See Annex II for attendance sheets

Session 1:[3]

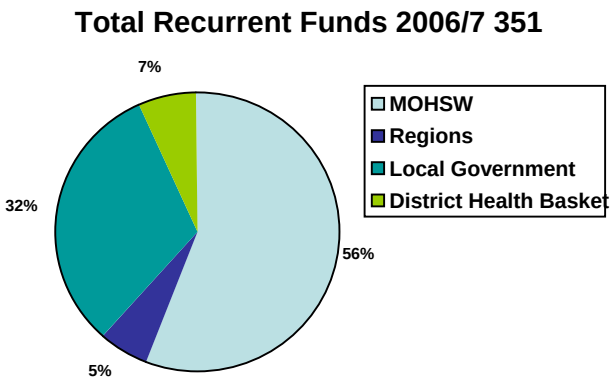
Time	Session
09.15 - 09.30	Introductions
09.30 - 11.00	Overview
11.00 - 11.30	Tea Break
11.30 - 13.15	The Budget Cycle
13.15 - 14.00	Lunch Break
14.00 - 14.45	MOHSW Recurrent Budget
14.45 - 15.15	MOHSW Development Budget
15.15 - 16.00	Budget Monitoring
16.00 - 16.15	Evaluation
16.15 - 17.00	HeqG Meeting (For HeqG members)

Introduction: Self-introduction & personal objectives (what you expect to get out of the training)

Session 1: Demystifying the Health Budget- Overview

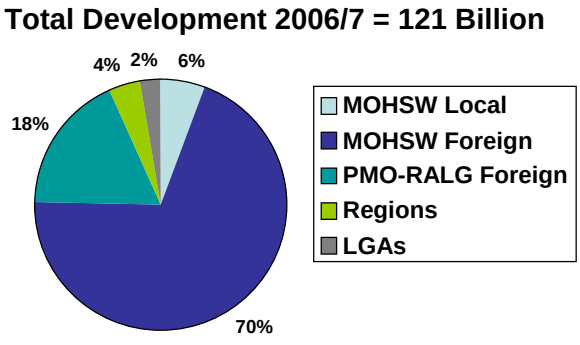
1. Where does health sector funding come from? Overview of all of the elements that make it up. Which ones appear in the Budget, which don't?
    1. Recurrent Budgets
        i. MOHSW government funds (Volume II, Vote 52)
        ii. Regional government funds (Vol III, Votes 70 thru 95 (Curative and Preventive Sub-votes))
        iii. Local government funds (Vol III, Votes 70 thru 95 "Health Transfers")
        iv. Local government basket funds - ??

        How does it all add up?



    2. Development Budgets (local and foreign)
        i. MOHSW local funds, foreign funds (including central basket) (Vol IV, Vote 52)
        ii. PMO-RALG local funds, foreign funds (including basket for infrastructure rehabilitation) (Vol IV, Vote 56)
        iii. Regional local funds, foreign funds (Vol IV, Votes 70 thru 95)
        iv. Local Government, local funds (individual council budgets?)

        How does it all add up?



    3. Off-budget sources:
        i. National Health Insurance Funds (the non-government contribution)

[3] See Annex III for power point presentation slides

Government contribution (30 billion) shown under Accountant General's vote, but not how much is disbursed to health facilities. Theoretically, if the government contribution is "matching" the collected revenue from premiums paid, about 60 billion shillings are not being budgeted, accounted etc.

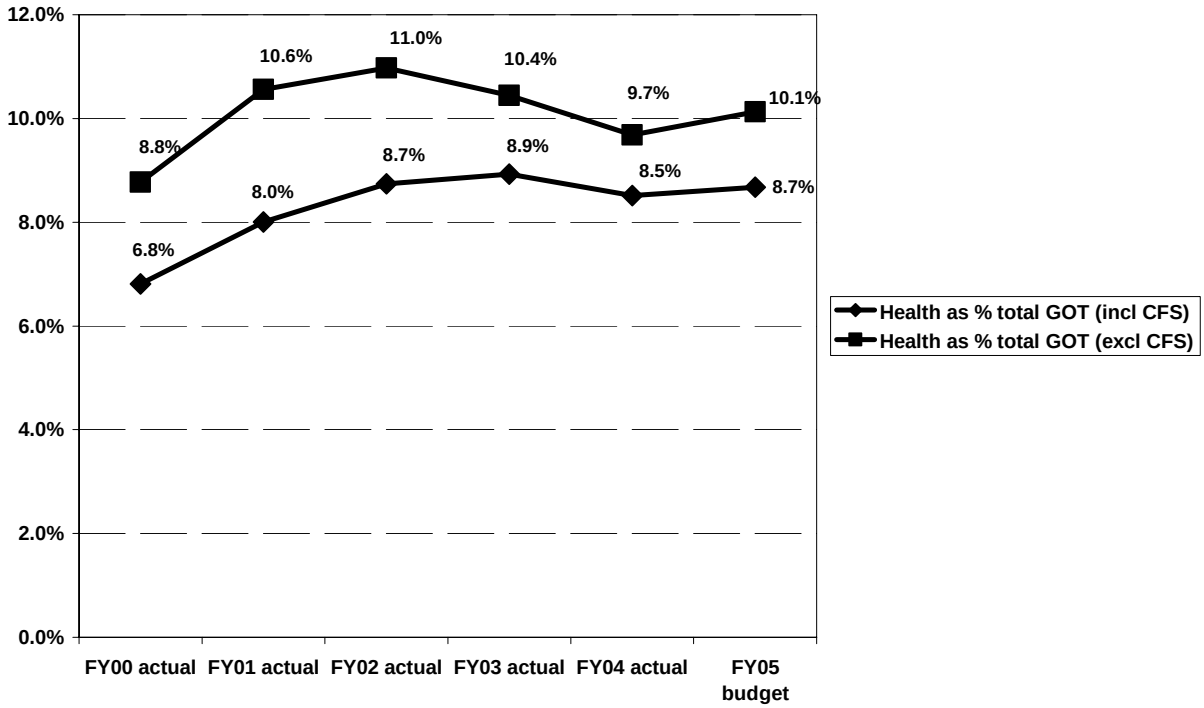
ii. User Fees/ CHF
No reliable figure is known, the PER estimated this at 11 billion for 2005/6

iii. Aid money not captured in development budget
No reliable figure known PER estimated this at 98 billion for 2005/6

iv. Money collected by Local Government

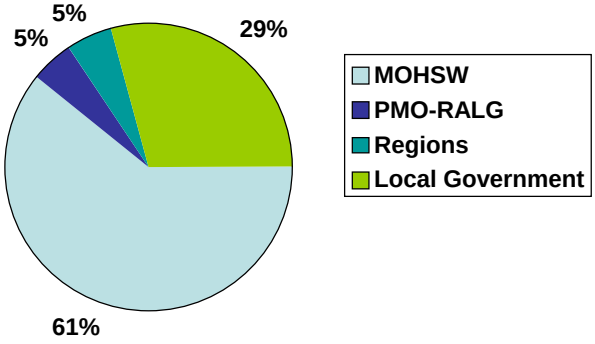
These four sources amount to about 140 billion – about a quarter of the total resource envelope for health.

2. What has happened to health sector funding in recent years? Overall amount, share of budget, composition

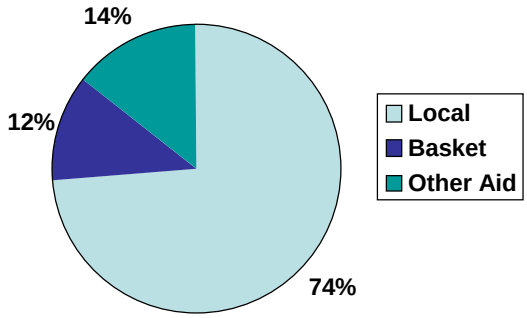


1. Recent Trends in Health Spending (from PER)
   - Total (on-budget) increase, nominal / real terms
   - Total (on-budget) increase, US$ per capita
   - Total (on-budget) Health vs Total government spending overall
   - MOHSW Recurrent vs All Central Recurrent
   - MOHSW Recurrent vs Central Recurrent excluding "CFS"
   - MOHSW Recurrent + Development vs Central Govt Recurrent + Development

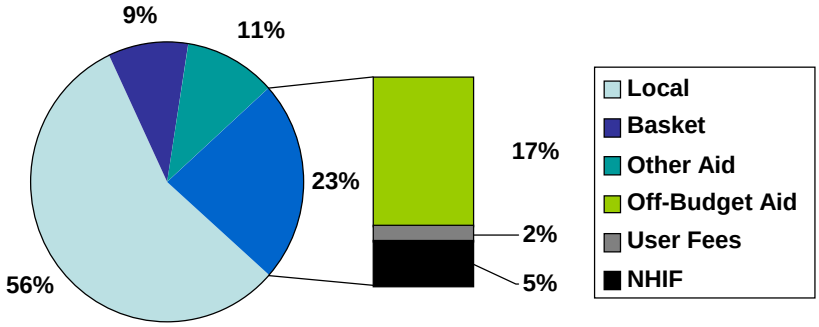
2. Overview of funding by level of Government 2006/7 (total 471 billion) - on-budget funding not including the government portion of the NHIF



3. Overview of Funding by Source (total 462 billion – on budget, not including NHIF)



4. Overview of funding including off-budget items (total about 600 billion 2006/7)



Session 2: The Budget Cycle

1. The budget cycle and key decision points
   - The Fiscal year runs from July 1 to June 30th.

   - The MOF and the Cabinet sets ceilings for each Ministry, now also decide on percentage allocations to MKUKUTA clusters (Dec/Jan)
     - MoF requests from sector ministries their estimate of requirements (budget circular produced in October)
     - Sector allocate their priority requirements – a bid of resources
       - This has not until now been informed by PER or estimates of requirements,
       - Usually values from last year are taken and a percentage added on.
       - List of priority ones probably the ones presented at the JHSR.
       - Budget Dept of MoHSW demoralized as even when there is a concerted effort to produce a good budget, ceilings are quite rigid, their work never gets funded – "they give what they want"
     - Using this, MoF sets sectoral ceilings, agreed by cabinet, then issue budget guidelines which states requirement of MoHSW against the allocation given by cabinet (November)
     - Ministries set ceilings by department, by asking for budget estimates from department heads, allocation done in the same manner as above.
       - This is not a rational of technical process – it is an entry point for engaging

   - Formulation of the budget (Jan/April)
     - Individual departments compile their MTEF
       - Done in March
       - About 120 pages of tables covering recurrent and development resources, divided up into local, pool (basket funding) and other (the remaining on-budget aid)
       - Outlines objectives, targets and activities for the next three years e.g. 2006/7, 2007/8 and 2008/9- however next years budget will not look like this year's allocations at all.
       - Theoretically should be budgeting according to the Health Sector Strategic Plan (which ends this year and a new one to be drafted next year)
       - However, impractical to budget that amount of detail (activities) for the next three years

        - Big budget allocations hidden within small ones in these tables.
    - Consolidated by Dept Policy and Planning (Head of Budget)
        - Regina Kikuli used to be the Head of the Budget Dept. Richard Mkumbo may be the new head (he is the desk officer for the PER)
    - Required to link to MKUKUTA clusters and MOHSW objectives, targets (Strategic Budget Allocation System (SBAS) that identifies activities according to MKUKUTA clusters)
    - Refinements and adjustments made (consultative process) – sometimes DPG consulted early enough to give significant contributions. There was conversation at JHSR 2005/6 to organize a meeting in February to have significant consultations on the draft MTEF and the proposed budget.
    - First version submitted to MOF

- Scrutiny of budget proposed by MOF (March/April)
    - MoF (budget commissioner- Mr. Mgambo (desk officer for Social Sectors in MoF) meets with MoHSW (Head of Budget and Dept. Head of Policy and Planning) – MoF usually requires amendments to be made

- Approval of budget proposed by Parliament (June/July/August)
    - Revised version submitted to National Assembly
        - Vote books (recurrent and development, by department and item of expenditure)
        - Budget Memorandum (compares proposed vs. previous years budget and some explanation)
    - National Assembly debates sector budgets in specific sessions and passes the "appropriation bill"
        - Social Sector Sub-Committee of Parliament debates the Health Budget (April)
        - The Budget speech is important to pay attention to as will outline the Minister's priorities and these are sure to receive funding.

- Implementation of the budget (rest of the year)
    - Approved budget input onto the government financial accounting system (Epicor, used to be Platinum)
    - MOF makes releases to sector ministries (usually full amount budgeted)
    - MOHSW spends
    - Spending monitored throughout the year (except project aid) by Acc Gen's Office
        - All budgets on this system except defense and state house
        - A daily status report of government expenditures can be obtained from this database – Tanzania faring great on this compared to other countries (this can also be requested by general public, however would need authorization)

- Reporting on budget implementation by MOF, and others
    - Narrative annual report prepared by Ministries and submitted to MoF (within several months, expenditure reports are produced with good estimates of what the final values will be (these are called out-turns))
    - Final accounts prepared by Accountant General's Office – "The Appropriation Accounts" – about 6 months after the year's end (supposed to be 3 months after, i.e. for 2005/6, report would be out by Dec 2006)

- Audit by Auditor General produced for Public Accounts Committee (about 18 months after budget is closed – massive improvement over several years ago)
    - All ministries' accounts audited every year
    - Submitted for audit 6 months after year end
    - Audit completed – about 1 year after submission i.e. 1.5 years after the year end
    - Audit reports scrutinized by Public Accounts Committee (PAC)
        - Parliament does not exercise oversight
        - Audit reports are public
        - Who is the PAC?

2. Key documents, sources of information
    - Budget Books Vol I – Vol IV

- Medium Term Expenditure Framework (MTEF) of the MOHSW
- Budget Memorandum (presented to the Social Sector Sub-Committee by the MOHSW)
- Document of questions asked by Social Sector Sub-Committee and the answers given by MOHSW

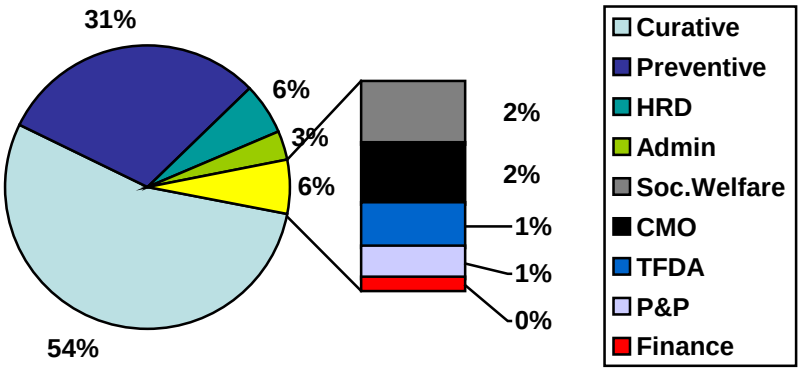
3. Discussion: at what points can CSOs influence the budget process? How? Who are the key actors at different stages?
   - Lack of medium term vision for strategic allocation of health sector resources. DPs have been insisting on this without success… MTEF should provide this in theory but does not…
     - Sector submission of requirements not circulated (but referred to in subsequent budget guidelines)
     - What is a good list of requirements (costed)- link to headline commitments? Engage with key departments and programmes of the Ministry of Health to enable them to provide the MOF with good estimates of needs into the medium term.
     - Paramount to have medium-term costing of the Roadmap
   - Can we get something into the Minister's budget speech?
   - The main locus of debate on the size and shape of the budget is cabinet
     - View and comment on inter-sectoral allocations through General Budget Support (GBS) donors (draft budget guidelines for Ministry shared with GBS donors)
     - Lobby MOF to have CSO consultations on draft budget guidelines
   - Draft MoHSW MTEF are share with DPs, but at very advanced stage, little/no scope for change. Unique among sectors?
     - Advocate to the MoHSW to have a meeting in February/March (either another meeting or move the JAHSR to this time) to review draft MTEF more substantially
       - In Uganda Social Sector Sub-Committee of Parliament actively participates, here they do not.
   - No further opportunity to comment until debated in Parliament.
   - Where are entry-points for the parliament to inform the budgeting process? – Not Many
     - Broad allocation across sectors already set by Cabinet back in Nov/Dec
     - Detailed budgeting already completed and cleared by MOF for submission to Nat'l Assembly
     - Any evidence of changes having occurred as a result of Budget Debate?
     - Parliament cannot stop the passing of a budget – risks being dissolved according to the constitution (check this?!)
     - Parliament asks "why" questions but does not suggest reallocations.
   - Enhance challenge function of parliament and media through informed analysis
   - MOF may go back to parliament for supplementary budgets later in the year – quarterly leaflets are produced to document these. That's why budget will always read "estimates" until the year is completed at which point it reads "approved estimates"

Session 3: MOHSW Recurrent Budget

1. Structure of the budget (Vote & Sub-Votes, departments)
   - Vote 52: Ministry of Health and Social Welfare
   - In the Volume 2 – Estimates as Submitted to the National Assembly
     - Divided up into sub-votes that correspond to MOHSW departments
     - For every sub-vote, all expenditure is analyzed into "items" e.g. salaries, employment allowance, medical supplies and services
   - Sub-Votes
     - 1001 Administration & General
     - 1002 Finance & Accounts
     - 1003 Policy & Planning
     - 2001 Curative Services
     - 2002 Govt Chemist Lab Agency (Now defunct. Has become semi-autonomous and is funded by subvention from CMO's sub-vote)
     - 2003 Chief Medical Officer (CMO)
     - 3001 Preventive Services
     - 4001 TZ Food & Drug Authority (TFDA)
     - 4002 Social Welfare Department (new to the Ministry)

