

2010/2011 Health Sector Budget Analysis

Sikika

May 2011

2010/2011

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By



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List of Abbreviations

FY	Financial Year
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan III
MDA	Ministry Departments and Agencies
MOHSW	Ministry of Health and Social Welfare
MP	Member of the Parliament
MTEF	Medium Term Expenditure Framework
LCDG	Local Currency Development Grants
PHSDP	Primary Health Service Development Programme
TSH	Tanzanian Shilling

Executive Summary

Health sector budget analysis is one of Sikika's major undertakings to advocate for efficient and effective budget allocation and utilization. Sikika has analyzed the allocation for the Ministry of Health and Social Welfare as well as regional health related budgets for Tanzania. We have come up with a perspective of the budget situation in the health sector as well as recommendations on how the budget can be improved.

Overall, in 2010/11 the health sector's share of the overall budget has gone down by 2.3 percent in comparison to last year. As it does not reach the Abuja target of allocating 15% to the health sector, it is our expectation that the Ministry will keep the efforts it has shown in its budget for this year by allocating its meagre resources more wisely.

This report also provides information on the budget allocations for development and recurrent funds for the directorates of preventative and curative services, policy and planning and human resource for health development. Generally, there seems to have been a slight increase in funds from the previous year, but there is a large variation in the allocation of funds depending on the particular directorate.

Sikika also compiled information about the budget allocation for human resources in the health sector and was able to point out some areas where the budget allocation could be improved as well as which issues need to be addressed in order to improve the distribution of health workers in Tanzania. It was noted that allocating funds for the recruitment and posting of workers alone would not solve the problem alone; factors such as poor working conditions, salary delays, and a lack of benefits for health workers in rural areas have led to difficulties concerning the recruiting and retaining of staff in these areas.

The examination of regional budgets shows that overall allocations for health have declined by 3.1%. This development is mainly caused by smaller contributions by the Global Fund which could only be partly offset by domestic sources. Furthermore, we identified development votes that are allocated across regions without considering their burden of disease.

After studying the budget allocation across departments for the health sector, it has been found that, although budget allocations tend to reflect strategic objectives, there are areas where activities that have to be performed were not consistent with the objectives that they were meant to achieve. There are also objectives that are outlined by the Ministry of Health which do not effectively contribute towards the realization of the long term strategies of the Health Sector Strategic Plan (HSSPIII). Furthermore, there are objectives in the strategic plans that are not clearly budgeted for in the MTEF; therefore it is difficult to track progress on these objectives.

It has been noted that there have been considerable decreases in areas of the budget that have been termed as 'unnecessary expenditures', and the government must continue this trend. At the same time, the government must ensure that the saved funds are then directed to programs that are of greater benefit to the citizens, rather than to activities that are of limited use to the majority of Tanzanian citizens. There are also areas where

there might have been incidences of double spending as well as allocation of funds to areas that may not need to receive as much as was allocated to them, that means an inefficient allocation of funds.

This report also touches on the MOHSW's plans for procurement and distribution of drugs and supplies and of the necessity that procurement and distribution are reflected by improved services at health facilities across Tanzania. Information was also gathered about the funds that are allocated to patients who need treatment in hospitals outside of Tanzania. In our research regarding this area, we were unable to ascertain whether there was a clear set of criteria for choosing who was to be treated abroad, which raises the likelihood that patients that were financially better off might have easier access to this service than poorer people who have more need for these funds.

1. Introduction

Sikika has been conducting budget analyses for the past 5 years. The purpose of these analyses is to gather as much information as possible about all public funds and resources available for the health sector. This information would then be used to assess the budget allocation in terms of how effectively the allocations have been planned to fulfil policy priorities and whether they actually fulfil the strategic objectives that have been set by the Ministry of Health and Social Welfare (MoHSW) and the government. The health budget analysis has been conducted using a variety of documents: the budget books volume I-IV, budget guidelines, the Medium Term Expenditure Framework (MTEF), the performance reports of the MoHSW, the constitution of the United Republic of Tanzania, parliamentary standing orders, Controller and Auditor General reports, the national health policy and health related strategic plans.

Information obtained from these budget analyses has then been used in joint consultative sessions with the Parliamentary Committee for Social Services and other forums in health sector dialogue structure**.** The purpose of these consultative sessions is:

- to seek changes in the budget tabled in the Parliament regarding allocative efficiency, commitment to policy priorities, and to share past budget and expenditure experiences;
- to increase skills, knowledge and to provide analytical information to MPs in order to enable them holding the government to account; and
- to assist committee members and policy makers tracking the implementation of their past years' recommendations to the health sector in order to promote the accountability of the government towards the committees.

What follows now is a brief analytical report about the health sector budget for the FY 2010/11. The principle objective of the analysis is to assess efficiency and effectiveness of the allocation of resources in the health sector and, more specifically, in the Ministry of Health and Social Welfare (MoHSW) for the financial year (FY) 2010/11.

2. Health Sector

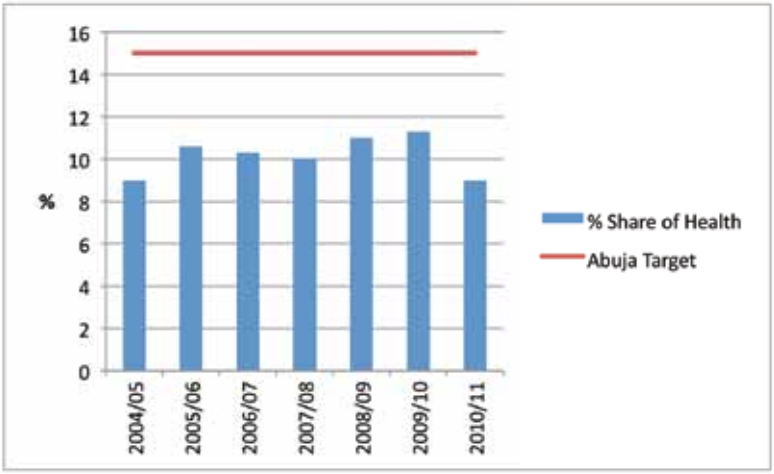
The main sources for health sector financing include: the health basket funds, a block grant for recurrent expenditures (personnel emolument and other charges), development expenditures, and the Health Sector Development Grant for the infrastructure development program through the health sector window under the LCDG. The budget allocation for the health sector has increased by Tsh 243 billion (bn) from Tsh 963 bn in the FY 2009/10 to Tsh 1206 bn in the FY 2010/11,[1] which implies a nominal rise of 25.2%.[2]

1 Ofisi Ya Bunge (2010a), section 50 (iv).

2 Most of the new funding comes from the Health Sector Basket Fund (+ Tsh 227 bn), which adds, among others, Tsh 153.7 bn to the directorate of Preventive Services and also Tsh 56.1 bn to the directorate of Policy and Planning.

However, the health sector's share of the total government budget has gone down from 11.3% in 2009/10 to 9% for the year 2010/11, thus diverging from the Abuja target of 15%. It has to be noted that, ever since our government signed the Abuja Declaration in 2001, it has never fulfilled this commitment. As it can be seen in Figure 1, for the past seven years, the shares of the health sector budget fell short of meeting the 15% allocation of the Abuja target. The most recent allocation is 6% short of the target and 2% smaller than the health sector's budget allocation in 2009/10. By looking at these figures, it becomes obvious that the process is moving in the opposite direction. It is, therefore, a challenge for the government to translate its political will into political accountability.

Figure 1: Health as a Share of the Total Government Budget



Source: Ofisi Ya Bunge (2010b).

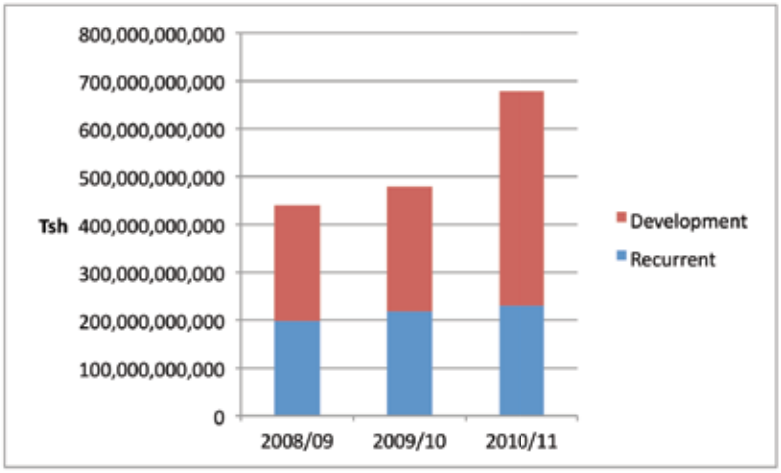
The budget for the health sector is directed to the MoHSW and its directorates and also to local government authorities. This analysis has concentrated on the allocations for the MoHSW and its directorates.

3. Ministry of Health and Social Welfare

Out of the Tsh 1205.9 bn of the total allocation to the health sector in the FY 2010/11, Tsh 678 bn, that is about 56%, has been allocated to the MoHSW. If one compares Tsh 678 bn to the last year's budget of about Tsh 479 bn, this is an increase of 42%. The government's contribution to the MoHSW is 35% while 65% comes from development partners (DP).

As indicated in Figure 2 (its corresponding Table 2 can be found in the annex), approximately Tsh 448.5 bn has been allocated to development expenditures, which is a 72% rise from the year 2009/10, and about Tsh 230 bn has been allocated to recurrent expenditures, which is approximately a 5% increase.

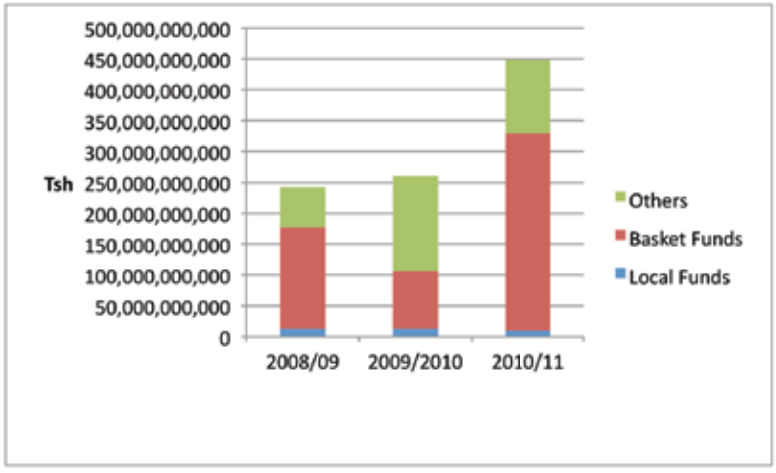
Figure 2: Budget Allocation for the MoHSW



Sources: URT (2010a), and URT (2010c).

While the recurrent expenditures are entirely financed by the Tanzanian government, 97.8% of the Ministry's development budget is contributed by donors. The contribution of the government to the development budget declined by 24%, from Tsh 13 bn in the FY 2009/10 to Tsh 9.8 bn in the FY 2010/11 (see Figure 3 below and Table 3 in the annex). The Basket Fund grows by 243%, from Tsh 93 bn to Tsh 320 bn, and 'other' sources[3] show a 23% decrease, from Tsh 154 bn to Tsh 119 bn.

Figure 3: Development Allocations of the MoHSW



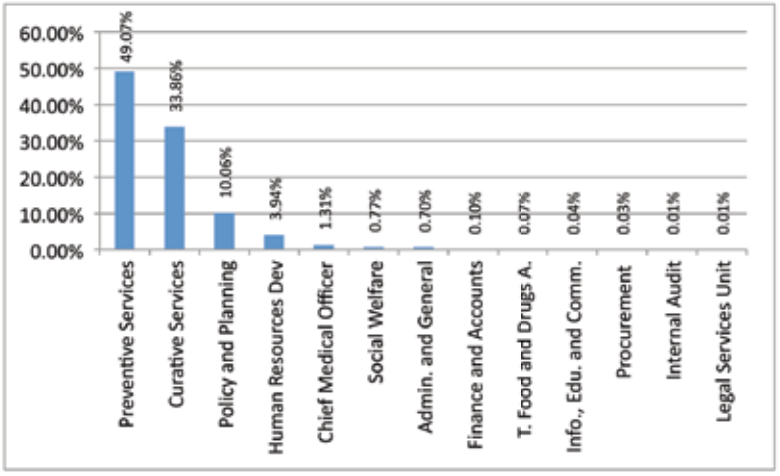
Source: URT (2010c).

3 These include contributions by the Global Fund, the African Development Bank and the World Bank.

4. Directorates of the MoHSW

Figure 4 below shows the allocations across directorates for the MoHSW in the FY 2010/2011 (also see Table 4 in the annex). There are four directorates, which receive the lion's share of the budget (altogether 97%): these are Preventive Services (49%), Curative Services (34%) and Policy & Planning (10%) and Human Resource Development (4%). The budget of those four directorates will be discussed below while the remaining nine directorates, which operate with less than 2% of the Ministry's budget, are not examined in this report.

Figure 4: Budget Allocation Share across Departments for FY 2010/11



Sources: URT (2010a), and URT (2010c).

4.1. Preventive Services

The Directorate of Preventive Services has received Tsh 332 bn, which is an increase of Tsh 107 bn from the allocations of the FY 2009/10. This shows increased financial efforts regarding prevention of communicable diseases. The basket funding for the Control of Communicable Diseases has risen from Tsh 49 bn in the FY 2009/10 to Tsh 204.6 bn in the current FY 2010/11 (compare Table 1 below). These are funds that can also be used for the prevention of HIV infection as well as the prevention of other diseases.

For recurrent expenditure in the Directorate of Preventive Services, Tsh 28.8 bn has been allocated to cover a number of different expenditure items. The allocation towards payment of staff salaries will cost Tsh 1.8 bn. Furthermore, Tsh 11.5 bn has been directed towards the procurement of drugs and vaccinations for anti-rabies yellow fever, ARVs and drugs to prevent the outbreak of cholera, and Tsh 1 bn will be spent to cover the expenses of moving goods and services from port.