- 5001 Human Resource Development (Really covers training of civil servants in the Health Sector, actual HR management is done by Director of Admin and Personnel (DAP) in the Ministry)

2. Where is the Money (by department), 2006/7?



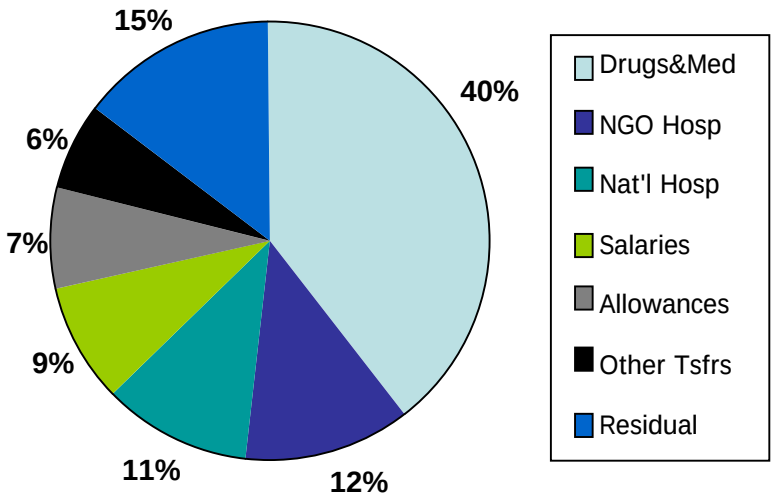
Department	PE	OC	Total
Admin	3.8*	2.7	6.5
Finance	0.1	0.6	0.7
Policy & Planning	0.1	1.8	1.9
Curative	7.6	98.3**	105.9
CMO	0	3.5	3.5
Preventive	1.3	58.5**	59.8
TFDA	0	2.5	2.5
Social Welfare	1.2	2.5	3.7
HRD	3.2	8.3	11.5
Totals	**17.4**	**178.5**	**196**

* This accounts for the salary adjustment,
hence wage bill more than doubled without salary adjustment

3. What are the big-ticket items?
   - Salaries & allowances for MOHSW HQ (under respective departments) including referral/specialised hospitals
   - This year "salary adjustment" put under Admin & General
   - Subsidies & Transfers to hospitals etc. (Bugando, KCMC, Voluntary Agencies and District Designated Hospitals that are Private)
   - Drugs & Medical supplies (only the chief chemist knows where this is being distributed – difficult to obtain this information)

   These four amounts to about 85% of the total

   The remaining,
   - Other Transfers (Government Chemist Lab, TFNC, NIMR, IHRDC, Social Welfare Institutions)
   - National, Referral and Specialized Hospitals (Muhimbili, MOI, Ocean Road Cancer Hospital, Mbeya + 3 others)
   - Allowances (for central ministry + those that are invited for training etc. ¾ of this is per diems)
   - Residual – honoraria, allowances etc. – local per diems, foreign per diems, extra duty (service above requirement – huge increase this year)



4. How much are Curative and Preventive receiving and how is it distributed?

CURATIVE SERVICES DEPT 2006/7

Item	Amount (Billions)	% (rounded)
Salaries	7.6	7%
Allowances	3.2	3%
National/Referral Hospitals	21.3	20%
NGO Hospitals	23.8	22%
Drugs & Med. Supplies	40.7	38%
Technical Equipment	5.1	5%
Others	4.2	4%
TOTAL	**105.9**	**100%**

PREVENTIVE SERVICES DEPT 2006/7

Item	Amount (Billions)	% (rounded)
Salaries	1.3	2%
Allowances	4.8	8%
Med. Supplies	36.7	61%*
Transfers (NIMR & TFNC)	8.5	14%
Others	8.5	14%
TOTAL	59.8	**100%**

* a large percentage for ARV's (PMTCT+ services)

5. Which parts of the budget pay for front-line service delivery?
   - Admin (most of the salary adjustment provision)
   - Curative Services
     - Most of the salaries and allowances (for hospital staff)
     - Subventions to national and referral hospitals (admin usually less than 5%)
     - Subventions to NGO referral hospitals
     - Subventions to DDH & VA hospitals
     - Drugs and medical supplies
     - Technical equipment
   - Preventive Services
     - Drugs and medical supplies (FP, TB, HIV)
     - Technical equipment
   - These two amount to about 70+% of the MOHSW budget

   - Most of the Human Resource Dev budget (for training institutions and running costs) – about 10 bn goes outside the Ministry
   - Most of the CMO budget (subvention to Government Chemist Lab Agency) – 2.2 bn
   - Preventive Dept (subvention to NIMR, TFNC, IHRDC) total 8.9 bn
   - Most of social welfare dept (to social welfare institutions) – about 3 bn
   - These four amount to about 15% of the total budget

How much is spent at MOHSW?

- The amount for HQ activities per se amounts roughly to 15% of the total (about 30 bn)
- Much of this is spent on training, supervision, workshops involving non-HQ staff
- And some on vehicles (2bn this year)
- Classification of the budget (especially the PE portion) makes it impossible to calculate HQ costs more accurately.

6. What sort of analysis is possible?
   - For analysis of spending in more detail, need to consult MTEF (activity costing table)
   - These figures sometimes differ from those in the final budget presented to Nat Assembly
   - Some breakdown given of the medical supplies (what kind of supplies, for which programme)
   - Some breakdown of technical equipment (what kind, for which programme)
   - Analysis of total spend by preventive programmes is possible (RCH, Malaria, HIV, TB/Lep etc) – most of this is workshops, reviewing guidelines etc.
   - Analysis of the main drugs/med supplies bill for curative services shows no detail on type / beneficiary institutions

Conclusions:

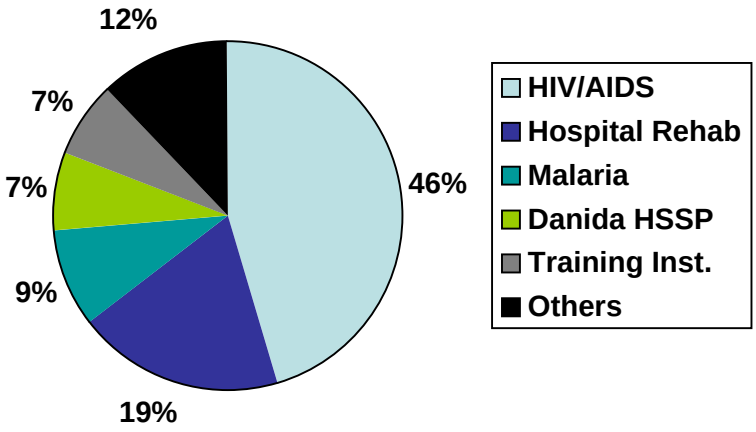
- The wood is concealed by the trees. Most of the MOHSW budget is found in 2 departments and in a handful of items.
- Teasing out who benefits from much of this central expenditure is very difficult
- It should be possible to track important changes in the "shape" of the budget by focusing on the big ticket items
- MOHSW budget seriously lacking in detail on beneficiary institutions, especially drugs/supplies and hospital PE (if national and referral hospitals were separated out we would know how much PE is for central)
- This makes it near impossible to re-classify budget into HQ overhead, Training, Tertiary, Secondary, Primary services – it is possible to do this but not in the way the budget is structured right now
- Also v. difficult to reclassify by types of service unless supplies have been specified under Preventive Services Dept

Session 4: MOHSW Development Budget

1. Overview
   - MOHSW Development Budget is about half as big as its Recurrent Budget (91 billion vs 196 billion)
   - The vast majority of the Development Budget comprises foreign (on-budget) funding (83.7 billion). Only 7.1 billion is local (government) funds
   - The foreign component is made up of basket funds (20.4 billion) and project funds (63.3 billion)
   - A vast amount of project funding is entirely missing from the development budget (about 90 billion last year)
   - If all foreign funding were included in the development budget, it would rise to nearly 200 billion – or about the same as the recurrent budget
   - Much of the foreign funding in the development budget is inaccurate (eg the books say that 73 billion is basket funding, compared with the 20 billion announced at JAHSR)
   - Better detail (and attribution by funding source) is found in the MTEF costing tables
   - Contrary to expectation, the development budget (esp. foreign components) actually pays for recurrent costs – e.g. 2 billion for contraceptive supplies + 1.8 million for malaria drugs
   - The obverse is true for the Recurrent budget – which includes capital items like cars, equipment and major rehabilitation
   - This makes it difficult to distinguish and analyse "true" recurrent and "true" capital investment

2. Structure of the budget
   - Development Budget (volume 4, Vote 52)
   - Allocated by sub-vote (same as recurrent) and project labels
   - 70 billion out of 83 billion foreign funding was allocated to curative & preventive
   - 6 out of 7 billion local funding was allocated for rehabilitation & construction at national / referral hospitals

3. What does the budget look like this year (2006/7)



Points of Interest:

- HIV/AIDS project money (41 bn) excludes >$100 million US PEPFAR money, and maybe others. All this in addition to the 20+ billion for ARVs under the Recurrent Budget
- Other programmes also under-declare project aid (eg TB/Leprosy zero)
- With exception of contraceptive supplies and 1.8 million for Malaria supplies, basket fund not used to support shrinking supplies budget
- Most of the basket fund allocated for capital investments such as rehabilitation of tertiary hospitals etc. (buildings, vehicles)
- Why does it matter if foreign funds are missing/inaccurate?
  - Ministry of Finance includes foreign development funds in its calculation of sectoral shares. Because it's a big amount, inaccuracies skew MOF's sectoral shares
  - Unless MOHSW clearly identifies parts of its costs covered by aid money, how can it allocate scarce government funds?

4. PMO-RALG Development Budget
   - Total health elements under PMO-RALG = 22.4 billion (70 million government funds)
   - 12.99 billion health infrastructure rehabilitation basket fund (for district health facilities)
   - 9.38 billion reflected as Global Fund grant for HIV/AIDS (details n/a)
   - Three quarters of next year's budget is for HIV/AIDS, Malaria, and Hospital Rehabilitation

   - Development budget is mostly foreign, often inaccurate, and often pays for recurrent costs
   - Spending is always much lower than budget (delays/under-spend)
   - Under-reporting of foreign spending

Conclusions:

- What do Basket Partners think of the proposed allocation?
- How can priority programmes bid for bigger share of basket funds?
- What further detail can be obtained on the PMO-RALG infrastructure basket?
- Development budget (local) released in "lumps" for project execution
- Procurement / implementation delays mean spending always below budget
- Most foreign funds on the budget are never captured in the government accounts. "Actuals" for aid expenditure in health not available

Session 5: Monitoring the Budget

1. At early stages
   - Lobby for greater transparency in the budget, especially medium term resource allocation intentions
   - Lobby departments as they prepare plans, estimates of requirements
   - Lobby DPs to obtain more meaningful engagement with budget formulation process
   - Lobby for key health challenges before budget guidelines are issued
   - Lobby Minister to present the case in Cabinet (maybe start with budget department, equip minister to justify a case for resources)

2. Once Budget Prepared
   - Routine annual analysis and commentary on the budget – MOHSW obliged to submit narrative semi/annual report to MOF
   - More detailed analysis of funding for key programmes (requires info not included in the budget books)
   - Formal feedback to JAHSR, MOHSW, others (MOF, Soc. Services Cttee?)

3. Key processes and documents & what they tell us
   a. Accounting and Auditing
      - Preliminary spending figures not publicly available
      - Final accounts (appropriation accounts) are public (from Accountant General). Generally little different from budget for Recurrent
      - Auditor General's report is public (18 months after year end)
   b. Public Accounts Committee
      - PAC Committee under office of the Speaker
      - Status of PAC hearings? PAC findings / minutes / report?
      - Amount of queried expenditure in health used to be more than half because money given to MSD was never accounted for to MOH and MSD was out of the Auditor General's control, hence it always looked like MOH was 'eating' money. This has now been sorted out.
   c. Public Expenditure Review
      - Post-hoc analysis of health sector spending (2006 report looks at figures up to 2004/5) – so always at least one year behind...
      - Supposed to feed into budget guidelines
      - Supervised by MOF Steering Committee (MOF PER WG- senior officials/ economists from donor agencies, this committee drafts TOR for PER consultants plus determines which sectors will conduct a PER in the year and will draft the TOR's for the sector consultants) and Sector Working Groups
      - Macro-group – Economists from General Budget Support donors – supposed to have an opinion on inter-sectoral allocations (usually same people as PER WG)
      - Health sector working group (the Technical Committee – PMORALG, donors, cso's, Chair – Head of Health Sector Reform Secretariat – CSO representative: TPHA) supposed to include CSO representation

      - A powerful, detailed analysis of what is going on in health sector funding
      - "Global analysis" of health spending from all the various elements
      - Analysis of change vs previous years (amount, US$ per capita, % of govt expenditure)
      - Analysis of composition of expenditure by department / item
      - Analysis of transfers for service delivery (including drugs & medical supplies)
      - Draws attention to key changes in the size & allocation of resources for health
      - But who is listening??

Session 6: Discussion on way forward

How do we propose to influence the budget process in future?

1. Evaluation of Health Sector
2. Engage in the new Health Strategic Plan to be drafted 2007, and see its follow-thru in the budget in subsequent years
3. Technical support to;
   - Social Services Committee
   - Other influential bodies within the Parliament
4. Following up on Audit and Public Accounts Committee
5. Upward budget formulating and planning
6. Link our advocacy with good governance activists
7. Publicize the process of budget formulation, implementation and monitoring for greater transparency. Publicize documents such as budget books, draft guidelines for General Budget Support donors (GBS) with key areas of concern etc.
8. Focus on Impact-Oriented Resource planning

9. Work with departments to come up with good budgets e.g. for the ROADMAP and support them to receive the resources needed
10. Review and comment on MTEF but at an early stage: Jan –Feb to influence it before Joint Annual Health Sector Review
    - Priorities
    - Dept allocations
11. Get Social Service Committee Members to Annual Review (like in Uganda)
12. Enhance "challenge function"
    - of government
    - of Media
13. Track "SHAPE" of the budget; the forest not the trees
14. Agree and design a new classification system (MoF) to make budgets more transparent and useful
15. Lobby for a tool like Burden of Disease (TEHIP) at Central level for priority setting and impact tracking
16. Track allocation to Allowances, Honoraria, Vehicles for increases ----and/ against salary wage bill
17. Find out what is the increase in Tshs 6.4bn to 17.0bn in salaries is it for
    - More money to existing health workers
    - New posted Health workers
18. Question why the Ministry of Health basket is being used for capital expenses?
19. Find out how the Tshs. 12.99 bn in PMO-RALG Development budget for rehabilitation of district health facilities (basket fund resources) will be spent
20. Ask basket donors their views on use of basket money for capital expenditure
21. Work with donors to create a series of meetings each year that analyses priorities and allocations.
22. Lobby and support Minister to present a strong case for more resources to cabinet to raise the Health sector ceiling
23. Analyze budget on an annual basis creating a commentary
    - Variables, formats include analysis of key programs
    - Feed information to various audiences (MPs, Media CSO)
25. PER Document
    - Add analysis of current years budget
    - Speed up process so PER is on previous year, not 2 years ago
    - See if/ how it feeds into the new budget guidelines
    - Use it in advocacy
    - Popularize/ simplify and get it out

Session 7: Short Evaluation

Participants Objectives and Attainment Ratings (average: 3.12):

1 – Not met, 4 – Completely met

- Have a better understanding of how MOHSW budget is constructed (4)
- How MOHSW budget information can be used to trace allocations + uses- if at all (3)
- How MOHSW money fits as a part of all money to Health in the country (3)
- Enable me to understand and engage effectively in ward and district budgeting (2)
- To know how the budgeting process are (3)
- Informed about different points of accessing information about the budget in the health sector (3)
- Became aware about different levels of information (3)
- Implications of 2006/7 budget to maternal health services (4)
- How we can influence the decision makers in future budget process (3)
- Sharpen analysis of health budgeting in terms of process and content (3.5)
- See how to identify % resources that reach end user (3)
- Get acquainted with the health budgeting system of Tanzania (4)
- Review the current health sector financing and how it does address priority health equity priorities (2)

- Tracking and monitoring of Health Budget in Tanzania (2)
- Clearly identify entry points to engage (3)
- Obtain a clear understanding of the budget cycle and monitoring processes (4)
- To understand construction of national budget (e.g. government funding/donor etc.) (4)
- To build collective sense of where can engage to influence budget design to be more impact oriented (3)

The session in general was deemed to be very useful. Participants obtained a good understanding of the budgeting process and it is something that should definitely be done for a wider audience. One challenge viewed was that not everyone in the room started with knowing the terminology and definitions, i.e. 'budget talk' so some people who were entirely new found it difficult in the beginning but then caught on.

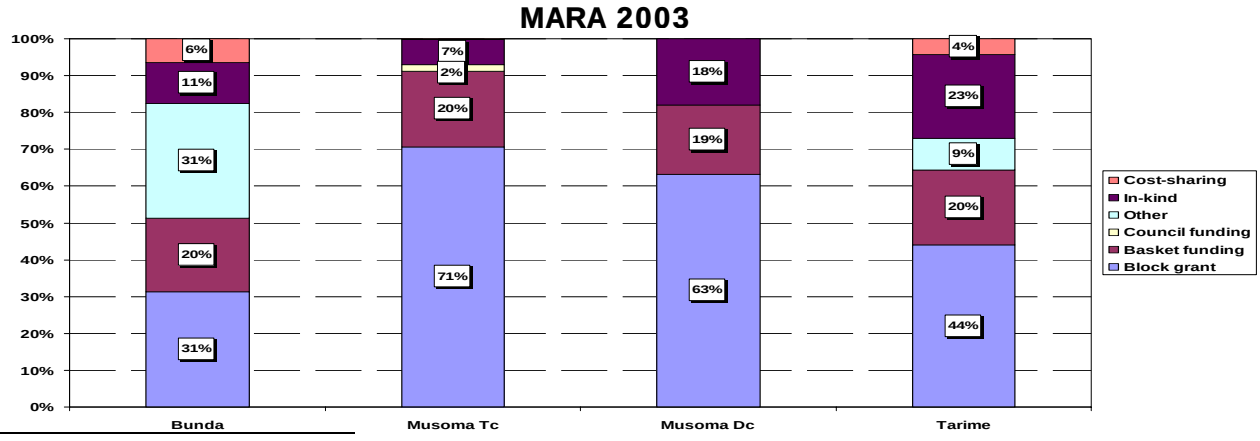
Session 2:[4]

Time	Session
09.00 - 09.15	Introductions & Objectives
09.15 - 10.30	Financing the health sector at LGA (district) level
10.30 - 11.00	Tea Break
11.00 - 12.30	More on the Major Funding Sources for CCHP's
12.30 - 13.30	Lunch Break
13.30 - 15.00	The district (health) budget cycle
15.00 - 16.00	Monitoring district health spending
16.00 - 16.15	Evaluation
16.15 - 17.00	HeqG Meeting (For HeqG members)

Session 1: Financing the health sector at LGA (district) level – an overview

1. Where does the money come from?
    a. On-budget sources
        i. Recurrent
            • Block grant (PE and OC)
            • Health basket funds
            • Medical supplies in-kind transfer (to Medical Stores Dept)
            • (Councils' own resources)
        ii. Development
            • Local Government Capital Development Grant, LGCDG (Domestic resource but may be supplemented with the Local Government Reform Programme (LGRP))
            • Health basket PHC rehabilitation funds
            • (Councils' own resources)
    b. Off-budget sources
        i. Cost Sharing
            • User Fees
            • Community Health Fund
            • Drug Revolving Fund
            • National Health Insurance Fund reimbursements to the facility
        ii. Other off-budget contributions
            • Official aid money not captured in development budget
            • NGO funding, faith-based organizations, churches etc.

2. How does it all add up?
    - We don't know at the moment… no central level aggregation of individual CCHP's to date (can be done but no one is doing this right now)
    - Should be easier with PlanRep in the future
        - Aggregation at regional and national level
        - Expected from this year (LGRP)
    - But there is a huge variation in sources of funding for each council

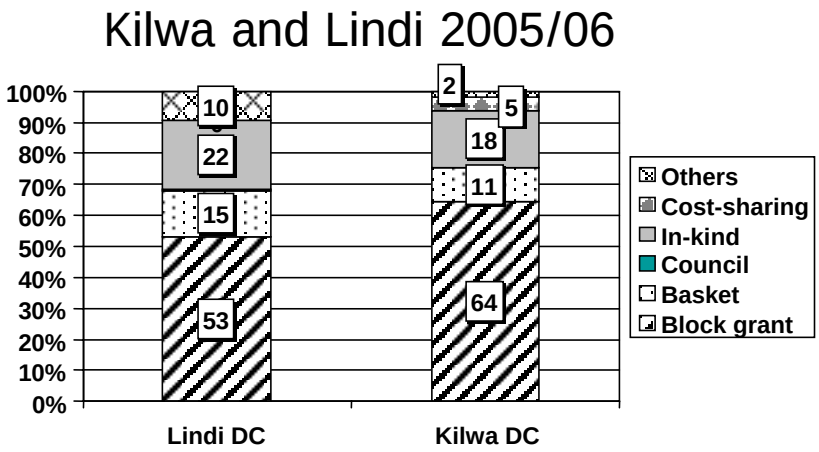


[4] See Annex IV for power point presentation slides

Above: "other" includes FBO, DP funding, NGO funding, TACAIDS etc.,
"In-kind" – MSD allocation for drugs and supplies,
"Council funding" – very small. There is the impression that health receives many transfers from central (quite small actually)

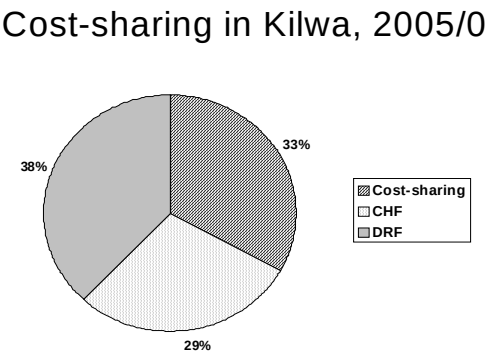
Aside: GPG – General Purpose Grant was established when nuisance tax was abolished. The grant was to enable councils to meet admin costs so that locally generated funds spent on local development.

Major funding sources are: health basket fund, block grant and MSD allocations (in-kind). Drug spending is a black hole in the Ministry. Now access to information getting more flexible… can be used to reflect burden of disease.

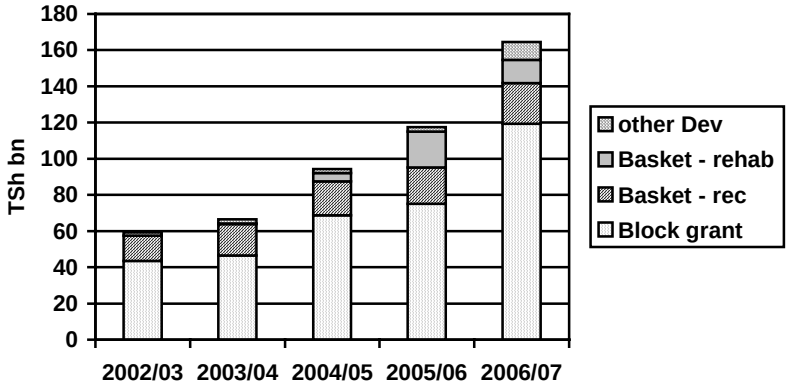


Data taken from www.districthealthservice.com

Cost-sharing at the LGA level includes a variety of schemes, not all well disaggregated within council plans

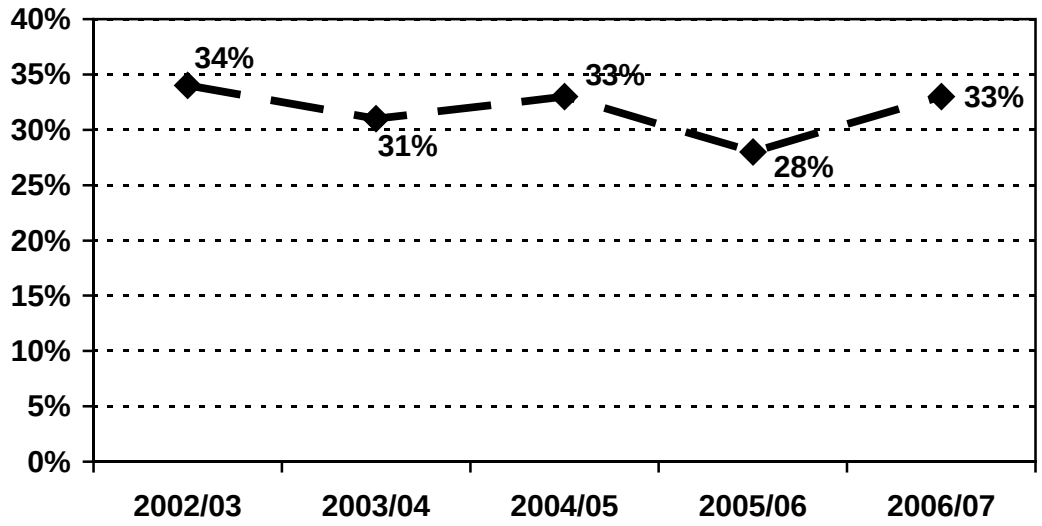


3. Recent trends in on-budget allocations to LGAs



"Other Dev" includes LGCDG and others, it is entirely discretionary and mostly utilized in rehabilitation.
"Basket-recurrent" has guidelines and ceiling but councils have the decision on how to spend it plus councils can be exempt from ceilings if follow the rules for three years.
"Block grant" has increased due to increase in wage bill. Council have the decision on how to split this between OC and PE but must meet PE requirements of the Council.

FY2002/03 to 200506 taken from Health sector PER update for FY06, while figures for 2006/07 are taken from budget guidelines for everything except Basket rehabilitation which is taken from Health Equity Group's Budget analysis (there are some differences in the figures, which should therefore be treated with caution).



Includes only the four main sources (block grant, basket – rec, basket – rehab and other development (estimated for FY07), and uses the on-budget sector total as the denominator.

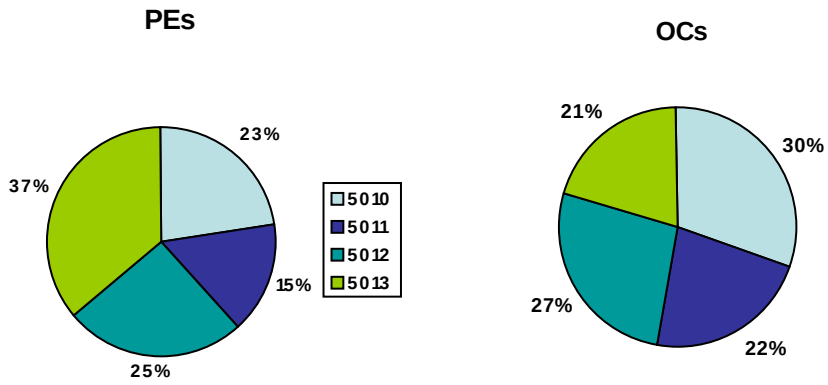
Session 2: More on the Major Funding Sources for CCHP's

1. Block Grant
    a. Allocated between LGAs according to a weighted capitation formula (since 2004)
        i. Population 70%
        ii. Poverty headcount 10% (absolute number of poor people as defined by the Household Budget Survey)
        iii. Under-five mortality 10%
            1. Regional figures
            2. Proxy for health need
        iv. Distance covered for routine tasks 10%
            1. Proxy for increased costs of rural health service delivery
    b. Covers both Personal Emoluments and Other Charges
        i. LGA decides upon the distribution between these categories,
        ii. However must meet PE requirements in the district, hence if you are overstaffed, squeeze on your envelope for OC because PE is high
        iii. PE – combination of locally employed and centrally posted
    c. 4 sub-votes (as per Volume III detailed appendix)
        i. 5010 – Health Services (Council Hospital) – When regional hospital, or a mission hospital is identified as a District Designated Hospital (DDH), this value may be zero.
        ii. 5011 – Preventive Services (CHMT and Programmes)
        iii. 5012 – Health Centres
        iv. 5013 – Dispensaries
    d. The total value of the block grant for all LGA's in the region is included as transfer under regional votes (Vol II of the Budget Books/ Estimates)

e. Detailed budget breakdown for all LGA's in Volume III Detailed Appendix of the Annual Estimates (available on www.parliament.go.tz for last year)
f. Listed according to item and sub-item (therefore no idea of activities until CCHP's are viewed)
g. Where did the block grant go (by sub-vote) in 2005/6?

Tsh Bn	PE	OC	Total	%
5010 Health Services	10.98	8.31	19.29	25.7
5011 Preventive Services	7.41	5.94	13.35	17.8
5012 Health Centres	12.15	7.25	19.39	25.8
5013 Dispensaries	17.43	5.61	23.05	30.7
Total	47.98	27.10	75.08	
%	63.9	36.1		

h. Share by sub-vote, 2005/6



2. Basket Fund
   a. US$ 0.50 per capita, allocated according to the same formula
      i. Increase to US$ 1.00 pc under discussion
   b. Covers OC only
   c. Allocated between 6 cost centres
      i. CHMT/Office of the DMO
      ii. Council hospital (regional hospital where it serves as a district hospital)
      iii. Voluntary Agency Hospitals (where appropriate) (evenly split between all VA's, can include DDH)
      iv. Health Centres (public and VA)
      v. Dispensaries (public and VA)
      vi. Community (includes Council Health Service Boards (CHSB), Health Facility Governing Committee, TBA activities, Community Based Distribution Agents, Participatory Planning Processes, Community IMCI etc.)
   d. HBF Allocation Ceilings

In circumstances, councils can apply for exemptions, if council adheres to these for 3 years, conditions an be removed (CCHP guidelines)

Cost centre	Allocation
Office of DMO	15% - 20%
Council Hospital*	25% - 35%
Voluntary Agency	10% - 15%
Health centres	15% - 20%
Dispensaries	15% - 20%
Communities	5% - 10%

e. Additional HBF Conditions

Item / activity	Ceiling / range
Allowances for supervision and distribution	Max 25%
Fuel for supervision and distribution, and vehicle maintenance (Transport)	Max 20%
Minor repairs and maintenance of health facilities	10 - 20%
Motor vehicles, large equipment	Not allowed
Drugs and minor equipment	If out of stock at MSD

3. MSD Transfers
    a. Included under MOHSW headquarters vote
        i. largely Dept of Hospital Services, some under Preventive
    b. Transferred to MSD on behalf of LGA
        i. For HC and dispensaries, based on number of kits or equivalent per facility amount for those LGAs on indent system
        ii. For hospitals, allocation criteria are not clear
    c. Study ongoing to track spending on drugs and supplies, and to consider possibility of allocating 20% of this transfer to LGAs

4. Joint Rehabilitation Fund
    a. Basket funded, with some GOT contribution
    b. Allocated in order of priority according to poverty rating and need (for rehab)
    c. Plan of works and equipment to be produced by relevant health facility committee, presented to Village council, forwarded through Ward Development Committee, to the council Health Committee for inclusion in CCHP
    d. 25% of facilities in a council included, at TSh14m per dispensary and TSh 52m per health centre
    e. Community contribution of 15% required (in cash or kind)
    f. To be harmonised with LGCDG in future

5. Development Funding
    a. Only local funding included in official budget (Volume 4, detailed appendix)
    b. Historically has supported rehabilitation of dispensaries, HC, and district hospitals
    c. Now incorporated in LG CDG or LGDG
        i. Which one depends on whether LGA meets performance criteria
    d. 80% of CDG expected to fund core sector activities of which Health is one (15% ceiling?)

6. Cost-sharing Resources
    a. CCHP guidelines stipulate use of funds at the facilities where they are generated
    b. CCHP supposed to include estimate for planning purposes
        i. Practice appears variable
    c. Often combines revenues from different schemes
        i. Difficult to monitor impact of a particular scheme

7. Cost-sharing Schemes
    a. Health Service Fund
        i. User fees at hospital level
        ii. In place since mid-90's, in all public hospitals
        iii. Guidelines for allocation (no detailed reporting at central level)
        iv. Revenues used for service delivery at hospital level

b. Community Health Fund
    i. Used to be World Bank funded, now Basket
    ii. Not yet national coverage (68 councils at end 2005)
    iii. 3 sources of funds
        1. Membership premia
        2. User fees at council facilities for those not joining
        3. Matching grant (equaling membership premia) from Basket funds (when doing budget analysis, beware of double counting as this value appears at national level)

c. Drug Revolving Fund
    i. For drugs and medical supplies at hospital level
    ii. Reasonably widespread
    iii. Used to supplement funding for drugs and medical supplies (50% cost recovery)
    iv. Where does this money come from??

d. National Health Insurance Fund
    i. Reimbursement of claims by accredited health facilities
    ii. Net addition at the LGA level, but not in terms of national resource envelope (transfer NHIF – LGA)
    iii. Major problems in accessing the funds

For more detailed analysis of the planned allocation of funding within the council need to consult the Comprehensive Council Health Plan (CCHP) - parallel with the need to consult the MTEF for details of the central level allocations.

Session 3: The district (health) budget cycle

Fnancial year of central and district harmonized since July 2004

1. Stages in the budget cycle (LGA)

What happens?	By when?
Receipt of ceilings	End Nov
Identification of needs, setting of priorities	Mid Dec
Formulation of the plan and budget	Mid-March
Scrutiny and approval of the budget	End April
Budget implementation	July - June
Reporting on plan and budget implementation	Quarterly
Audit	Annually

2. Notification of Budget Ceilings
    a. For main sources of funding, LGAs receive ceilings rather than proposing requirements
    b. Guidelines emphasise active role of council in chasing ceilings from all partners
    c. Ceilings are already determined by sector, so no bidding between departments at council level, however councils own resources and development budget are open for bidding.

3. Identification of Priorities
    a. LG Budget Guidelines refer to *"a participatory planning process from the grassroots level to the District level"*
    b. CCHP Guideline: *"CHMT collect priorities/needs from hospitals, health centre, dispensaries community level and other stakeholders to accommodate them in the CCHP"*
    c. Use of tools such as Opportunities + Obstacles to Development, triple A, community dialogue, PRA etc is recommended, but no details are given
    d. Time set for consultations too short

e. Priority-setting: possible entry points
    i. Pre-planning meetings (CCHP guidelines stresses need for such meetings to ensure ownership and involvement by all stakeholders)
    ii. Council Health Planning Team membership (Guidelines explicitly include representatives of NGOs, faith-based providers, private sector) – DMO is the head of this team – RCHS coordinator could be a co-opted member but not required to be a part of the team.