Table 1: Breakdown of the MoHSW's Development Budget for the FYs 2009/10 and 2010/11

Code	Description	2009/10			2010/11		
		Local	Foreign	Total	Local	Foreign	Total
	Preventive Services						
2208	Health sector development Programme	350,000,000	1,581,074,000	1,931,074,000	100,000,000	0	100,000,000
5406	Control of communicable diseases	0	49,489,047,700	49,489,047,700	0	204,652,727,907	204,652,727,907
5485	Health sector development Programme	350,000,000	0	350,000,000	0	0	0
5492	HIV/AIDS control programme	0	103,174,086,600	103,174,086,600	0	92,220,440,000	92,220,440,000
5496	Tanzania Food and Nutrition Centre	200,000,000	430,850,000	630,850,000	150,000,000	500,000,000	650,000,000
5498	Support to TB/Leprosy control Programme	0	34,215,983,700	34,215,983,700	0	6,399,636,100	6,399,636,100
	Total of sub	**900,000,000**	**188,891,042,000**	**189,791,042,000**	**250,000,000**	**303,772,804,007**	**304,022,804,007**
	Curative Services						
5409	Support to maternal mortality reductions	3,000,000,000	14,578,605,400	17,578,605,400	1,800,000,000	19,053,000,233	20,853,000,233
5411	Strengthening of refferal hospitals	1,411,855,000	20,015,272,000	21,427,127,000	3,899,173,000	42,695,400,000	46,594,573,000
5412	Ocean Road Cancer Institute	1,200,000,000	1,401,000,000	2,601,000,000	0	0	0
5487	Muhimbili National Hospital	2,850,000,000	800,000,000	3,650,000,000	1,200,000,000	0	1,200,000,000
5491	Muhimbili orthopaedic Institute	2,000,000,000	1,430,000,000	3,430,000,000	1,200,000,000	400,000,000	1,600,000,000
5494	Chief Government Chemist	231,497,300	1,218,905,400	1,450,402,700	0	0	0
	Total Sub	**10,693,352,300**	**39,443,782,800**	**50,137,135,100**	**8,099,173,000**	**62,148,400,233**	**70,247,573,233**
	Policy and Planning						
5416	Health plans and Management	700,000,000	1,467,156,000	2,167,156,000	624,588,000	309,386,800	933,974,800
5486	Health sector programme support	0	7,690,346,300	7,690,346,300	0	64,443,677,170	64,443,677,170
6251	Public finance management programme	0	0	0	100,000,000	1,104,288,480	1,204,288,480
6254	Public sector reform programe	0	244,648,300	244,648,300	0	763,349,310	763,349,310
	Total Sub	**700,000,000**	**9,402,150,600**	**10,102,150,600**	**724,588,000**	**66,620,701,760**	**67,345,289,760**
	Human Resources Development						
2204	Human Resources Development	635,820,700	5,395,998,600	6,031,819,300	800,000,000	4,171,570,000	4,971,570,000
	Total of sub	**635,820,700**	**5,395,998,600**	6,031,819,300	**800,000,000**	**4,171,570,000**	4,971,570,000
				0			0
	Social Welfare Programme			0			0
5451	Support to social welfare services	0	637,560,000	637,560,000	0	1,355,278,000	1,355,278,000
5485	Support to social welfare services	0	2,658,960,000	2,658,960,000	0	0	0
6204	social welfare programme	0	903,200,000	903,200,000	0	0	0
	Total of sub	**0**	**4,199,720,000**	**4,199,720,000**	**0**	**1,355,278,000**	**1,355,278,000**
	Tanzania Food and Drugs Authority						
5493	Tanzania food and drugs authority	100,000,000	238,000,000	338,000,000	0	500,000,000	500,000,000
	Total of sub	**100,000,000**	**238,000,000**	**338,000,000**	**0**	**500,000,000**	**500,000,000**
	Grant Total	**13,029,173,000**	**247,570,694,000**	**260,599,867,000**	**9,873,761,000**	**438,568,754,000**	**448,442,515,000**

Source: URT (2010c).

Tsh 304 bn will be spent for development expenditures of which, according to the MTEF, Tsh 204.6 bn is directed to the procurement of mosquito nets, STI drugs, SD Bioline and vaccines. We can also see that there has been a very significant decrease of foreign funds to support TB/Leprosy Control Programme, from Tsh 34.2 bn to Tsh 6.4 bn (compare Table 1). This decrease originates from the fact that, in recent rounds of Global Fund proposals (rounds 7-9), the focus has moved away from tuberculosis and focused more on HIV/AIDS and in particular to malaria. Despite this fact, the HIV/AIDS Control Program also suffered a slight decrease with its funds dropping from Tsh 103 bn to Tsh 92 bn.

4.2. Curative Services

The area that has received the second priority in the MoHSW is the Curative Services Department with Tsh 229 bn. This is a 15% increase from the amount of Tsh 199 bn allocated for 2009/10. To strengthen referral hospitals, local funds increased from Tsh 1.4 bn to Tsh 3.9 bn, and foreign funds have more than doubled from Tsh 20 bn to Tsh 43 bn. Other areas to note are the Chief Government Chemist section and the Ocean Road Cancer Institute, which did not receive any local or foreign funding in 2010/11, despite rising cases of cancer in Tanzania.

The analysis shows that Tsh 31 bn under the recurrent budget is directed to the procurement of drugs and supplies, whereas Tsh 99.6 bn is for the provision of grants to hospitals such as designated district hospitals and voluntary agencies. Despite these efforts by the government to allocate resources according to priorities, the department has allocated Tsh 1.4 bn for the maintenance of x-ray machines and ultra sound machines, an activity which is being done by the Philips Company. The amount had decreased by Tsh 1.1 bn, or 78.5%, from Tsh 2.5 bn in the FY 2009/10.

The examination of the development budget for the curative department shows that Tsh 19 bn from the African Development Bank and Tsh 1.8 bn have been allocated to support the reduction of maternal mortality in three selected regions of Tabora, Mtwara and Mara. The allocation shows an increase of Tsh 3.2 bn, or 18.6%, from the Tsh 17 bn allocated in FY 2009/10.

Sikika's analysis also reveals that Tsh 46.5 bn has been allocated for the strengthening of the referral hospitals as one of the target objectives in the primary health care development program, which is an increase of Tsh 25.1 bn, or 117%, from the Tsh 21.4 bn allocated in the FY 2009/10.

4.3. Policy and Planning

The directorate of Policy and Planning received Tsh 68.2 bn in the current FY 2010/11. The sharp increase of basket funding for the Health Sector Programme Support (+ Tsh 56.7 bn) led to the biggest percentage budget increase among all directorates in the Ministry (+479%).

In the Policy and Planning activities, we see that the government has only allocated money for two of the activities**:** Health Plans and Management and the Public Financial Management Programme. The Health Plans & Management activity suffered a reduction of both foreign and local funds. The government has cut its allocation from Tsh 700 mil to Tsh 624 mil, and foreign funding has shrinked from Tsh 1.467 bn to Tsh 309 mil between 2009/10 and 2010/11. Apart from that activity, we also noticed that there has been a significant increase in foreign funding for all the other activities in the Policy & Planning directorate.

This development is welcome. However, it is difficult to assess how efficiently these additional funds are going to be spent: the MTEF indicates that Tsh 52 bn, which corresponds to 76% of the directorate's total budget, have been allocated for the `support to strengthening of health systems´. But the specifications for the activity's related costs have been reduced to `miscellaneous´, which leaves no room for further budget examinations.[4] Sikika demands an explanation from the Ministry on how this huge amount of public funds is going to be used.

4.4. Human Resource Development

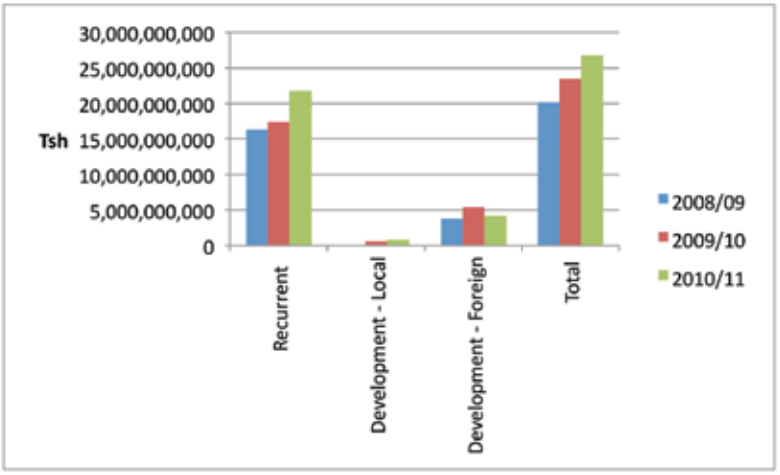
The provision of adequate human resources for health is a big challenge in Tanzania. For the FY 2010/11, the allocations for the Human Resource Development-directorate amount to Tsh 26.8 bn or 3.9 % of the MoHSW's budget (compare Figure 5 below and Table 5 in the annex). But this quantum represents only one third of what is actually needed: the Human Resource for Health Strategic Plan budgets about Tsh 90 bn for the FY 2010/11 to be able to cope with the Human Resource for Health crisis. This would correspond to about 13.3% of the MoHSW's total budget. Thus, one can conclude that the Government's strategic planning is not adequately reflected by its budget lines.

The Directorate allocated Tsh 21.8 bn for recurrent activities, which is a 25% increase from the previous year. The spending includes Tsh 5.9 bn for salaries, Tsh 5.3 bn for domestic training and 2.5 bn for food and services for students in those medical schools.

Locally obtained development funds increase to Tsh 800 mil, which is almost 29% more than in the year 2009/2010. Contrary, development funds which were obtained from donors show a 28% drop from Tsh 5.4 bn 2009/2010 to Tsh 4.2 bn in 2010/11. This is worrying because the reduction of foreign development funds is not being compensated by the increase of local funds.

4 MoHSW (2010a), p. 46.

Figure 5: Allocations for Human Resources for Health



Sources: URT (2010a), and URT (2010c).

According to the Health Sector Performance Profile Report 2010, Tanzania still exhibits a human resource shortage of 39.4%.[5] There have been efforts by the Ministry to recruit and post health workers since 2008 through the Human Resource for Health Strategic Plan (HRHSP). For example for the FY 2009/10, the ministry has been able to recruit 472 workers without medical background and 4020 health professionals in various districts and councils.[6] This number is small compared to the PHSDP goal of allocating 16,492 for each two years of the program (8,246 health workers per year).[7]

From the results of a tracking study that Sikika conducted in 2009, we see that of 2275 health workers of various cadres that were deployed, only 1743 (77%) reported to their duty stations. This means that 532 deployed health workers (33%) never reported; that is quite a large number. Areas that suffer most from this trend are the underserved regions. In urban areas, 93% reported to their duty stations, whereas, in rural areas, only 74% reported to their duty stations. Attrition has also been an issue. From 1743 health workers who reported to their duty stations, 123 left. Attrition rates have been particularly acute among pharmacists (18%), medical doctors (15%) and assistant medical officers (13%). Health facilities in rural areas often lack the resources to offer incentives that would attract and retain workers. There have difficulties obtaining wages since salary payments for the newly posted staff takes between 6 to 9 months.

5 MoHSW (2009a), p. 41.
6 Ofisi Ya Bunge (2010b).
7 URT (2007), p. 60.

The HRHSP mentions some activities which should address the present issues of deployment and retention of new health workers, but it seems that the HRHSP has not been properly considered by the financial planners: by looking at the activities for Human Resource Development in the MTEF, one observes that a lot of money (Tsh 5 bn for 2010/11) is allocated to the objective to 'facilitate production of skilled human resources from 3831-6000 annually', but there are no activities that would help to relocate these newly trained health workers to assure equitable distribution at all levels as is stated in the HRHSP under the strategy 'Redressing rural urban disparity'. Two other measures that were supposed to be implemented during this year include 'Design and implement program for worker's satisfaction' and 'Facilitate provision of enough supplies, housing, equipment and transport for health workers'. None of these activities have been mentioned in the current MTEF.

Nevertheless, Sikika acknowledges the fact that LGAs have been given more flexibility using their budget in the past 2 years, and they are being given more freedom to use their budgets for better salaries and benefits to their health workers in order to attract and retain staff in their areas.

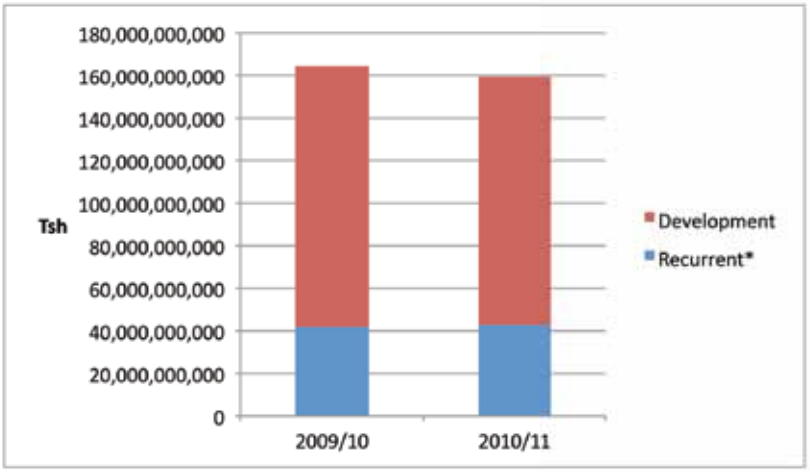
In order to meet its strategic goals, the MOHSW should insure an increasing amount of funds for human resources for health and also to prepare a budget that tackles the root problems for the a lack of qualified health workers in healthcare facilities. The allocation process needs to be transparent to increase the confidence of donors and their willingness to provide funds for the development of the human resources for health infrastructure.

5. Local Government Authorities

For the current FY 2010/11, the Government has allocated Tsh 159 bn to fund health expenditures across regions. This is slightly less (3.1%) than in the former FY 2009/10 (compare Figure below). From that overall amount, Tsh 43 bn (27%) have been earmarked for recurrent expenditures[8] which are entirely financed by the Tanzanian government. To the development expenses, the Government contributes Tsh 21.2 bn and Development Partners Tsh 95.1 bn. This adds up to Tsh 116.3 bn, which is Tsh 6 bn, or 4.9%, less than in the former FY. This negative development is mostly driven by reduced foreign grants (-14.3 bn Tsh) which could only partly be offset by an increase of domestic funding (+8.3 bn Tsh).

8 For the recurrent health expenditures at regional level, we considered the sub-votes 'Preventive Services' and 'Regional Hospital'.