4. Plan and budget formulation
    a. CHPT sits to pull together the draft CCHP
        i. Guidelines stipulate format
    b. Priority problems – possible tools to use include
        i. EHP (list of interventions)
        ii. Burden of disease profile (TEHIP district health accounting tool, highlights 7 most cost-effective interventions)
        iii. Council performance indicators
        iv. MKUKUTA cluster 2 targets
        v. Millennium Development Goals
    c. Where there is a Council Health Service Board, they should be involved in evaluation and approval of CCHP
    d. Sector Budgets (recurrent and development) drawn from the CCHP
    e. Both CCHP and budgets integrated into the Council Budget (through PlanRep)

5. Scrutiny and Approval
    a. Draft CCHP submitted to Regional Secretariat
        i. Check for conformity with national guidelines, regulations, policies and directives
        ii. Comments in writing back to Council Director by the end of March
        iii. Amendments through Finance Committee of the Council
    b. Approval of Council plan and budget (including CCHP) through Full Council meeting (1st week of April)
    c. LG BG: date of Full Council meeting to be publicised widely to enable broad attendance
    d. Following approval:
        i. RS combines approved council budget, submits to PMO-RALG
        ii. PMO-RALG consolidate for all Regions and submit to Ministry of Finance (by end April)

6. Budget implementation
    a. Approved budget is on PlanRep, and uses EPICOR coding system for strategies and GFS coding for items
    b. Release of funds depends on source
        i. Block grant – automatic, quarterly
        ii. Basket Funding – quarterly, based on previous performance and availability of satisfactory plans/budgets or reports
        iii. Rehabilitation funds – dependent on progress (40%, 30%, 30% with 2nd and 3rd dependent on spending of at least 70% of previous tranche)
        iv. MSD – quarterly transfer from MOHSW, drawdown depends on council Possible entry points
7. Reporting
    a. Technical and financial reports produced each quarter
        i. Council Director is the overall Accounting Officer for the LGA
        ii. DMO responsible (with CHMT) for preparation of quarterly technical reports on implementation of CCHP and submission to MOHSW and PMO-RALG
        iii. Council Treasurer is overall in charge of Council financial department, and responsible for preparation of financial reports
            1. Informs DMO of receipt of funds
            2. Reports monthly to Finance Committee on financial performance
            3. Reviews financial reports for correctness and compliance
    b. Timeframe

i. Councils produce quarterly reports 4 weeks after end of each quarter
ii. Submitted to Regional Secretariat for review and summary
iii. Submitted up to MOHSW and PMO-RALG 2 weeks after council deadline, ie 6 weeks after end of quarter

c. Basket Finance Committee
i. Two sittings per year
1. June for approval of CCHP, triggering release of Q1 and Q2 funds
2. Nov for review of previous year TFIR, triggering Q3 and Q4 funds
ii. Members: PS of PMO-RALG and PS MOHSW
iii. Relevant staff of the two Ministries
iv. Basket development partners

8. Audit
a. According to regular government procedures
b. Undertaken by National Audit Office or appointed auditor
c. Concerns brought before Local Authorities Accounts Committee rather than PAC
9. Core documents
a. PMO-RALG Local Government Budget guidelines
i. Updated annually
ii. Useful summary of on-budget funding, processes, and conditions
iii. Can be downloaded from the web
b. MOHSW / PMO-RALG Comprehensive Council Health Planning guideline
i. Updated periodically (currently under revision)
ii. Includes all sources of funding
iii. Details of health-specific processes and conditions
iv. Available from MOHSW or PMO-RALG, and possibly also through web eventually (www.districthealthservice.com)
10. Possible entry points
a. Plan and Budget Formulation
i. Potential entry point through CHPT to stress maternal and child health issues
ii. LG BG refer to Council Committee meeting in which stakeholders and civil society organisations participate in the drafting
b. Scrutiny and Approval
i. Local MP is a member of the Finance Committee in the LGA in which s/he is based, therefore potential for lobbying at the revision stage
ii. MP again should be present at the Full Council meeting; other stakeholders also able to attend "to listen to the targets and intentions of the Council"
c. Budget Implementation
i. LG BG indicate that all stakeholders should receive copies of the approved plan and budget
ii. Also that these should be posted in public places, and extracts posted at ward, villages and *mitaa* in an accessible format
iii. Increased awareness of contents can facilitate improved monitoring and accountability

Session 4: Monitoring district health spending

1. Reports on LGA Activity
a. Central level
i. Technical Financial and Implementation Report (TFIR) is done at MOHSW level – uses the same format as the MTEF to report however MTEF coding is not always followed and some activities may be left out. The report is not very detailed and includes some reporting on centrally funded council activities
ii. MOHSW Appropriation Accounts includes Health Service Fund information (i.e. user fees at hospital level. The annex of these accounts provides information on user fees hospital by hospital.
b. LGA level - Quarterly Technical (Physical) and Financial Implementation Reports from each Council
i. 4th TFIR reports on cumulative annual spending – equivalent to annual report
ii. Presented to CHSB, Finance Committee, Full Council
iii. Forwarded to RS for compliance check and preparation of regional summary

iv. Forwarded to PMO-RALG and to MOHSW

c. No Narrative report to link these to impact priorities

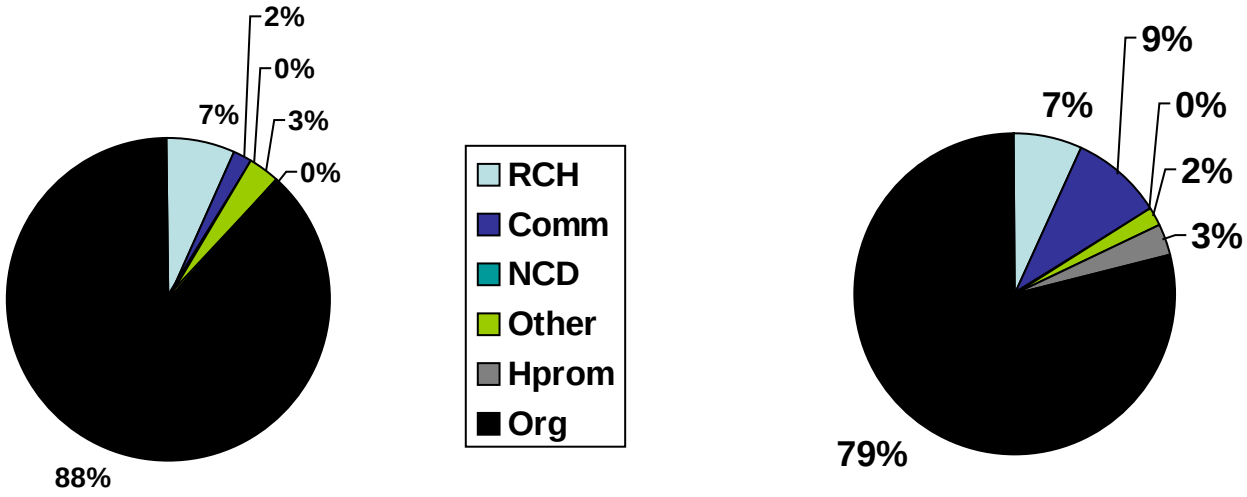
2. Analysis of the CCHP (should include "off-budget" funds)
   a. Analysis of budgetary intent
   b. Allocation of funds
      i. By source, within the total resource envelope
         1. Domestic/Foreign
         2. Discretionary/earmarked
         3. Central transfers / local resources
         4. "public" / cost-sharing
      ii. By level of the health system
         1. The 6 levels indicated for basket funding, which are also used for all sources
      iii. Between EHP areas
         1. Organisation of technical areas (ie EHP priority areas 1 – 6)
         2. By individual EHP area

- Categorization of activities may not be true to the priority area

- Main problem is the allocation of the shared costs, eg the human resources, the drugs and supplies that come through MSD. These are budgeted in full under organisation.

- In this example, the use of cost sharing resources is also budgeted under this line. This may be due to general purchase of drugs and supplies with CHF and DRF funding, or spending on activities which cannot be attributed to one or other EHP priority area. Would need to see all of the CCHPs to determine whether this is the case throughout.

Priority area	Kilwa DC	Lindi DC
RCH	62.64	61.62
Communicable	21.58	82.31
Non-Communic.	0	3.00
Other diseases	27.72	21.98
Health Promotion	1.38	26.42
Organisation	833.13	739.29
TOTAL	***946.45***	***934.63***



Up to now, these can only be done by reviewing individual CCHPs, therefore a consolidated picture for the country as a whole, or even the region as a whole is difficult to obtain.

3. Analysis from Quarter 4 Technical Financial and Implementation Report (Annual Report)
    a. Analysis of *effective* priorities can be done, i.e. spending decisions will reflect priorities. Similar to those for CCHP, plus,
        i. Analysis of actual income compared with projections
        ii. Actual expenditure in comparison to budget

    -But

        iii. Format makes it harder to extract useful information (at present, PlanRep (LGRP program: www.poralg.go.tz - there's a link to this website from the MOF website too) should simplify things)
        iv. Focus in Accounts summary on cost items rather than EHP areas or interventions

4. Health Sector Accounting Forms

	Current Qtr	**Cumulative**	**Budget YTD**
Cash Book BF			
Block grants			
Basket fund			
Council fund			
Cost-sharing			
In-kind			
JRF			
Others			
Total rec'd			
Total available			

YTD = Year to Date

	Current Qtr	**Cumulative**	**Budget YTD**
Council HD			
Council Hosp			
VA Hospital			
Health centre			
Dispensary			
Community			
Total payments			
Cash book CF			

5. Concerns
    a. The large share to Organisation doesn't give a true picture of allocation to priority areas
    b. Variation in council capacity to plan and report accurately
    c. No real idea of who benefits from the spending
    d. No apparent process for popular monitoring of progress or finance
    e. Large sums of unused resources for drugs and supplies remain at MSD and these are unavailable when people visit facilities.

6. National Level Linkage
    a. PER supposed to indicate:

i. Aggregate LGA health spend as % of total LGA spend
ii. More detail on the transfers to LGAs (eg volume of MSD transfers)
iii. Cost-sharing aggregates
iv. At present analysis limited to national level data (block grant by subvote, PE:OC or specific sub-items; and basket in totality)
v. In future could include more detailed analysis using PlanRep database (possibly)

b. The poor quality and incomplete set of CCHPs and TFIRs at national level has precluded analysis of council spending in depth
c. PlanRep appears to offer potential for more detailed analysis of council spending BUT still won't answer questions about who benefits? What % reaches the end user? Would need specific tracking studies for this. (e.g. REPOA/ESRF in 2001?)

To familiarize the group with the district health plans, the consultant was asked to prepare a case study which uses information from several Comprehensive Council Health Plans in order to demonstrate some of the analyses that are possible with the CCHP, and to illustrate some potential differences in content. (**Annex V** – Comprehensive Council Health Plan Case Study)

Session 5: Short Evaluation

Participants Objectives and Attainment Ratings (average: 2.62)

1 – Not met, 4 – Completely met

- Learn the thru-flow of district level planning processes (2)
- Identify the composition of district budgets, their sources and conditionality (3)
- Informed about the process of the budget at the district level (3) (3) (2) (3)
- Main actors involved and the point of entry (3)
- To get acquainted with district level budgeting process and how it is encouraged/discouraged by central level budgeting (3)
- Understanding the district budgeting cycle (3)
- To understand the content of the CCHP budget (3)
- To see where and how we can engage with the guidelines/content to lobby for impact-oriented budgeting (3)
- Learn about how district budget can be effectively monitored and evaluated (3)
- Understand what funds get to the district level and from where (3)
- Understand how these funds are divided up and potentially used (3)
- Understand what discretion district authorities have with funds (2)
- Better understanding of the relationship between national and district funds (2)
- Enable understanding of how we can engage people at village, ward and district level in budget planning and monitoring (1) (3)
- To understand how to track resources used (1)
- To understand where to get CCHP and how it is drafted (3)
- Learning the connectivity of national engagement with the district level budgeting (3)
- Learning initiatives of Health Equity Members in Budget Tracking/Engagement (4)

Funding Flows – National and District Level (Sally Lake)

Task: A fairly simple diagram of the budget process – who is involved and how and major budget flows (national and other sources – down to budget district and facilities).

Notes:
In terms of the major budget flows, there are three main challenges.

- Firstly, basket funds are officially development, yet are recorded within (some but not all) GOT documents as recurrent – hence the need to be clear on where they feature in the diagram.
- Secondly, the flows relate to the budgetary relationships, rather than the physical flows of funds. For example, Basket funds for the MOHSW go into a special account with BOT rather than to the MOHSW, and (as far as I am aware) withdrawals go to either PMO-RALG or to MOHSW. For on-budget flows, these are shown in relation to capture within the relevant Ministry, Region or agency budget.
- Thirdly, the number of different flows, particularly when off-budget sources are considered.

5 diagrams are presented. The first four split the budget into – national/sub-national and recurrent/development. The last diagram attempts to combine the four into one picture.

1. National/central level
Flows into the MOF/Treasury (very simplified and not distinguished in the diagrams)

1.1 National - recurrent
There are two principal sources of income to government which are then transferred on through the recurrent budget:
- Domestic taxes and duties, largely through the Tanzania Revenue Authority (black line into MOF)
- General budget support from bilateral and multilateral partners (red line into MOF)

The diagram shows only the government (GOT) recurrent budget, with flows from Ministry of Finance/Treasury:
- Official Health sector allocations here budgeted under Vote 52 Ministry of Health and Social Welfare; and the allocation to Vote 23 Accountant General's Department to cover the government contribution to the National Health Insurance Fund (green lines)

Transfers of funds from these two Votes are shown by dotted green lines:
- Transfers/subventions from MOHSW to National, referral and special hospitals, under the Department of Hospital Services subvote
- Transfers to National Institute for Medical Research and to the Tanzania Food and Nutrition Centre under the Department of Preventive Services
- The allocations of GOT funds to Medical Stores Department on behalf of councils and health institutions at all levels for the procurement and distribution of drugs and medical supplies
- The transfer of the GOT contribution to NHIF from the Accountant General's Department (Sub-item 250503).

In addition, the reimbursement of claims by NHIF from national, referral and special hospitals is shown on this diagram as an orange line[5].

1.2 National - Development
Five principal sources of income to the sector are reflected here:
- Domestic taxes and duties (black line into MOF)
- General budget support (red line in to MOF)
- Sector budget support, through basket funding (purple line into MOHSW and PMO-RALG)
- Other foreign assistance through the budget (yellow line into MOHSW and PMO-RALG)
- Off-budget foreign spending (gold dashed line into MOHSW)[6]

[5] Note: it is also shown on diagram 2.1 Local – recurrent.

Domestic taxes and duties and GBS combine to fund "local" development budgets, along with some on-budget foreign assistance that is non-health sector specific and therefore not shown here explicitly (can be considered as incorporated within the other GBS or other foreign assistance – for example, support to the Local Government support Programme which co-funds the Local Government Capital Development Grant, part of which may be spent on Health at council level).

Please note: as made clear in the presentations, in some areas, the distinction between recurrent and development is currently artificial. All foreign funding is treated within these diagrams (at the national level) as development, yet much of it ultimately supports recurrent items (eg drugs, allowances, transport running costs etc), as will be seen below.

Major flows are:

- GOT (local) development funding to both MOHSW and to PMO-RALG (blue lines)
- MOHSW development spending on national, regional and referral hospitals and on NIMR (dashed blue line)
- Basket development funding on major hospitals and NIMR (purple dashed line)
- Other on-budget development funding on major hospitals (yellow dashed line)
- Basket and other on-budget foreign funding for NHIF (purple and yellow dashed lines respectively)
- Other on-budget foreign funding to MSD (yellow dashed line)

Much of the off-budget foreign funding remains within MOHSW as it is funding to technical programmes such as RCH, malaria, AIDS, and TB-Leprosy. This is a grey area which needs more exploration, not least as it also impacts on council budgets.

2. Local level, i.e. regional and council

2.1 Recurrent

Local is primarily interpreted to mean the sub-national level, including both Region and Council levels. Recurrent includes both on-budget and off-budget, i.e. cost-sharing, as it appears in the CCHP and is primarily, though not exclusively, targeted at recurrent expenditure items (again, supplementing drugs budgets, paying for fuel).

The boxes at the Regional and Council level refer to the administrative level itself, i.e. the Regional Vote, and the individual LGA. Facilities within the jurisdiction are shown as ovals within boxes. This is another potential source of confusion as some of the ovals represent sub-votes, but others don't. Arrows to an oval indicate that funding goes right to that level (or should). Arrows to the box imply that funding goes to the council.

It is important to note that basket funding to councils, via PMO-RALG, is shown on this diagram, ie as recurrent, even though it is reflected on Diagram 1.2 as Development. This can be changed if necessary, but reflects how it is treated within the Comprehensive Council Health Plan.