Figure 6: LGA Allocations for Health in the FY 2009/10 and 2010/11



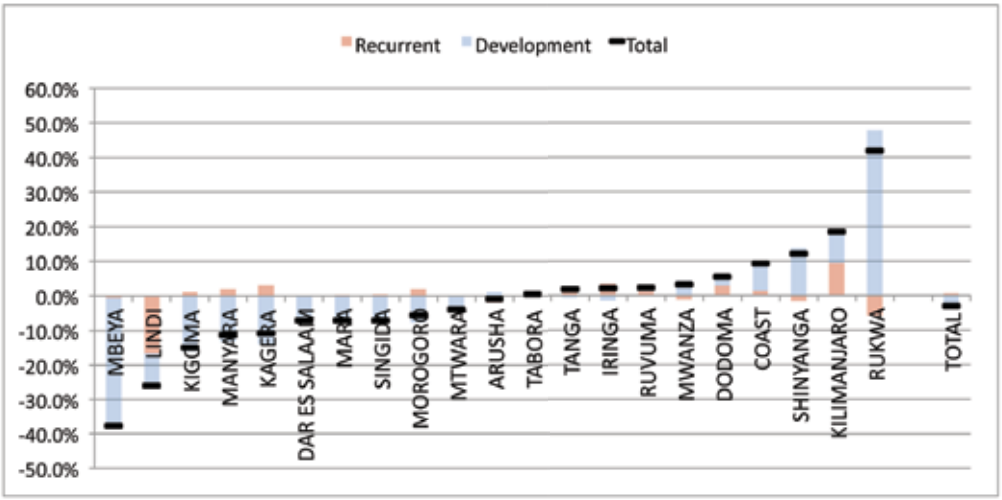
*Recurrent expenditures imply the allocations for Preventive Services and for Regional Hospitals.

Sources: URT (2010a), and URT (2010c).

5.1. Allocations to Regions

Figure 7 below shows how reallocations have affected each particular region. Mbeya has experienced the largest total cuts (-37.9%), which mainly arise from trimmed development expenditures. The region that has mostly benefitted from reallocations is the Rukwa region. The reduction of its recurrent expenditures (-11.4%) have been offset by a doubled development budget, which accounts for about 2/3 of Rukwa's total budget. On balance, the region is to receive 41.2% more funds than in the previous fiscal period.

Figure 7: Budget Changes in Regions from FY 2009/10 to FY 2010/11



Note: the bars of recurrent and development budget changes reflect their impact on the total budget.

Sources: URT (2010b), and URT (2010c).

Unfortunately, a deep analysis of how the development budget is used could not be conducted since we failed to obtain the MTEF of the PMO-RALG. Hence it was not possible for us to examine health related activities in conjunction with their objectives. Therefore, we relied on the available Budget Book Vol. IV, which gives only a vague idea of how the money is to be spent; the sub vote descriptions indicate both funding sources as well as purposes.

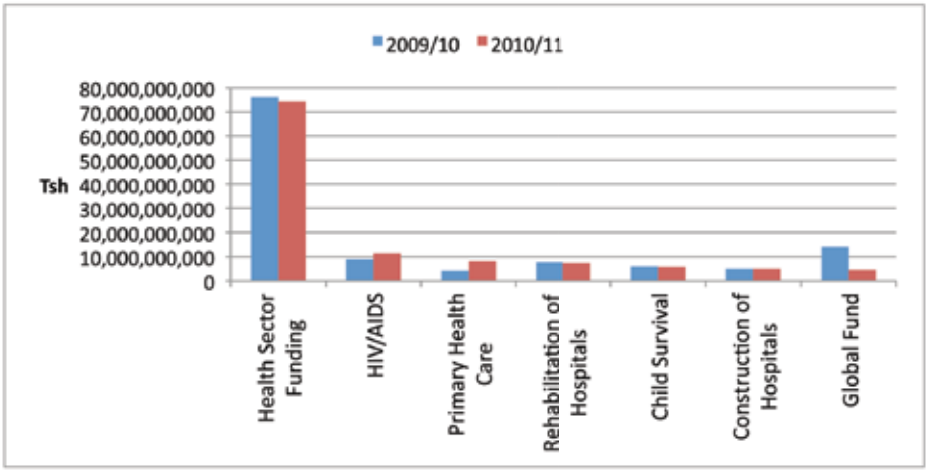
Figure 8 below shows that 'health sector funding'[9], which amounted Tsh 76.1 bn in the FY 2009/10, has diminished by 2.4% towards Tsh 74.3 bn in the current FY 2010/11. The sum of Global Fund allocations (excluding the HIV/AIDS Prevention Project in Arusha which we attributed to 'HIV/AIDS') has dropped from Tsh 14.1 bn to Tsh 4.4 bn. We could not identify the reasons for this staggering reduction of 69%.

The regional development allocations for HIV/AIDS have experienced a substantial rise from Tsh 8.9 bn in the FY 2009/10 to Tsh 11.2 bn in 2010/11; that is an increase of 26.7%. On the other hand, the development expenditures for constructing district and regional hospitals have been almost stagnating (+0.8%) at nearly Tsh 5 bn in the current FY 2010/11. Meanwhile, the estimated expenditures for the rehabilitation of regional and government hospitals have declined by 4.2% towards Tsh 7.4 bn in 2010/11.[10]

9 This category includes the sub votes Health Sector Basket Fund, Health Basket Project, Health Sector Program Support, Health Sector Development Grant and the UNICEF Support for Health.

10 More details can be found in Table 8 in the annex.

Figure 8: Changes in Development Votes for Regions from 2009/10 to 2010/11



Source: URT (2010c).

5.2. Allocative Inequalities

While the increased development expenditures to fight HIV/AIDS are welcome, we can see in Figure 9 that these funds have been allocated without the consideration of HIV/AIDS prevalence rates. Regions which suffer most do *not* receive significantly more development funds to curb the spreading of the pandemic disease.[11] While Iringa region exhibits the highest HIV/AIDS prevalence rate of 16%, its per capita[12] development spending on HIV/AIDS amounts only Tsh 328, whereas Arusha region, which is among those with the lowest HIV/AIDS prevalence rate in the country (2%), receives Tsh 411 per capita.

Another example highlighting allocative inequalities are the per capita allocations for the construction and rehabilitation of regional and district hospitals. As depicted by Figure 10 below, those development expenditures are not corresponding to reported outpatient department (OPD) attendance.[13] While the Health Sector Performance Profile Report 2010 Update claims[14] that a high OPD attendance 'implies that the population is highly satisfied by provision of services in these facilities', Sikika relates a high OPD attendance to greater service needs which are straining the limited capacities of the health system.

11 In fact, the correlation between the per capita development spending on HIV/AIDS and corresponding prevalence rates is zero.

12 Per capita spending has been calculated using de jure household population data from TACAIDS (2008), p. 19.

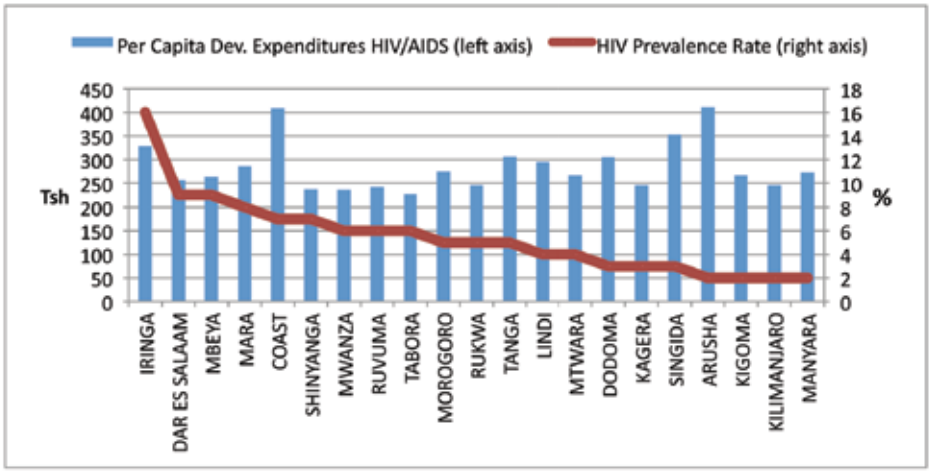
13 The correlation between per capita development spending on the construction and rehabilitation of regional and district hospitals and the OPD attendance rate is (-0.08).

14 MoHSW (2010b), p. 11.

Accordingly, Mara region suffers from the highest OPD attendance (1.45) in the country, but when it comes to investing in regional hospitals the Mara region is only ranked in the midfield (9th) of all 21 regions receiving Tsh 364 per capita. Meanwhile, Manyara region has an OPD attendance of 0.46 and it receives Tsh 1565 per capita. Thus, it operates with more than 4 times of Mara region's funding while featuring less than 1/3 of its OPD attendance.

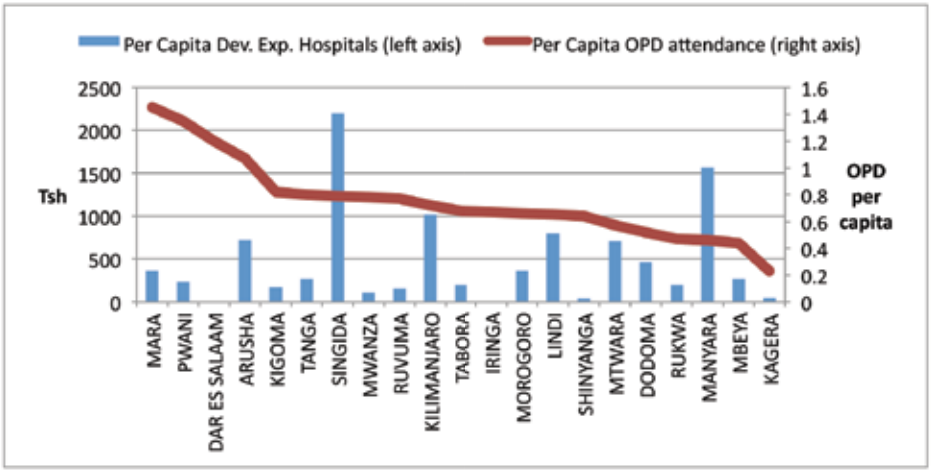
Sikika asks itself why the scarce development funds are not devoted for the most burdened regions.

Figure 9: Regional Development Votes for HIV/AIDS in 2010/11



Sources: URT (2010c), and TACAIDS (2008).

Figure 10: Regional Development Votes for Hospitals in 2010/11



Sources: URT (2010c), and MoHSW (2010b).

6. Selected Subjects

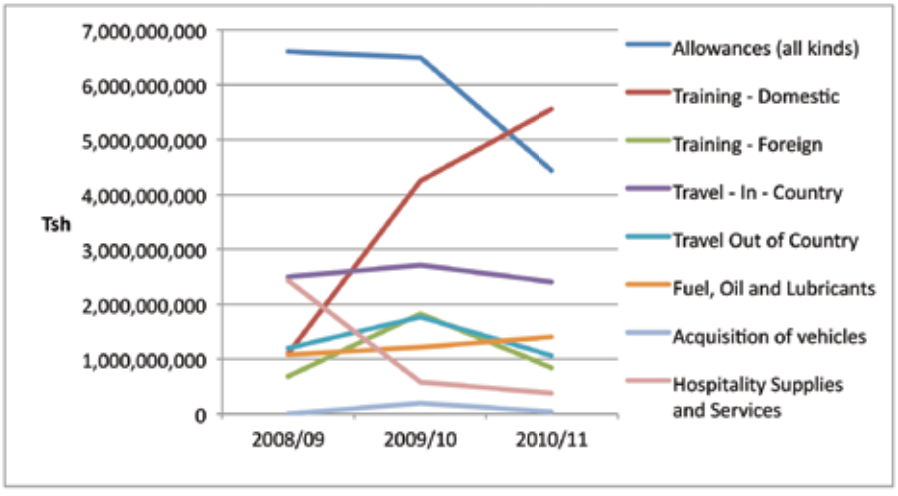
6.1. Unnecessary Expenditures

Unnecessary expenditures occur if money is spent inefficiently or ineffectively. That means that, either, certain objectives could be achieved with fewer resources, or that an activity does not necessarily benefit deprived citizens. Efficient expenditure is realized when the value for money is maximized and services or goods are delivered at a minimum cost.

Sikika has identified a number of items in the budget books that are at risk containing unnecessary expenditures such as allowances, trainings (which might include ineffective seminars and workshops), and the acquisition of expensive vehicles. The Ministry's budget indicates some progress reflected by an overall decrease of 15 % in such expenditures (see Figure 11 below and Table 11 in the annex). This is an indication that at least the MoHSW is somehow implementing the directives given by the Prime Minister Mizengo Pinda in 2008, which requires all Ministries, Department and Agencies (MDAs) to focus on activities that benefit the majority of the citizens, especially in the rural areas where most people live rather than planning for seminars and workshops with questionable efficiency and which would also imply more allowances that benefit only some officials.

There is a steady decrease in the allocation of allowances. Compared to the last FY, they have been reduced by one third to Tsh 4.4 bn. This favourable development also applies to 'Travel – In – Country' (-11%), 'Travel Out of Country' (-40%), 'Acquisition of Vehicles' (-83%) and 'Hospitality Supplies and Services' (-35%). These savings altogether sum up to about Tsh 4.4 bn for which the Ministry should be highly commended.

Figure 11: Unnecessary Expenditures in the MoHSW



Sources: URT (2008), URT (2009), and URT (2010a).

There is a 15% increase in the budget for fuel, oil & lubricants, from 1.2 bn to 1.4 bn. If one considers the surging world prices for energy, this increase does not raise serious concerns.

The MOHSW has increased the allocation for 'Training - In - Country' by 31 % which is accompanied by a drastic fall of 'Training Foreign' (-54%). This indicates that the ministry continues to focus on training using the capacity within the country. The question if these activities are implemented efficiently and if they achieve value for money remains unanswered. With publicly available performance indicators regarding health training institutions one could approximate the efficiency and effectiveness of financial management.