"Downward" flows, i.e. from central/national level, shown on this diagram are the following:

- GOT recurrent allocations to two sub-votes within each Regional vote: 3001 Curative services (for the regional hospital) and 3002 Preventive services (green lines).
- The GOT health block grant, from MOF to council, and allocated within the council to four sub-votes (5010 health services, 5011 Preventive services, 5012 Health centres and 5013 Dispensaries) (green line, dashed once it enters the boxes at each level)
- MOHSW transfers to Designated District hospitals (under the Hospital Services sub-vote) (green dotted line)
- Transfers in kind from Medical Stores Department to Regional hospitals, to Councils (and facilities within councils), and to Designated District Hospitals (dark green dashed line)
- Reimbursements of claims from National Health Insurance Fund to Regional Hospitals, DDHs, and council health facilities (orange line).

[6] It is likely that there is direct off-budget support to NIMR and to national and special hospitals but I am not sure of this and have not therefore included it.

In addition, there are "upward" flows, from the people, into the health system. These are:

- User fees to primary health facilities, and Community Health Fund membership fees to councils – all under the CHF scheme (pink hollow line).
- User contributions to the Hospital Service Fund and Drug Revolving Fund at government hospitals (purple hollow line).

Note: user charges at DDHs have not been included as I am not sure of the extent to which these can be considered as "council" revenues. User contributions to public facilities are used within the public system.

2.2 Local – Development

At this level, the major flows are as follows:

- Local GOT development funds direct from MOF to Regions and councils (blue lines, dashed inside the boxes to reflect transfer/spending on individual facilities)
- MOHSW basket funding to councils for the CHF matching grant[7]
- PMO-RALG (Joint Rehabilitation Fund) transfers to councils (purple line, dashed within the box as it is assigned to specific facilities)
- Other (non-basket) on-budget foreign development funding for Regions (yellow line)[8]
- Off-budget foreign flows to all levels and institutions (gold dashed line).

Note: what is not included in any of these diagrams are a number of minor flows, e.g. local development funds from MOHSW to national training institutions, and to the Tanzania Food and Drug Authority, etc.

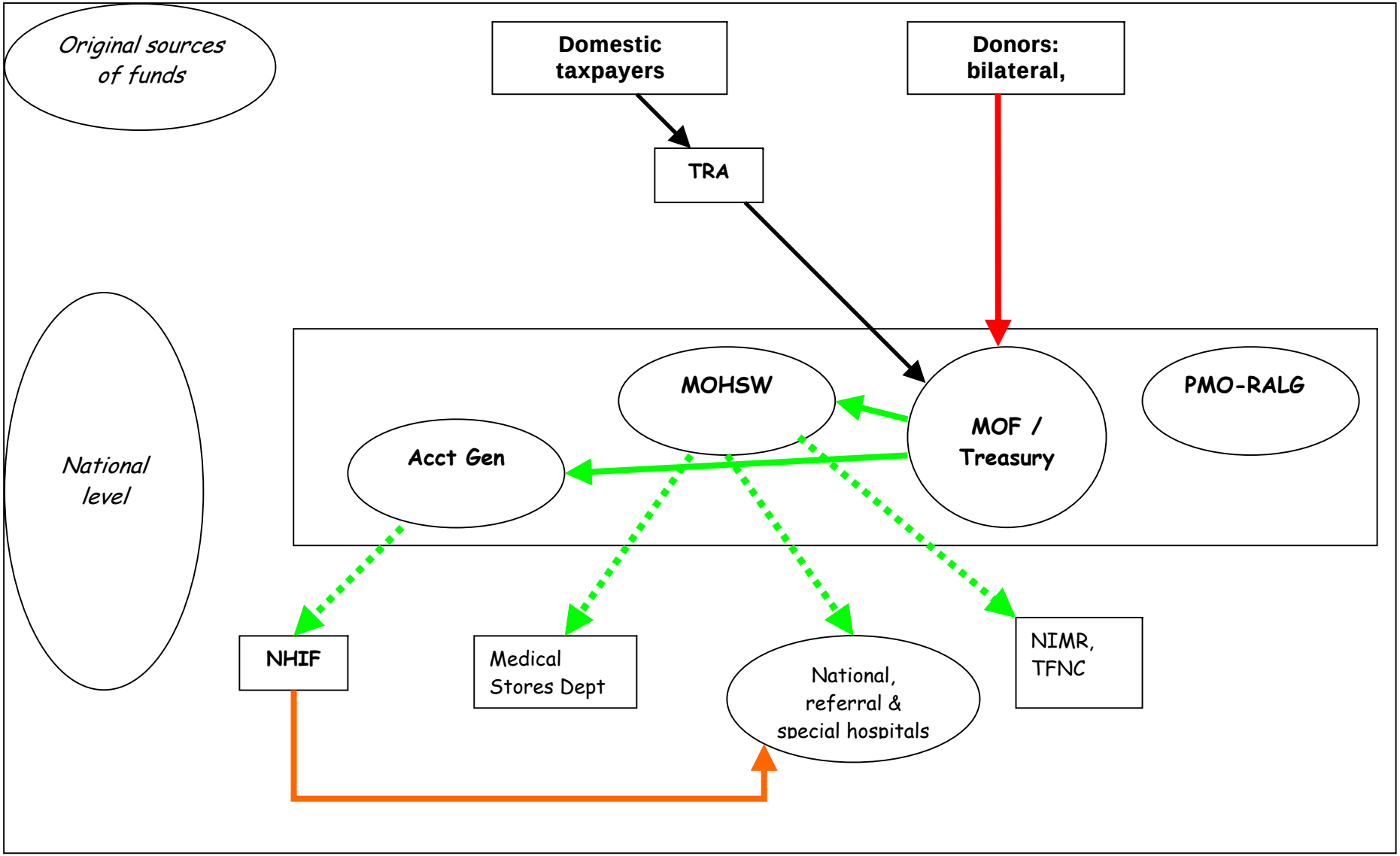
[7] This could also be considered as recurrent, in the same way as the main council basket funding.

[8] This includes UNICEF funding for Child Survival Development and Protection, which is sometimes, but not always, included under Health sub-votes.

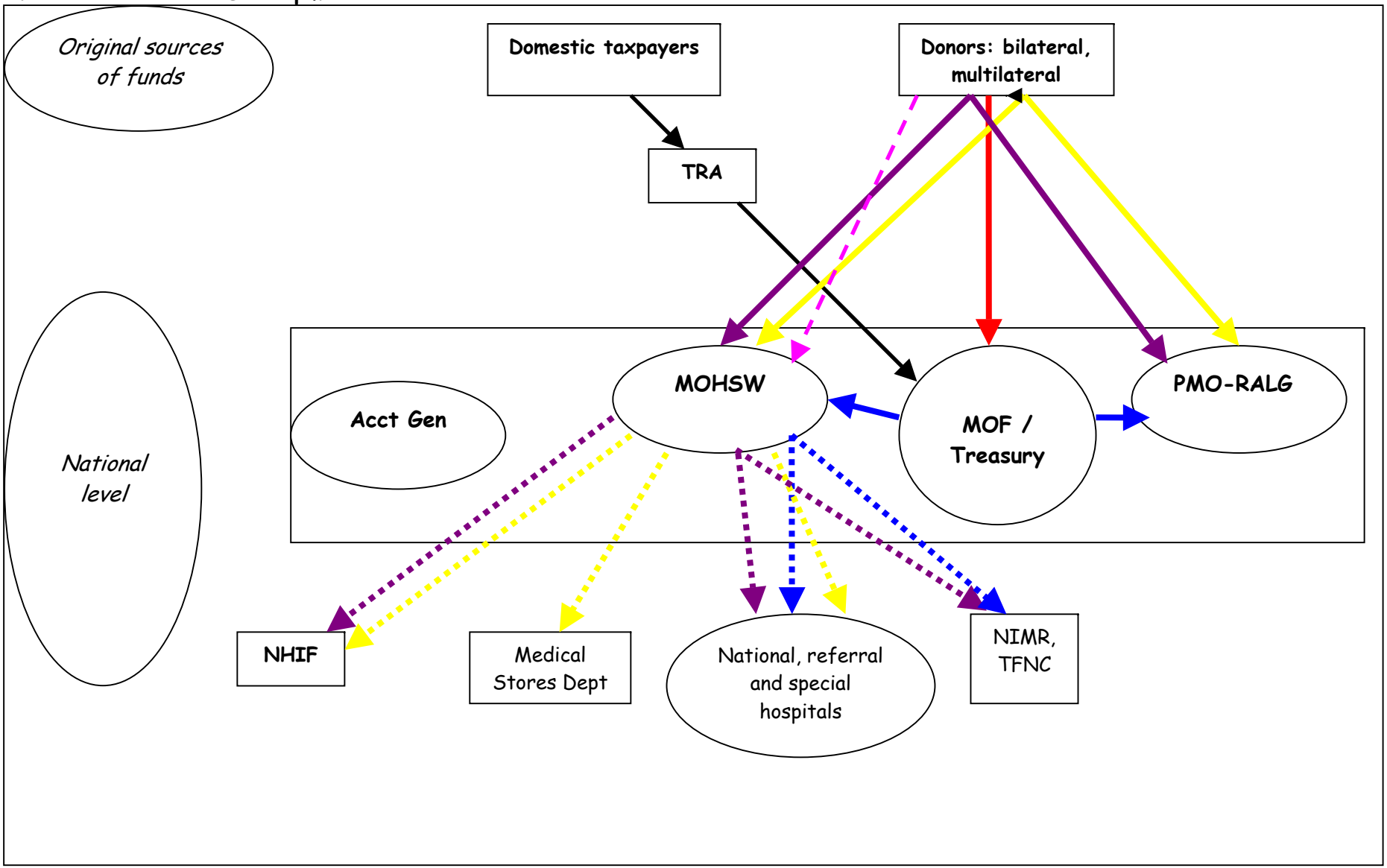
Key to different funding flows

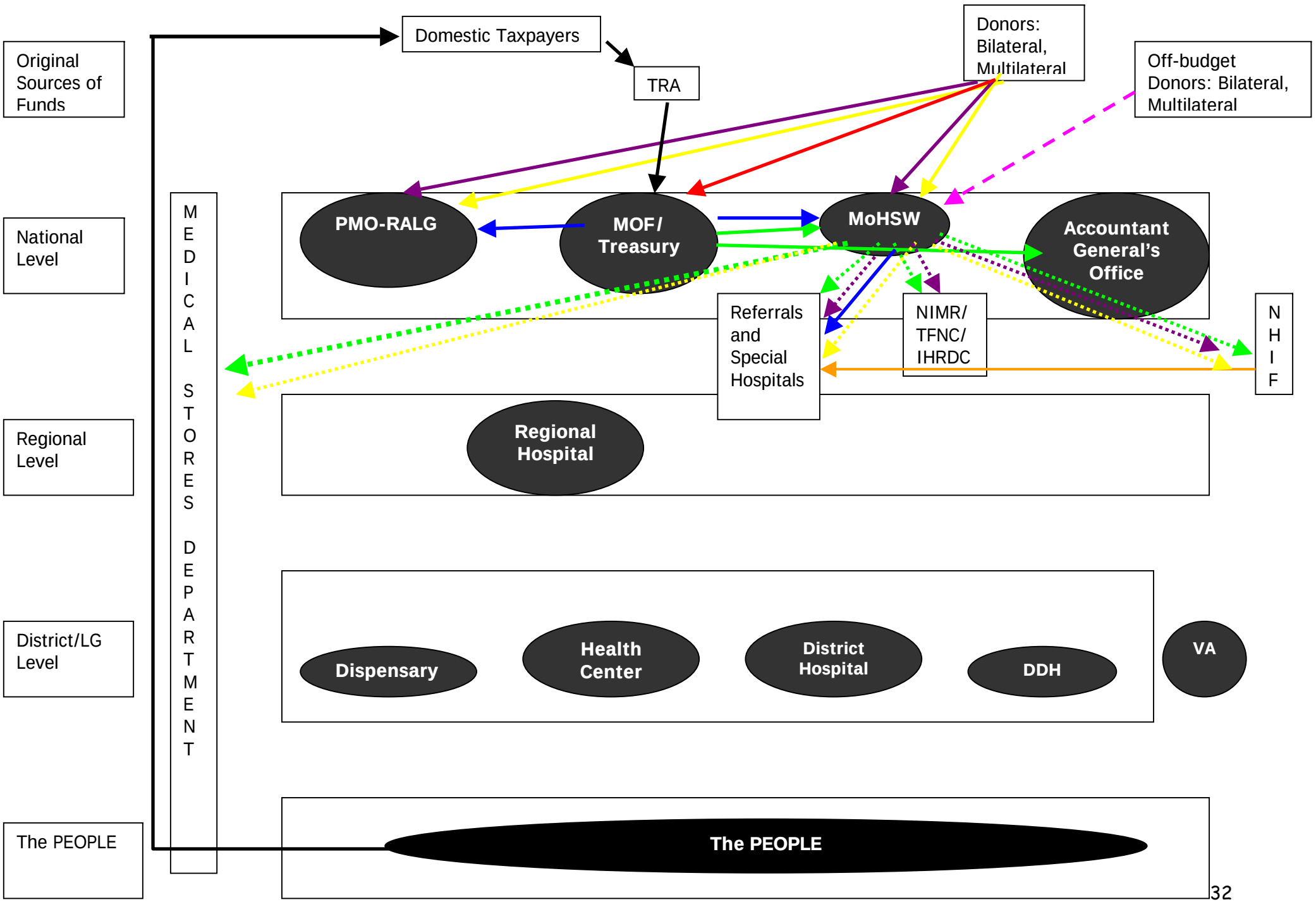
Symbol	Description
	Domestic income
	General budget support
	On-budget recurrent (local)
	On-budget development (local)
	On-budget, foreign funds (excluding basket)
	Basket funding
	(any colour) - transfers
	Community Health Fund contributions to PHC facilities
	Health Service Fund/Drug Revolving Fund contributions to government hospitals
	Off-budget foreign development
	National Health Insurance Fund payments