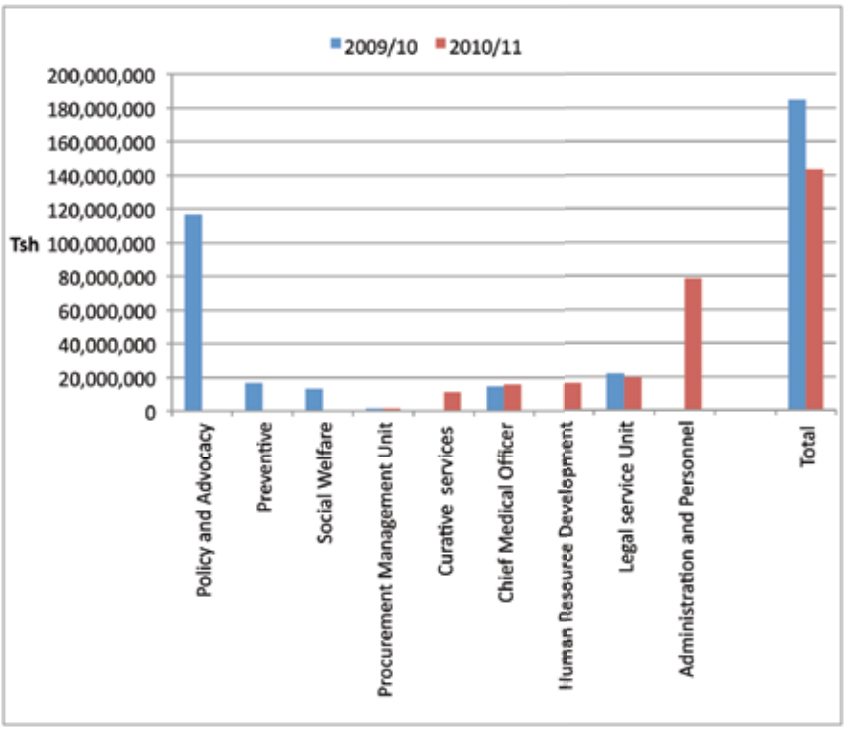
Given the scarcity of resources and the potential need to improve the health system and its facilities, the Ministry needs to continue prioritizing its activities and ensure that funds are not being allocated wastefully. The generated savings from cutting down on unnecessary expenditure should be properly allocated and spent.

6.2. Participation of MoHSW Staff in Parliamentary Sessions

This analysis shows that in the FY 2009/10, the Ministry spent about Tsh 184 mil for staff to participate in the parliamentary sessions, and in 2010/11 the plan is to spend Tsh 143 mil for the same activity (see Figure 12 below and Table 12 in the annex). Again, the Directorate of Policy and Planning will spend 75 mil shillings for the Minister, Deputy Minister and four officials to visit their respective constituencies. It is obvious that the National Assembly is responsible for the budget of the Members of Parliament who need to visit their constituencies. This, therefore, raises the question of double allocations. A discrepancy such as this is also unacceptable considering the fact that the Tsh 75 mil alone is more than twice what regions will receive as allocations for their multi-sectoral HIV/AIDS projects or for the activities for the prevention of transmission of HIV/AIDS. The allocation per region for these projects in the PHSDP is Tsh 30 mil per region. These kinds of occurrences raise not only questions concerning the extravagant use of funds, but may also indicate the difficulties of having one person serving as both an MP and as a Minister at the same time. Where is the separation of powers? Could this be the reason why the same activity is being allocated more than once?

Another example shows that the Legal Service Department has allocated Tsh 19 mil to facilitate the MOHSW State attorney to participate in parliamentary activities 5 times a year with a per diem of Tsh 3.4 mil per trip or 17 mil annually and diesel of Tsh 2.2 mil, while the Curative Services Department has allocated 11 mil for the participation in the parliamentary budget session. This will include per diems of Tsh 4 mil for ten staff and 2025 litres of diesel for Tsh 4 mil and expenses for motor vehicles which costs Tsh 3.3 mil. This shows inefficiency in the planning and budgeting process and it also indicates that a lot of resources are directed toward activities that are benefiting relatively few people rather than achieving objectives set by the ministry.

Figure 12: Participation of the MoHSW Staff at the Parliamentary Sessions



Sources: MoHSW (2009c), and MoHSW (2010a).

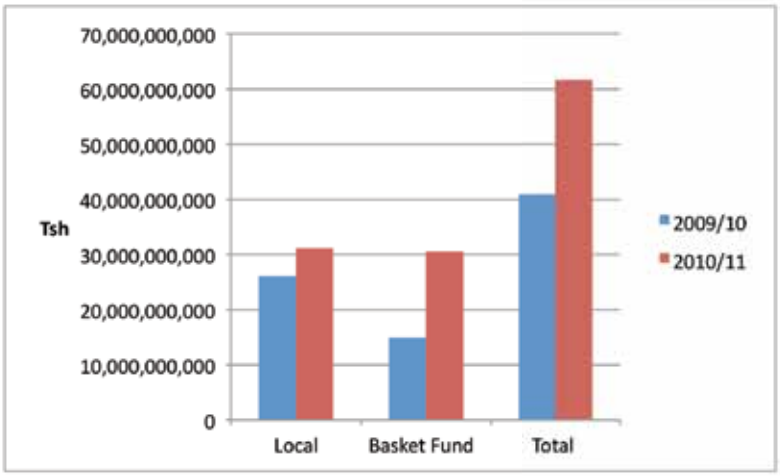
6.3. Drugs and Pharmaceuticals

The budget information for the procurement and distribution of drugs and pharmaceuticals is recorded and kept by the Medical Stores Department (MSD). Unfortunately, Sikika was not able to obtain budget records from the MSD; so information on this section is limited.

For the year 2010/11, the government will spend in total Tsh 342 bn for drugs and pharmaceuticals. About Tsh 62 bn will be financed 'on-budget', whereas Tsh 281 bn is added by the Global Fund this year. From the MoHSW budget speech we know that the Tsh 61.7 bn is about equally financed by the Tanzanian government, which contributes approximately Tsh 31 bn, and the development partners who contribute Tsh 30 bn through the basket fund.[15] Accordingly, the on-budget allocation shows an increase of 51% compared to the FY 2009/10 which allocated Tsh 40 bn to drugs and supplies (compare Figure 13 below and Table 13 in the annex).

15 Ofisi Ya Bunge (2010b), p. 86.

Figure 13: On-Budget Allocations for Drugs & Pharmaceuticals



Sources: Ofisi Ya Bunge (2010b).

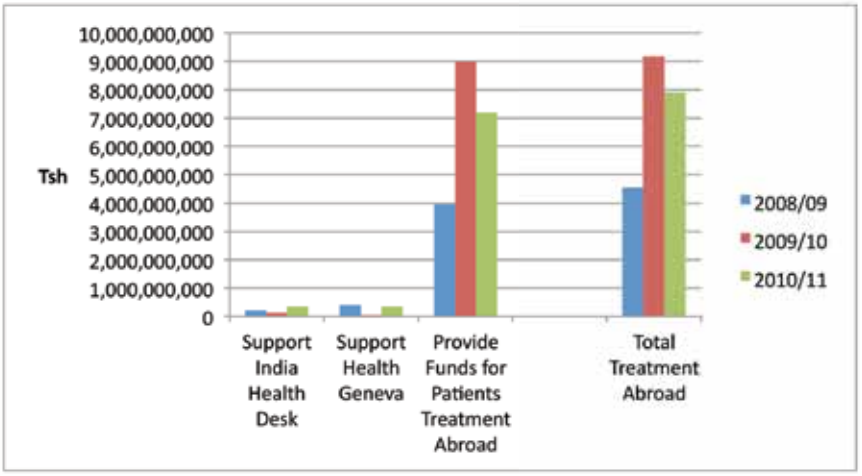
The large off-budget contribution from the Global Fund is to help fighting HIV/AIDS, malaria and tuberculosis by adding drugs to various health facilities around the country.