1.1 National/central level - Recurrent (excluding basket funds)

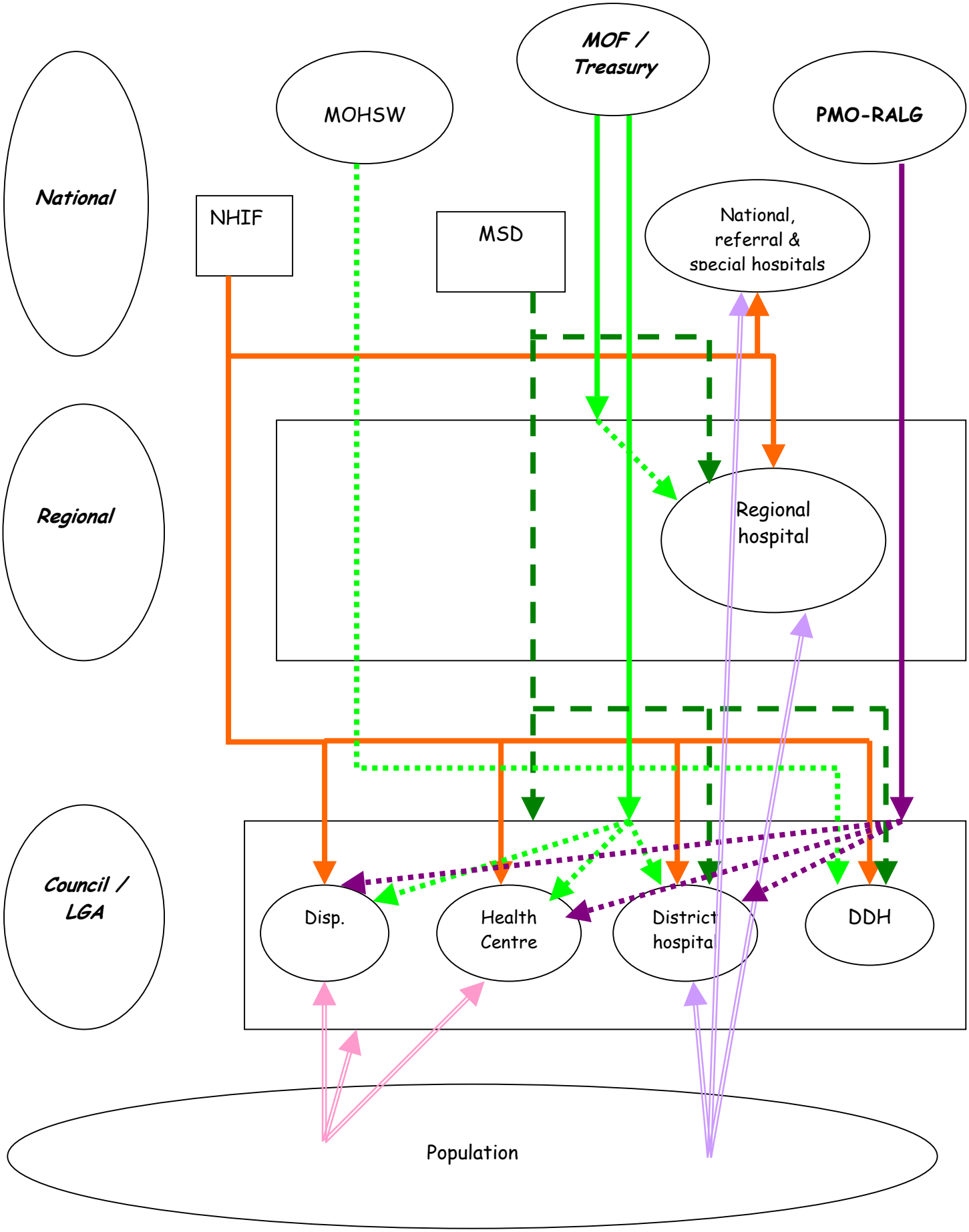


1.2 National level - Development

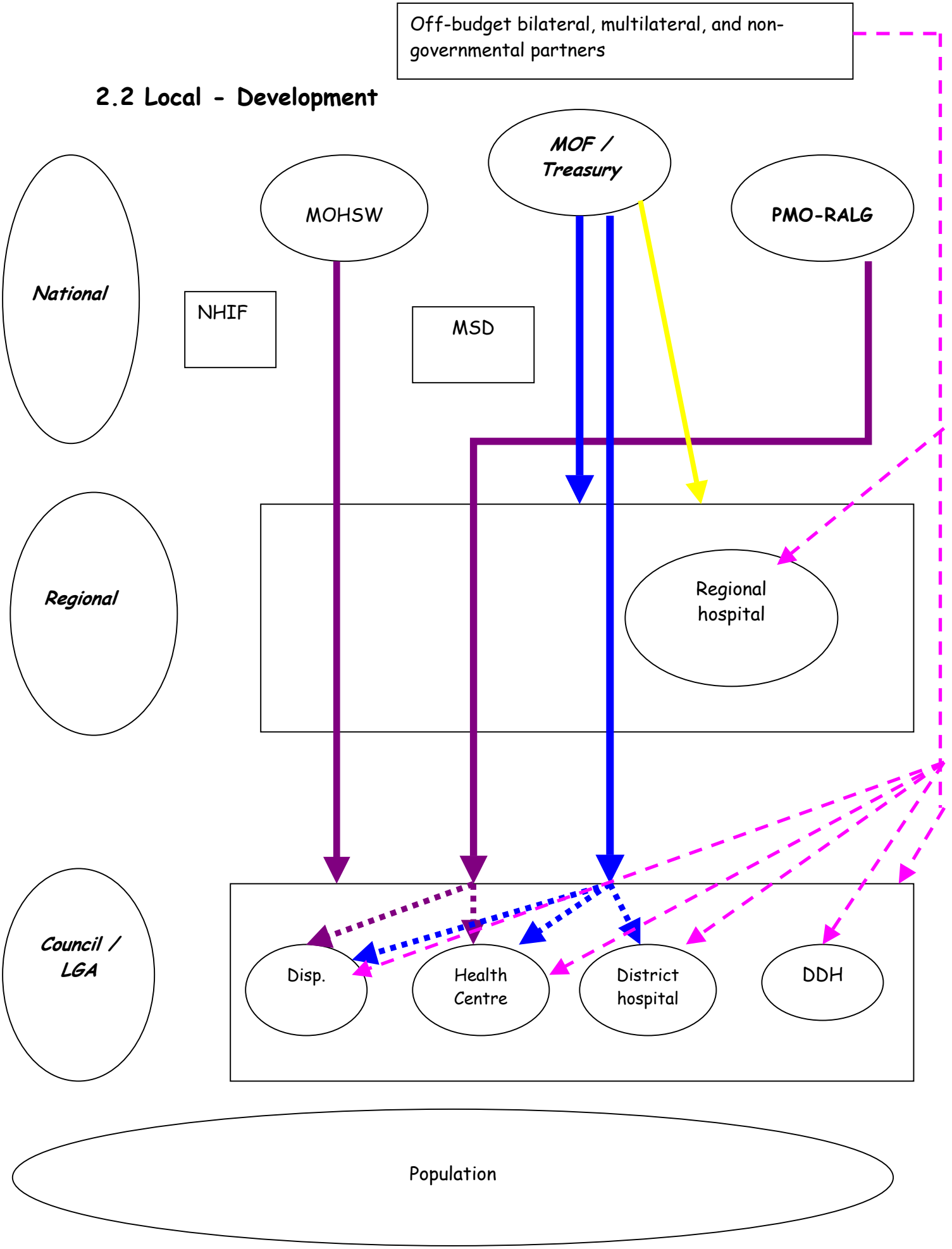


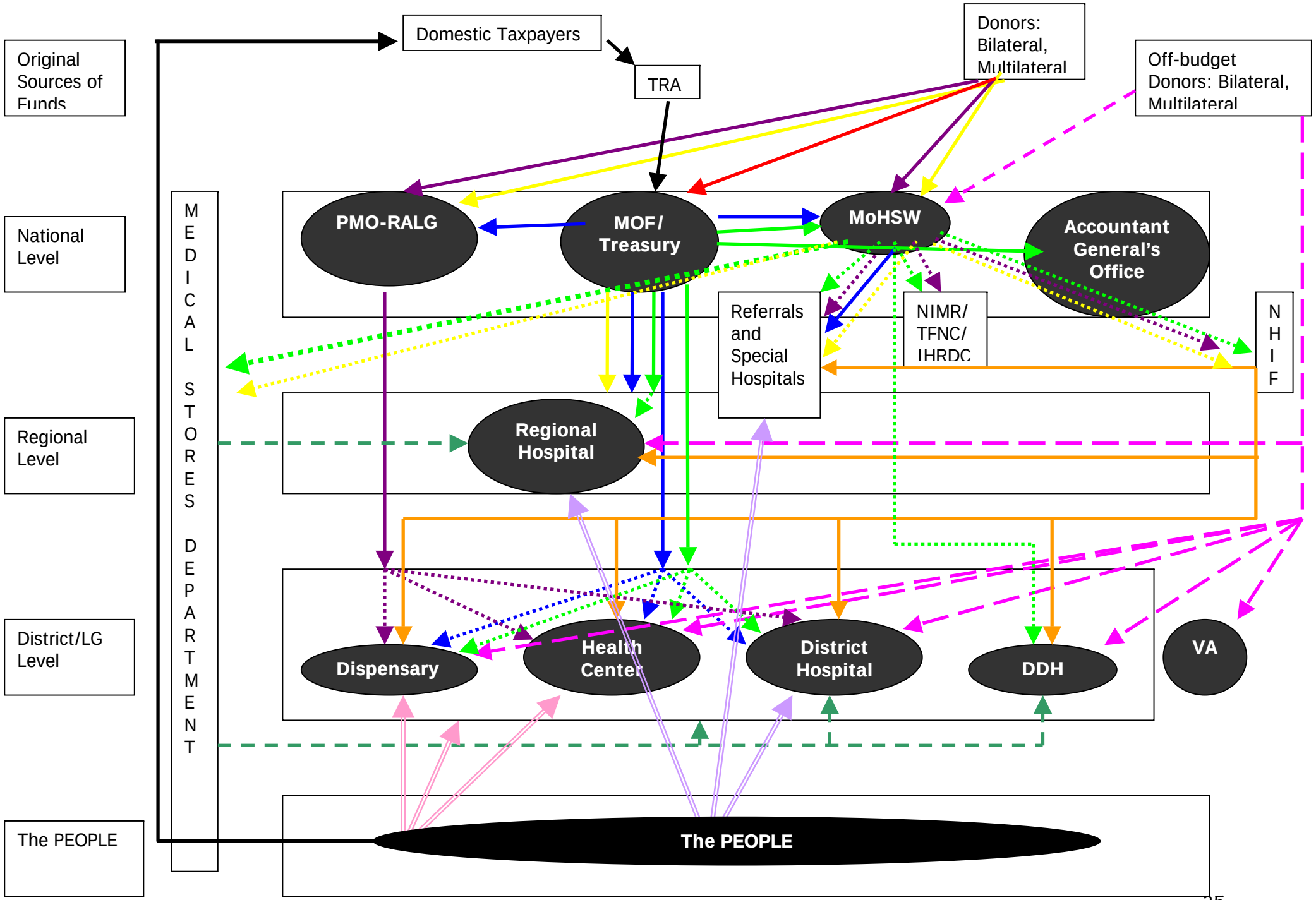

Original Sources of Funds
National Level
Regional Level
District/LG Level
The PEOPLE
Domestic Taxpayers
TRA
Donors: Bilateral, Multilateral
Off-budget Donors: Bilateral, Multilateral
MEDICAL STORES DEPARTMENT
PMO-RALG
MOF/ Treasury
MoHSW
Accountant General's Office
Referrals and Special Hospitals
NIMR/ TFNC/ IHRDC
NHIF
Regional Hospital
Dispensary
Health Center
District Hospital
DDH
VA
The PEOPLE

2.1 Local - recurrent



2.2 Local - Development

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PMO-RALG
MOF/ Treasury
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Accountant General's Office
Referrals and Special Hospitals
NIMR/ TFNC/ IHRDC
NHIF
Regional Hospital
Dispensary
Health Center
District Hospital
DDH
VA
The PEOPLE

Session 3:[9]

Time	Session
10:00 – 11:00	Introductions and Tea
11:00 - 1:30	Gender Budgeting Presentation - Background - Gender related concepts - Gender budgeting tools and processes - Basic steps in gender budgeting - Gender-sensitive Budgets - Entry points to Gender Mainstreaming - 4 tools to analyze Gender sensitivity - Gender Analysis of Health Sector Budget - Role of Parliamentarians
1:30 – 2:30	Lunch

Gender Budgeting Presentation

Background:
The Gender Budgeting Initiative in Tanzania began as an NGO process from 1997, with a focus on mainstreaming gender approaches in the government economic polices, planning and budgeting. It was developed/started to influence policy makers, economists, statisticians and researchers to adopt more progressive and gender approaches.

Various factor triggered the GBI, some include:
- Cost sharing and retrenchment policies implemented as part of structural adjustment programs in Tanzania in the 1980s
- SAP precipitated vital social services, i.e. health care and education, being dramatically cut.
- Liberalisation and privatisation caused massive layoffs of government workers and others.
- The majority of civil society, i.e. the majority of women, youth and poor men were not part of the on-going discussions around SAP policies, and not consulted effectively, therefore were experiencing serious marginalisation.

Rationale for Gender Budgeting
- It address the Beijing Platform for Action
- It responds to the commitment by UN and SADC declaration
- It is addressing the issue of equality and equity which is specified in the Constitution
- The government has committed to and has institutionalized GB
- It addresses accountability & corruption in the system.

Gender Budgeting Initiative held the following objectives:
- Strengthen Consensus building, collective action strategies, acquisition of skills relating to economic literacy & lobbying and advocacy for women/gender and human rights oriented groups as regards to gender equity and equality and transformation in policy and budgeting process
- Broadening, in particular, women's and poor men's participation in policy-making and their exposure to management structures of public resources.
- Examining the budgeting process in Tanzania from a gender perspective so as to see how national/local budgets are allocated and thus allow for the tracking of the utilization of budgeted resources
- To gauge the impact this allocation of resources has upon women and other groups such as youth and poor men within Tanzania
- Laying foundation of an effective consensus building campaign to influence the public, decision makers, law makers & government officials on the necessity of increasing resources/ budget to sectors impacting women, youths & other disadvantaged groups

[9] See Annex VI for power point presentation slides

Gender Related Concepts

- *Sex Needs*
  The biological needs/requirements of females and males,
- *Gender Needs: needs to address gender issues/roles*
  - Empowerment and Decision making issues
  - Social and Economic & Resource issues
  - Activity issues, workload
  - Age issues
  - Women & and men gender specific issues
- *Gender sensitivity*
  - Appreciates the gender differentials, gender concerns and needs, the attributes & opportunities associated with being *male* and *female,* i.e. privileges, rights and obligations that women and men, girls and boys have in society.
  - It recognises the different contributions of women and men, girls and boys in different responsibilities
- *Gender responsiveness*
  - Appreciating the gender differentials, gender concerns and needs and take measures to address the needs accordingly, coming with measures, which address the needs of different groups.
- *Gender Bias*
  - Discrimination faced because of one's sex. This could be the attitude adopted by society or community or policy focus, resource allocated and service provided that specifically focus one sex only, in most cases it focuses on men, or continuous focusing on women too. In schools gender bias can be directed to marginalize girls or women teachers.
- *Gender blind*
  - There is no particular mention of women, but no particular mention of men either, nor of any other groupings. There is no consciousness at all of gender differentials therefore no consciousness at all that there are differences in needs and gender concerns of the different groups.
- *Gender inequality*
  - Gender differences and inequalities between girls and boys, in women and men, in able and disabled, in activities, access to, control over resources and decision-making opportunities
- *Gender Equity*
  - Deliberate efforts to put in place systems, policies, or programmes, activities or/and budgets that favour a specific marginalized group, such as girls in schools. A remedial measure to fill the gender inequality, gap, recognising that, due to different factors such as culture, sex, ethnicity, or economic status, there are groups which have been put aside and marginalized e.g., women/girls
- *Gender Analysis*
  - Gender desegregation of data and information: analyzing issues by taking gender as a point of analysis. It is the method of analyzing data and information to details and specifics - a tool that comes out with clear information and data on specific issues/concern that should be the basis of planning, budgeting and allocations.

Gender Budgeting

- Gender budgeting does not mean a separate budget for women, or for any specific group, it is a budget that examines how the overall budget addresses the needs of women and men, of different groups of women, and poor women in particular.
- It examines if the national budget further entrenches women's disadvantages and other powerless groups such as youths and powerless men, or whether they promote women's empowerment and gender equality.
- Gender Budget Initiative addresses the macro economic policies that negatively impact the poor majority of the Tanzanians, e.g. the World Bank and the IMF policies, the imbalance and marginalization in the World Trade Organizations etc.
- GBI attempts to analyse a country's national budget with a focus on allocating resources in a manner that recognises and seeks to remedy gender inequalities within the country. It does

this through the analysis of resources generated and how they are allocated and utilized and what output is achieved.

- Furthermore, it traces how the central planning and budgeting processes address the varied needs of women, men and youths and further recognizes that, there are different categories within each group.
- It analyses the gender capacities of the planners and budget officers.
- It analyses the involvement and participation of the different stakeholders in budgeting and resource allocation processes from a gender perspective.
- It is about monitoring the government expenditure, delivery of public services, and taxation from a gender perspective.
- It addresses both the strategic needs and the practical needs of the different groups in the society
- It acknowledges that there are different needs, which would require more attention and more resources e.g. maternal mortality and morbidity.
- It calls for special preference in certain cases where needs be, and especially because of the varied needs of women and men, girls and boys, and children.

Gender Budgeting as a Process

Gender budgeting is a step-by-step approach to analysing policies, plans, programmes and resource allocation. It analyses specifically what the needs of the different groups are and sets priorities according to that.

It scrutinizes who gets what, how much and for what, who decides, and who is affected more by the adopted plans and policies, and what can be done to ensure that distribution of resources is equitable. It is actual a process of mainstreaming gender into every aspect of the budgetary planning process, including preparations, planning, stakeholders analysis, monitoring, and expected impact of the budgeted activities.

It involves monitoring the allocation of resources to the budgeted activities and utilization of that resource. Lastly, it is a process of monitoring the output of the resource utilization checking and balancing the leakage which can be a detective measure of corruption.

Basic Principles/Steps in Gender Budgeting

There are four main steps in gender budgeting:

1) A description of the situation of women and men, girls and boys and their gender practical and gender strategic needs. Therefore one needs updated gender desegregated data and information.
2) Analysis of government policies in relation to the sector in order to examine the extent of gender objectives.
3) Analysis of the sector goal, mission, vision, objective and the targets.
4) Prioritizing the activities and allocating the resource following the priorities but allocating more resources to the specific needs.

For example, in the fight against HIV/AIDS, allocation of resources should be directed to address the root cause of HIV/AIDS rather than locating a lot of resources to awareness raising. The challenge to HIV/AIDS include lack of employment, /idleness, inefficiency in heath measures, food requirement and food security, poverty in its totality and inability to afford the required drugs, although being wealthy can also be the cause.

It needs a thorough analysis to come out with where to spend more money for HIV/AIDS. More resources should than be allocated to address the causes. There should be proper monitoring as to whether the allocated resources reach the intended benefits. That is the tracking of the budget implementation.

Gender-sensitive budgets:

Are about mainstreaming gender issues – ensuring that gender issues are mainstreamed into all national policies, plans and programmes rather than regarding women as a “special interest group".
They are about addressing poverty – ensuring that government resources are used to meet the needs of the poorest women and men, girls and boys.

There are about taking government's commitments to gender equality in treaties, conventions and declarations and translating them into budgetary commitments.

A gender-sensitive budget process:

- *Looks at gender awareness and mainstreaming* in all aspect of budgeting at national and local levels.
- *Promotes active involvement and participation* of women, men and other marginalised groups such as youth and rural people.
- *Monitors and evaluates* government expenditure and revenue from a gender perspective.
- *Promotes more effective use of resources* to achieve both gender equality and human development objectives.
- *Stresses reprioritisation within and across Ministries* rather than an increase in overall government expenditure.

A gender-sensitive budget asks a simple question:

Are women's and men's needs, interests and priorities included?

- It appreciates the different needs, privileges, rights & obligations that women & men, girls & boys have in society.
- It recognises the different contributions of women and men, girls and boys in production of goods, services and human labour in mobilising and distributing resources. It recognises the contribution from unpaid labour and allocate the required resources to these groups.

There are 4 tools for gender sensitive analysis of budgets:

- Gender-aware revenue analysis - the differential impact and contribution of women and men on the economy
- Gender-aware public expenditure incidence analysis: quantitative analysis.
- Gender-aware policy evaluation (policy assumption – Gender analysis can be outside and inside the government)
- Gender-aware budget statement (gender implications)

What Are the Entry Points to Gender Mainstreaming in Tanzania?

- The opportunities provided by the MTEF Process that addresses the Vision/Mission of Ministries, Departments and Agencies, the Environmental Scan, (SWOT) analysis and the gender weakness, the analysis of the stakeholders: who is to be involved and prioritization of the targets and activities.
- The ownership of Gender Budgeting by the Central Ministries of Finance and Planning and privatization
- There is an opportunity also in the monitoring as a process through the PER.
- The MKUKUTA process

How to ensure budgets are gender responsive

- Follow up the budgets while they are still in preparation to ensure that targets and activities set by the sector have taken in the gender and pro-poor needs/issues.
- Follow up the allocations if they are addressing the raised needs/issues
- On what impact and what focus/directions is the budget. Take an example, of the current budgets, for example of Health MTEF:
    - What is the focus of the budget?
    - Is it addressing the high gender and pro-poor needs and issues?
    - Where could the allocations be concentrated to create impact?
    - How much of the health budget is addressing the maternal death?
    - By using what strategy?
- Analyze the budget to identify whether major gender and pro-poor needs/issues have been addressed/taken on board.
- Follow up the reimbursement and the utilization of the budgets and this should be the main role of CSOs, the public, partners, and Parliamentarians at their constituency level.
- Track the utilization of the budgets at the implementation level.

- You may utilize the expertise that exists in gender budgeting to do the above and demand for provision of space in public hearing for discussions to improve the sector and the national budgets.
- Utilize studies /researches that have been conducted and other materials produced by NGO's plus recent work done on budget analysis.

The Process & Strategies taken to insitute Gender Budgeting

TGNP took an initiative of understanding the concept and learning from others, i.e. the South African Women Budget and the Australian Gender Budgeting.

Preparatory Activities

- Instituting a programme within TGNP and FemAct structures
- Building a Coalition around it
- Building linkages with other Initiatives
- Identifying entry points
- Action Oriented Research and data gender analysed for six sectors that involved gender experts, academician and actors from the respective sectors
- Feedback and dissemination of research findings – to respective sectors, FemAct and other Networks
- Development of Lobbying strategies and tools for Parliament and for the public
- Capacity building and enhancement on gender as related to Macro-economic Policies and Budgets
- Development of Tools/instruments for Gender Budgeting such as the one commissioned by the Ministry of Finance, "the Checklist."
- Information sharing and coalition building and networking around GBI in and outside the country
- Enhancing the gender capacities of the key actors, budget officers, planners and others in the priority sectors and influencing the PER processes at sector levels and national level. (Greatly focusing on Health and Water sectors for tangible GBI results)
- Enhancing the Local government /councils capacities on GBI for effective gender mainstreaming at the local level where the implementation of programmes, projects and development activities are and enhance the overall participation of the community in policy making, planning and budgeting.
- Enhancing the capacities of Parliamentarians in GBI for effective monitoring the allocation and implementation of the government and national resources as representative of the people, but also as key policy makers.
- Development of GBI – Processes to address Policies, Planning Budgeting, allocation, utilization and outputs
- Access to the government structures, strategic decision making bodies and processes so as to influence i.e. TAS, PRSP and PER, MKUKUTA
- Broadening the Initiative to address macro-economic Models, ie the Social Accounting Matrix (SAM)
- Influencing the guideline to carry the gender approaches
- Lobbying & advocating for the recognition of the unpaid labor, i.e. care burden contribution in the economy, therefore initiated for a study on Time Use. Tanzania becoming the first country in East, Central and northern Africa to conduct this study, and the fifth in Africa (other 4 are in Southern Africa)
- Budget analysis and development: sharing /publicizing budget briefs.
- Identifying other networks in and outside the country and to share and develop their GBI skills
- Linking with other networks for collective action around GBI related issues, such as in budget analysis, with Tanzania Networks and with the East African Gender Budget network.
- Taking another angle of the Campaign, i.e. the campaign around GBI policy and resources, the famous " Return Resources to people Campaign " with a focus on HIV and AIDS, Water, & campaign against privatization and cost sharing in social sectors. (Ongoing)
- Identifying and proactively taking opportunity in influencing gender issues in other processes

Gender Analysis of the The Health Sector Budget:

- Taking the health Budget Of 2006/07, is the budget gender sensitive?

- There is a lower budget allocation this year than last year. What does it mean?
- How much has been allocated to address the maternal death?
- How much has been allocated for the HIV/AIDS intervention,
- How much to increase the labor force in Health?
- How much to deal with the increased women cancer? Cervix and Breast cancer?
- How much go to address the Health infrastructure, and what infrastructure?

Role of Parliamentarians

The Role of Parliamentarians/Parliamentary Committee on Finance and Economic Affairs in Promoting Gender Budgeting objectives:

- The parliament is an important agent of monitoring both policy and budget impact. Promoting gender budget goals. This is because, gender budgeting is an approach aimed at enhancing policy impact/budget directions.
- To ensure that budget and allocations per sector / prepared, reaches out women and men (pro-poor groups) in an equitable way.
- To ensure more allocations are made to those sectors of high impact for women and children such as health, education, water etc.
- Giving out vision of the budget as against the policies
- Redirecting /guiding the budget to address the high gender and pro-poor needs
- MPs are representative of people's interests, therefore have to make sure that they are responsible for overseeing that the budget meet their needs
- A gendered approach of budgets ensures that national budgets are for women and men benefiting /contribution

Conclusions:

The Budget Training Sessions were deemed to be useful by all participants. It helped enhance our understanding of processes at national and district level, and identify entry-points to engage in better governance of health sector resources as well as more equitable distribution of resources to achieve access to quality health care for all in Tanzania.

Of the entry-points identified, the Health Equity Group will prepare its strategy of engagement for the next year at subsequent meetings. HEqG has also concluded that these sessions are useful for other groups to undergo and may plan to hold such sessions for other organizations/partners. Agencies with district linkages will also disseminate the experience gained in these sessions to other groups and partners at district and national level e.g. Femact, Mwanza Policy Initiative and others. It is hoped that as awareness increases on processes, there will be increased civil society participation in the governance of public resources.

Annex I: Scope of Work

"All about Budgets!"
Training Sessions for Health Equity Group and Partners
Scope of Work

Name of Activity: Training on Pro-poor public budgeting for improved health service delivery in Tanzania for HEqG and Partners.

- **Part 1:** Public Budget Formulation Processes and CSO possible entry points (national and district) in Tanzania.
- **Part 2:** Public Budget Analysis and Performance Monitoring/Tracking Processes at central and district levels in Tanzania.
- **Part 3**: Training on Gender Budgeting for HEqG & Partners

Prepared by: Health Equity Group
Date of preparation: May 5th, 2006
Consultant: Part 1: Paul Smithson
Part 2: Sally Lake
Part 3: Gemma Akilimali – TGNP

Background: The Health Equity Group constitutes five civil society organizations, namely CARE Tanzania, Women's Dignity Project, Save the Children Tanzania, Youth Action Volunteers and Tanzania Gender Networking Program. The group has identified a need to learn more about the health sector public budgeting, analysis and performance monitoring processes at national and district levels in Tanzania. The aim is to advance the group's budget literacy so as to be able to engage in public policy and budget advocacy for improved maternal and child health service delivery. . In addition the group wants to be trained on Budget analysis (i.e. how to read, understand, and carry out simple analyses on the National, Ministerial and District-level Health budgets) and Gender Budgeting in Health.

Overall Objective of the Consultancy:
To enable the Health Equity Group to engage effectively in National and District level budgeting and monitoring processes in order to influence policy and decision-making for better maternal and child health outcomes.

Questions to Guide Training:

- What are the different sources of revenue available to the Health Sector? (Central and District)– donor, domestic revenue, etc. and how is this generally allocated to:
    - Recurrent spending
    - Development spending
    - Cost sharing (user fees, CHF matching and membership, etc.)
    - Spending across different levels (central, region, district, facility)
- What are the overall rules applied to each of the major funding streams (e.g., in the Basket funds that X% must go to hospitals; Y% must go to health centres; etc.)

- **Budget Process:**
    - Explain the Budget cycle:
        - Time frame of the key stages of budget preparation/approval
        - What is the role of each of the following agencies in the preparation, etc. of the budget: DPG? MoF? PMO-RALG? MoHSW? Regions? Zones? Districts? Facilities? Members of Parliament? District Councilors?
        - How does the Civil Service Department, in terms of Human Resource Allocations integrate with the MoHSW Budget? MoF?
        - How do the PER, JHSR, and various different milestones influence actual development of the budget?

    - Who within the MoHSW is responsible for creating the annual budget and what are their specific roles?
    - Who sets the annual budget request within the MoHSW? What criteria are used to do this?

- Who sets ceilings for the MoHSW? What are the criteria used to do this? (a % higher than the previous year? Or something else?)
- How are budget guidelines created (national and district)? Who is able to input on these? Any shortcomings? (i.e. How is the budget drawn up?)
- How are the PER recommendations from the previous year brought into play if at all?
- How are the JHSR milestones brought into play if at all?
- What are other limitations on the MoHSW's ability to use their resources, as they would like? E.g. weighting on different areas within the budget? Varying from set budgets, particularly in light of the new Strategic Budget Allocation System (SBAS) software?
- What is the Medium Term Expenditure Framework and how is it developed?
- Who drafts the Medium Term Expenditure Framework?
- How does the MTEF shape the development of each particular year's annual budget?

- **Ministry of Health Budget**
  - How is the MoHSW budget structured?
  - How is the budget prioritized? Are any "lenses" put on the budget? E.g. Equity? Gender? Burden of Disease? Donor Interest?
  - What line items are actually for use at district level but included in the central budget (e.g. drugs and supplies)?
  - Analysis:
    - Sector share of national budget (how is this calculated?)
    - Allocations to hospital and preventive services; other major category allocations (e.g. drugs and supplies)
    - Monitoring of decentralization of resources below the central level for example funds allocated to Regional, Zonal, District levels and how these differences in resource allocations are determined/set
    - Can we measure the actual percentage/amount that reaches the end user? (UNFPA Country Profiles for Tanzania, 2005 claim 2.7% of GDP goes to Health, and USD 7.16 per capita – where do these values come from?)

- **District Budgets**
  - Who are the individuals responsible for budgeting at district level?
  - What is the composition of district budgets, generally, across Block Grants, Basket Grants, Other donor funded, local tax base, etc.?
  - Comprehensive Council Health Plan budgets – What is the process of these budgets being created? Who makes the decisions on these?
  - On what % of the funds can the Councils make their own spending decisions (what money is discretionary?)
  - Who decides on the rest?
  - Are funds that are requested usually made available?
  - How do funds from vertical programs tie in with district budgets? (HIV/AIDS funds?)
  - How do we measure the actual percentage/amount that reaches the end user?

  - What are the current major debates on the contracts between MoHSW, district councils, and FAITH BASED institutions over reimbursements?

- **Monitoring Processes**
  - What data and analysis is available? Where are the gaps?
  - How do we measure the actual percentage/amount that reaches the end user?

  - What are the budget/actual expenditure monitoring processes in Tanzania? National and District (SWAp, PER, Macro-group? Etc.)
  - Who is able to participate in these groups?
  - How effective are these processes?
  - What are avenues to access these processes?
  - What are avenues of participation for citizens and civil society organizations?
  - What are ways to make these processes effective?

- What is the role of Members of Parliament and/or Parliamentary sub-committees in monitoring budgets and expenditure?

- **Gender Budgeting (Pro-Poor Analysis):**
  - What is gender budgeting as a concept?
  - How is it done?
  - What is the connection between Gender and Class inequality/inequity issues? urban-rural?
  - What are the health burdens that women and girls carry unequally in communities? (Linkages between health, HIV/AIDS, water in terms of health and well-being)
  - How does health service delivery reach out to minimize the negative effects of this burden?
  - What are the implications of gender budgeting for maternal (women & girls) health?
  - How to mobilize public support for gender pro-poor health concerns in the budget [national, district]?

  - Strategies to increase participation of women, the poor, and the grassroots [in general] in budget and health governance processes

  - Source of resources/revenues: paid and unpaid labour; where the bulk of the latter is produced by women, unpaid labour provides substantial proportion of production and reproduction but tends to go unrecorded and unvalued, can also be unavailable to reinvest in the health of labour force (i.e. women and girls) - How does access to resources vs. amount of labor figure in the equation of receiving adequate quality health care services for women and girls?

Deliverables:

- A fairly simple diagram of the budget process – who is involved and how and major budget flows (national and other sources – down to budget district and facilities). This should appear as a result of session 1 and 3.
- Three one-day training sessions over the next three months:
  - Session 1: Part 1 and 2 at National Level – July 13th 2006
    - Participants: HEqG only

  - Session 2: Part 1 and 2 at District Level – July 21st 2006
    - Participants: HEqG and Partners

  - Session 3: Part 3 – August 18th 2006
    - Participants: HEqG and Partners

Qualifications/Skills Needed:

- Part 1 and 2: Experience of Budget Processes in Tanzania
- Part 1 and 2: Ability to, and Experience of Analyzing the Health Budget
- Part 3: Experience in conducting Training on Gender Budgeting

Annex II: Participants List

Name	Organization	Telephone	Email	Session Attended		
				1	2	3
Ismat Dewji Sheriff	CARE	071 326 6383	idewji@care.or.tz	✓	✓	✓
Johansen Kasenene	YAV	071 323 7897	civic@yav.or.tz	✓	✓	-
Dorcas Robinson	CARE		drobinson@care.or.tz	✓	✓	✓
Festa Andrew	WDP	074 461 3082	network@womensdignity.org	✓	✓	✓
Irenei Kiria	YAV	078 427 4039	irenei@yav.or.tz	✓	✓	-
Simon Shayo	TGNP/BBC WST	078 426 8778	shayo2000@yahoo.com	✓	✓	-
Marjorie Mbilinyi	TGNP	074 444 2297	marjorie.mbilinyi@tgnp.org	✓	✓	-
Aba Sey	CARE	074 698 1129	asey@care.or.tz	✓	-	-
Sally Lake	KUWA Znz	077 741 9381	slake@gn.apc.org	✓	✓	-
Maggie Bangser	WDP	074 439 6740	mbangser@womensdignity.org	✓	✓	-
John Jingu	YAV	078 450 8007	johnjingu@yav.or.tz	✓	✓	✓
Emmanuel Ndaki	CARE	074 449 8749	endaki@care.or.tz	-	✓	-
David Rwegoshora	SCF	074 456 4298	drwegoshora@scuktz.org	-	✓	-
Derrick Mbelwa	SCF	078 474 9293	dmbelwa@scuktz.org	-	-	✓
Joyce Tesha	CARE	074 457 1671	jtesha@care.or.tz	-	-	✓

Annex III – Presentation slides of Session One (attached separately)

Annex IV – Presentation slides of Session Two (attached separately)

Annex V – Comprehensive Council Health Plan Case Study

Analysis of the council health plan and budget, as presented in the Comprehensive Council Health Plan (CCHP)

Background

This case study uses information from several CCHPs in order to demonstrate some of the analyses that are possible with the CCHP, and to illustrate some potential differences in content. They are taken from FY2005/06, and were therefore were drawn up according to the 2004 guidelines[10]. These are currently under revision, and so there may be some changes. The main elements are expected to remain the same however.

Main budget summary

Two of four CCHPs consulted included a main budget summary table at the very start of the document. This provides a useful breakdown of the total **budgeted** volume of resources (referred to as the Resource Envelope, RE) available to the council, split by individual source of funds, and by EHP priority area.

Table 1: Main budget summary – Council A

	Priority area	Block grant	District council	Basket fund	SCF	ITI	GTZ/ TGPSH	TACAIDS	Receipt in kind	TOTAL
1	Reproductive and child health	22,000,000	-	25,611,251	7,000,000	-	7,013,150			**61,624,401**
2	Communicable diseases	10,398,000	-	11,291,003	-	-	878,400	59,744,400		**82,311,803**
3	Non-communicable	-	-	3,005,200	-	-				**3,005,200**
4	Other diseases	-	-	9,822,488	-	12,160,000				**21,982,488**
5	Health promotion	13,378,000	-	13,040,898	-					**26,418,898**
6	Organisation	450,203,400	3,024,000	75,445,360	-		2,416,000		208,200,000	**739,288,760**
TOTAL		**495,979,400**	**3,024,000**	**138,216,200**	**7,000,000**	**12,160,000**	**10,307,550**	**59,744,400**	**208,200,000**	**934,631,550**

Table 2: Main budget summary – Council B

	Priority area	Block grant	Basket fund	Cost sharing	GTZ	Community Health Fund	Receipt in kind	Drug Revolving Fund	TOTAL
1	Reproductive and child health	-	36,355,496		18,127,700		8,159,000		**62,642,196**
2	Communicable diseases	-	13,407,457				8,174,320		**21,581,777**
3	Non-communicable	-							**-**
4	Other diseases	-	5,965,000				21,756,300		**27,721,300**
5	Health promotion	-	1,377,800						**1,377,800**
6	Organisation	607,759,096	49,570,320	13,997,300		12,520,043	132,914,340	16,368,300	**833,129,399**
TOTAL		**607,759,096**	**106,676,073**	**13,997,300**	**18,127,700**	**12,520,043**	**171,003,960**	**16,368,300**	**946,452,472**

From this table, we are immediately able to determine the following :

- The absolute volume of resources for the health sector
  - Council A: TSh 934,631,550
  - Council B: TSh 946,452,472

- The relative shares of public versus private funding for health in the council, where public funds include government (central and local) and external (bilateral and multilateral) sources, and private sources are all others (international and national NGOs, faith-based organizations, contributions by private individuals through cost-sharing etc[11])

[10] MOH/PORALG (2004). Health Basket Fund and Health Block Grants Guidelines for Disbursement of Funds, Preparation of Comprehensive Council Health Plans, Financial and Technical Reports and Rehabilitation of PHC Facilities by Councils. Dar es Salaam: 22 April 2004

[11] Cost-sharing revenues are included here (and in the Public Expenditure Review) as public as they are generated at, and provide a source of funding for, public health facilities, rather than being a

Table 3

	Council A			Council B		
	Source	**TSh**	**%**	**Source**	**TSh**	**%**
Public	Block grant, district council, basket fund, GTZ, TACAIDS, Receipt in kind	915,471,550	97.9%	Block grant, basket fund, GTZ, Receipt in kind	903,566,829	95.5%
Private	SCF, ITI	19,160,000	2.1%	Cost-sharing, CHF, DRF	42,885,643	4.5%

- The relative domestic versus external shares

Table 4

	Council A			Council B		
	Source	**TSh**	**%**	**Source**	**TSh**	**%**
Domestic	Block grant, district council, TACAIDS, receipt in kind	766,947,800	82.1%	Block grant, receipt in kind, cost-sharing, CHF, DRF	821,648,699	86.8%
External	Basket fund, GTZ, SCF, ITI	167,683,750	17.9%	Basket fund, GTZ	124,803,773	13.2%

Note: the category of domestic includes those external resources channelled via General Budget Support. These could in theory be separated out by calculating the proportion of the total discretionary budget funded through GBS but it is unlikely to be worth it. It may also be that part of the receipt in-kind is externally funded, through donor contributions to the "basket" for drugs and medical supplies. Again, this is likely to be too difficult to separate out at this level.

- Expected cost-sharing resources
  - Council A: zero
  - Council B: TSh 42, 885,643 / TSh 946,452,472 = 4.5% of the RE

Combining the data in the Main budget summary with population data – which should be available in the Situation Analysis section of the CCHP - enables us to calculate similar information in *per capita* terms, ie per person. This is more useful than the absolute values when comparing the resource envelope available to different districts.

- Per capita total
  - Council A: TSh 934,631,550 / 215,920 = TSh 4,329
  - Council B: TSh 946,452,472 / 175,718 = TSh 5,386

This shows that although the absolute volume of funding for the two councils was relatively similar (a difference of only TSh12m or about 1.5%), there is a sizeable difference in the per capita resource availability. To some extent this should be due to the factors influencing the resource allocation formula employed for block grant and basket funds, as these account for the majority of the overall resource envelope.

Analysis by level of the council health system

The summaries at the start of the CCHP also give information on the allocation between the various cost centres within the district. These broadly represent different levels of the district health system, as follows:

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public financing source *per se*. This is **not** how they are classified for National Health Account purposes.

1. Council Health Management Team (CHMT) / Council Health Services Board (CHSB)
2. Council hospital (this can include the Regional hospital or a District Designated Hospital, either of which function as the "District" hospital in the particular council)
3. Health centres
4. Dispensaries
5. Community
6. Voluntary Agency hospital/Unallocated

Table 5 shows the allocation of the total RE in Councils A, B, C and D between these cost centres.

Table 5 Allocation by cost centre (TSh m)

	Council			
	A	**B**	**C**	**D**
CHMT/CHSB	116.81	106.78	472.91	217.05
Council hospital	35.13	426.66	156.48	9.12
Health centres	193.07	172.80	88.51	14.87
Dispensaries	498.97	189.90	436.97	58.63
Community	69.92	34.29	131.35	14.77
VAH/Un-allocated	20.73	16.02	16.07	
Total	**934.63**	**946.45**	**1,302.28**	**314.43**
% primary facilities	*74%*	*38%*	*40%*	*23%*

The table shows that there is significant variation in the share of the total RE allocated to primary level facilities (ie health centres and dispensaries) between the councils. However, it is worth exploring in more detail why this may be. For example, Councils A and D are the rural and town councils of the Regional capital, and their hospital services are provided by a separately funded Regional hospital. Council D, being an urban council, has only two health centres. The outpatient department of the Regional hospital almost certainly also serves as a "health centre" but is not captured in this allocation. Council A on the other hand, covers quite a large geographical area, and has 32 dispensaries and 4 government health centres, in addition to faith-based facilities.

Analysis between EHP priority areas

The CCHP also show the allocation to the different priority areas within the Essential Health Package. Our primary interest in this case study is on allocations to Reproductive and Child Health, which is the first of the six listed EHP "Priority Areas", as shown below.

1. Reproductive and Child Health Promotion and Care ("RCH")
2. Communicable Disease Control
3. Non – Communicable Disease Control
4. Treatment and care of common diseases of local priority ("Other diseases")
5. Health Promotion and Environmental Management
6. Strengthen Organizational Structures and institutional capacities for improved Health Services Management at all levels ("Organisation")

All CCHPs reviewed have a summary by Priority Area for the total RE, as shown in Table 6 below. This enables us to calculate the share of the total RE allocated to Reproductive and Child Health.

Table 6 Allocation between EHP Priority Areas in Councils A, B, C and D (TSh m)

	Council			
	A	**B**	**C**	**D**
Reproductive and Child Health	61.62	62.64	55.12	8.85
Communicable diseases	82.31	21.58	27.65	55.50
Non-communicable diseases	3.01	-	1.66	0.61
Other diseases	21.98	27.72	16.47	4.65
Health promotion	26.42	1.38	26.60	5.39
Organisation	739.29	833.13	1,174.77	239.43
Total	**934.63**	**946.45**	**1,302.26**	**314.43**
% RCH	*6.6%*	*6.6%*	*4.2%*	*2.8%*

Although there is some variation in the allocation to RCH between councils, perhaps the revelation from this data is that the share is uniformly low, in relation to the potential need for RCH services. This is partly due to a number of key inputs being captured under Organisation, notably health facility staff salaries and the drugs and supplies received "in-kind" from MSD. This particular analysis therefore only shows a partial picture in relation to the allocation to RCH.

The budget summary table given for Councils A and B shows the breakdown by Priority Area and by source of funding[12]. This enables us to determine how much, by funding source, is being allocated to RCH in these two councils, as shown in Table 6.

Table 7 Composition of RCH funding, Councils A and B (TSh m)

	Council	
	A	**B**
Block grant	22.00	
Basket fund	25.61	36.36
SCF	7.00	
GTZ	7.01	18.13
In-kind		8.16
Total	**61.62**	**62.64**

Although the overall volume of funds allocated to RCH is relatively similar in the two councils, at around TSh 62m[13], the composition in terms of sources of funds is substantially different, as shown in Figure 1 below.

Figure 1 RCH funding in Councils A and B, variations in source

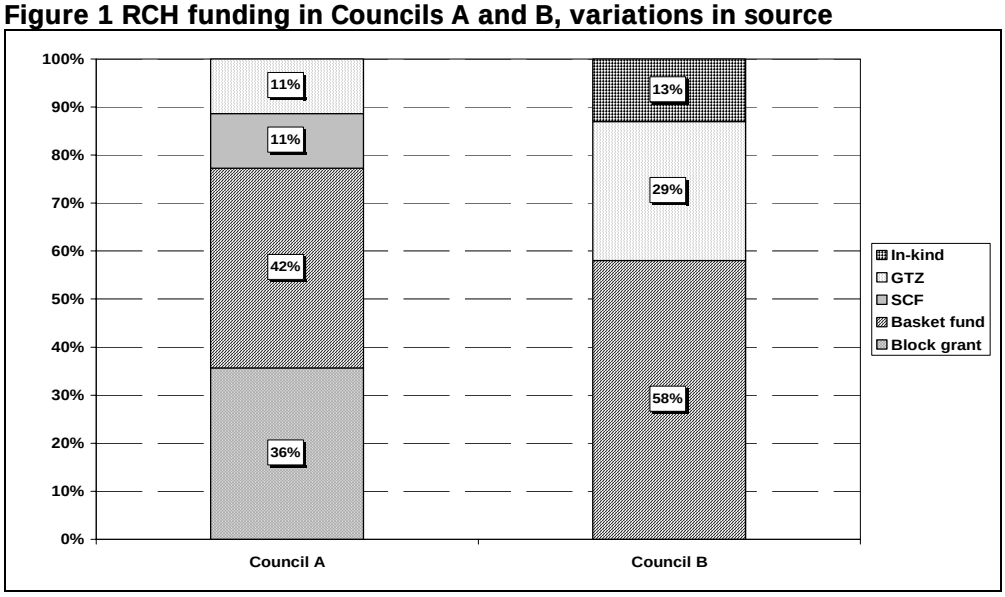

Figure 1 indicates a 13% contribution of "in-kind" resources for RCH. In theory, to find out more about this, we would look in the detailed Cost Analysis section of the CCHP, which presents virtually all the information in tabular form. This is currently under revision, along with the overall CCHP Planning Guidelines, and Figure 2 below shows the proposed format. In practice, this particular example was not there. But it might have related to some of the drugs and supplies received from Medical Stores Department or from technical programmes specifically related to RCH, eg drugs for delivery, family planning commodities, or vaccine supplies from the Expanded Programme on Immunisation etc.

[12] The same information can be found, although less easily, in the Cost Analysis table.

[13] It should be remembered that this is quite different in per capita terms for these two councils.

Figure 2 Proposed new Cost Analysis table

Priority	Intervention	No	Activity	Code for cost centre	Code for source of funds	GFS code	Inputs	Unit cost	Total unit cost	Total activity cost	When?	By whom?	PPM

Reproduced from MOHSW/PMO-RALG Draft Revised CCHP guideline @ July 2006

Explanations of the various columns in the Cost Analysis table are given below.

Priority	Refers to the 6 EHP priority areas
Intervention	From the list for each EHP priority area
No	Serial number for each activity
Activity	Description of the activity
Code for cost centre	Provided in the Guidelines
Code for source of funds	Provided in the Guidelines
GFS code	Government financial system codes for inputs
Inputs	Description
Unit cost	no x no x unit cost (eg Allowances for 20 participants in a 2 days workshop: 20 x 2 x 15,000)
Total unit cost	Total of the above calculation (eg 600,000)
Total activity cost	Sum of all the unit costs for inputs
When?	which quarter is implementation expected?
By whom?	Who is reponsible for ensurng the activity takes place?

The CCHP planning guidelines identify a number of interventions under each EHP Priority Area. For RCH, these are given in Box 1 below.

Box 1 Itemised interventions for RCH within the CCHP (proposed)

- Antenatal care (ANC)
- Obstetric care including emergency care
- Post-Natal Care
- Gynaecology
- Sexually transmitted Disease and HIV (STD/HIV)
- Post Abortion Care
- Family Planning
- Integrated Management of Childhood Illnesses (IMCI)
- Perinatal care
- Immunization
- Nutritional deficiencies
- Adolescent sexual reproductive health
- Other maternal conditions including infertility, rape and FGM.
- Care for most vulnerable children including orphans, children with disabilities, abused and neglected children.
- Early childhood development.

So, if we go back to the information in Table 7, and want to now more about how GTZ funds for RCH are to be used in the Council A, we can go to the Cost analysis table and look for GTZ (or in the future, the appropriate code) in the funding source column and RCH in the Priority Area column.

Note: the figure below shows the details in the new format. This differs slightly from the current format in that the new table will combine details both from the costing table and the action plan (e.g. when and by whom)

Figure 3 GTZ-funded RCH activities in Council A

Priority	Intervention	No	Activity	Code for cost centre	Code for source of funds	GFS code	Inputs	Unit cost	Total unit cost	Total activity cost	When?	By whom?	PPM
RCH	Obstetric care	1		(Hosp)	**(GTZ)**					**574,200**	Q1	MO i/c	
			Refresher course of 3 doctors, 2 clinical officers, and 12 nurses on Life Saving Skills			250312	Allowance participants	17 x 3 x 5,000	255,000				
							Venue	1 x 3 x 10,000	30,000				
							Flip chart	1 x 1 x 8,000	8,000				
..	..	..	..	..	..	..	..	..	..				
RCH	Family planning		To conduct a 3 days refresher training on CBD activities to 70 CBDs in the five wards for 5 sessions	(Comm)	**(GTZ)**					**4,153,450**	Q2	DRCHCO	
RCH	Family planning		To conduct refresher course on FANC to 28 active CBDs	(Comm)	**(GTZ)**					**1,000,000**	Q3	DRCHCO	
RCH	Family planning		To organise and conduct meetings with 50 traditional initiators from 2 wards for 2 sessions		**(GTZ)**					**1,285,500**	Q4	DRCHCO	
TOTAL FOR GTZ-funded RCH activities in Council A										***7,013,150***			

It is therefore possible, for any given funder, or for any given level of the council health system, or for any given RCH intervention, to calculate the allocation within the council RE. The figure below, for example, shows activities related to obstetric care, at all levels, funded by any source.

Priority	Intervention	No	Activity	Code for cost centre	Code for source of funds	GFS code	Inputs	Unit cost	Total unit cost	Total activity cost	When?	By whom?	PPM
RCH	Obstetric care	1		(Hosp)	(GTZ)					**574,200**	Q1	MO i/c	
			Refresher course of 3 doctors, 2 clinical officers, and 12 nurses on Life Saving Skills			250312	Allowance participants	17 x 3 x 5,000	255,000				
							Venue	1 x 3 x 10,000	30,000				
							Flip chart	1 x 1 x 8,000	8,000				
..	..	..	..	..	..	..	..	..	..				
RCH	Obstetric care		To sensitize and increase skills on use of emergency obstetrical drugs for 2 doctors, 2 CO, 8 nurses and 5 nurse attendants	(Hosp)	(Basket fund)					**558,600**	Q2	MO i/c	
RCH	Obstetric care		To conduct refresher course for 2 doctors, 2 CO, 8 nurses and 5 nurse attendants on comprehensive filling and interprettion of partogram	(Hosp)	(Basket fund)					**558,600**	Q2	MO i/c	
RCH	Obstetric care		Comprehensive management of difficult labour and newborn resuscitation for doctors, 10 nurses, and 11 nurse attendants	(Hosp)	(Basket fund)					**448,100**	Q4	MO i/c	
RCH	Obstetric care		To conduct refresher training to 5 HW on LSS for 3 days	(HC)	(Basket fund)					**373,800**	Q1	DRCHCO	
RCH	Obstetric care		To facilitate referral of obstetric emergencies from RHCs to Hospital (Nyangao & Sokoine)	(HC)	(Basket fund)					**1,640,000**	Q1-4	TO	
RCH	Obstetric care		To purchase and distribute 4 delivery kits	(HC)	(Basket fund)					**678,800**	Q1	D/Pharm	
RCH	Obstetric care		To purchase Equipment and supplies for Labour ward	(HC)	(Basket fund)					**3,781,935**	Q1	D/Pharm	
RCH	Obstetric care		To purchase and distribute 14 Delivery Kits and 4 delivery beds	(Disp)	(Basket fund)					**4,359,558**	Q1	D/Pharm	
RCH	Obstetric care		To purchase 70 kgs Chlorine powder (35%) for labour ward disinfection	(Disp)	(Basket fund)					**187,200**	Q1	D/Pharm	
RCH	Obstetric care		To conduct sensitization meetings to 20 villages on health facility delivery	(Comm)	no cost					**-**	Q3	DRCHCO	
RCH	Obstetric care		..	..	..					..			
RCH	Obstetric care		..	..	..					..			
Total for Obstetric Care activities in Council A										***16,247,951***			

Total spending in these sub-analyses can be compared with the information in the summary tables at the start of the CCHP. However, it should be borne in mind that errors in calculation sometimes occur.

Spending on drugs and supplies

The Summary table indicates that Council A has included TSh 208,200,000 from the financing source "in-kind". This reflects the value of drugs and supplies received "in-kind", rather than as a monetary transfer or cash, from Medical Stores Department[14]. The breakdown of this figure is given in the Executive Summary.

Blue Kits (for Health Centres): 4 @ TSh 585,000 each x 12 months **= TSh 28,080,000**
Plus
Yellow kits (for dispensaries): 38 @ TSh 395,000 each x 12 months **= TSh 180,120,000**

Giving a total of **TSh 208,200,000**

[14] The monetary transfer is made on the Council's behalf from the Department of Hospital Services to Medical Stores Department. It remains as a credit to the District Executive Director until the full value of drugs and supplies has been delivered to the Council.

The breakdown between these two levels of the health system, or cost centres, can therefore be calculated.

RHC	28,020,000 / Total 208,200,000	= 13.5%
Dispensaries	180,120,000 / Total 208,200,000	= 86.5%

It should be noted that this does not include all the drugs and supplies which are provided to councils. Others are provided directly by technical programmes, and it is currently very difficult to determine the value of these. A tracking study on the whole area of drugs and supplies is planned at central level and it is hoped that more detail will become available once this is complete. It is also hoped that mechanisms for measuring and monitoring such allocations will be designed, to ensure improved information both on types of supplies and geographical distribution, as well as by level of the health system.

Annex VI – Presentation slides of Session Three (attached separately)