These increases of the allocation for drugs and supplies need to be reflected in the services which are delivered in the health facilities, and it is our hope that the increased allocation is spent wisely so that the problem of drug shortages in public health facilities can be dealt with as soon as possible.

6.4. Treatment Abroad

For the year 2010/11, the MoHSW has allocated Tsh 7.9 bn for treatment abroad (see Figure 14 below and Table 14 in the annex). This is a decrease of 14 % compared with Tsh 9.2 bn for the FY 2009/10. This money will be spent on providing support for patients who are going to receive care and treatments in various hospitals outside of Tanzania. In the FY 2009/10, 535 patients were sent abroad for treatment, mainly on heart diseases, kidney problems and cancer. One thing that is still not clear is how the patients who are to be treated abroad are selected. Is there a likelihood of improving the services within the country if our leaders are the ones that are benefitting from the treatment abroad? Figure 14 below shows these allocations for three years.

Figure 14: Treatment Abroad



Sources: MoHSW (2009c), and MoHSW (2010a).

7. Budget Allocation vs. Strategic Planning

The planning and budgeting in the health sector is guided by key policies and strategic plans which are meant to achieve better health services for all. The activities of the MOHSW for each financial year use several guidelines and key policy documents. One of these guidelines is the Medium Term Expenditure Framework (MTEF) that gives the breakdown of the budget in line with objectives and the amount allocated for each activity. The other documents include the Health policy (2007), Development visions 2025, the Human resources for health development policy (2008-2015), the Health Sector Strategic Plan (2009-2015) and Primary Health Care Development program (2007-2017). Particularly the conformity among, and inconsistencies within those documents was seen as a significant area of concern. We also identified areas of ineffective and unrealistic budget plans.

Nonconforming Plans

The HSSP III and PHSDP seem to contradict each other in terms of how certain issues will be addressed, and their strategies are not completely in tune with the MoHSW's plans. For example, according to the PHSDP, the FY's 2010/11 budget of Tsh 59.8 bn is indicated to be spent for the implementation of activities relating to human resource for health. The HSSP III plans to spend USD 79.4 mil (or Tsh 119.1 bn)[16] while the HRH strategic plan indicates to spend Tsh 90.3 bn for the same activity. But the 2010/11 budget allocations indicate that the MoHSW has set aside only Tsh 26.8 bn for the directorate of Human Resources Development. We, therefore, notice problems here: firstly, in terms of aligning the budget for the Ministry with what is stipulated in the long term strategic plans and, secondly, the fact that the allocation targets of the national policy framework contradict each other.

16 This conversion from USD into Tsh is based on an assumed exchange rate of USD 1 = Tsh 1500.

Non-conform planning can also be seen if one compares the Health Sector Strategic Plan III with the Abuja declaration: in the former document, the ministry has set an objective to enhance the total budget of health services to 10% by 2015, while, in the latter one, the target is to allocate at least 15 % of the total budget to the health sector. Thus, the ministry had already achieved the HSSP III objective (the sector has received 11% and 11.3% for the year 2008/9 and 2009/10, respectively) while it has repeatedly failed to reach the Abuja-target. Therefore, the planning of the Ministry calls for attention because it does not seem to be integrative.

Inconsistent Plans

It has been noted that some activities in the MTEF have been moved to different objectives in annual budgets. For example, in the same Human Resources Department, the MTEF 2010/11 activity 'Facilitating expatriate exchange program with China, Cuba and Russia, India, and Israel' falls under the objective of 'Equitable and Gender sensitive health and social welfare'. In 2009/10, the same activity is found under the objective 'Burden of Disease Reduced'. And in the MTEF 2008/09, this activity was found under the objective 'Research, Training and continuous professional development for improved performance enhanced'. This activity for facilitating an expatriate exchange program does seem to facilitate the achievement of the objective mentioned in the 2008/2009 MTEF, but it is difficult to determine how this activity would be used to complete the objectives under which it was placed in the 2009/2010 and the 2010/2011 MTEFs. These inconsistencies make it difficult to track how the objectives are being implemented and cast doubt whether all of the activities that are being implemented are indeed necessary to enable the achievement of the stated objectives.

The 'Memorandum of revenue estimates, recurrent expenditure and development budget for the year 2010/11' normally gives details of how allocated funds are going to be spent. The allocation for the ministry shows that a total of Tsh 1 bn is allocated for medical supplies and services in sub vote 4002 (budget book vote 52). That means the money is targeted to purchase medical equipment or other essentials, but the description of how the money will be spent shows that money will be used to purchase food for 2000 residents in old age homes, and supply of food staff for orphanage centres at Kurasini instead of purchasing medical supplies essentials.

Ineffective Plans

In the MTEF, the objective 'Reducing the Burden of Disease' implies the target 'Improve accessibility of malaria pharmaceuticals and diagnostic supplies to both the public and the private sector to reduce morbidity and mortality by 50% by 2013'. To reach that target, a number of activities are planned to be implemented incurring total costs of about Tsh 95.5 mil. One of those activities is commemorating the World Malaria Day by June 2011. The event is planned to use more than Tsh 62 mil, that means 2/3 of the total amount, which could be cut and be directed to areas like purchases of mosquito nets which will help reducing the dissemination of malaria.

Unrealistic Plans

In the MTEF under objective A of 'Services improved and HIV and AIDS infections reduced' under the target of 'The impact of HIV and AIDS at work place and institution for vulnerable groups mitigated by 2012/13' the planned activity is to provide care and support to 100 staff living with HIV/AIDS by 2012/13. We can see that this activity facilitates the target of mitigating the impact of HIV/AIDS in the workplace, but it does not satisfactorily address the completion of objective A. Providing care and support to 100 staff may improve services for at least those staff being treated, but it does nothing to reduce the overall amount of infections of HIV/AIDs as there is no preventative measure mentioned in this activity.

Moreover, for recurrent expenditures in sub vote 1005, under the category item 'Travel out of country', the Ministry allocates 100,000 for travel, but, realistically, the money is not enough for that activity. This shows that the money which is allocated to achieve certain goals has not been properly planned.

Other problems with regard to planning are unrealistic or over ambitious targets; their formulation is still a problem. For example, under the objective 'Reducing the Burden of Disease', one of the targets is to reduce maternal mortality by 50% from the current levels of 578/100,000 by 2011. This is sincerely unrealistic given the struggles reducing maternal mortality. The Government has allocated Tsh 37 bn to reduce the maternal mortality in the country. A total of Tsh 3 bn is planned to be spent on the procurement and distribution of delivery kits in all health facilities, and Tsh 20 bn will be used to support the program for reducing maternal mortality rates in three regions of Tabora, Mara and Mtwara.

The setting of general targets gives room for the misuse of funds since one may decide to direct the resources into other (unnecessary) expenditures. For example: the targets 'strengthening referral systems by June 2013', 'expanded Program on Immunization capacity to manage, monitor, supervise and facilitate service delivery improved by June 2011', and 'efficient administrative and welfare services provided' are difficult to measure as they are not specific. Words like 'improved', 'provided', and 'efficient' are vague and they don't indicate the actual situation and the actual target, i.e. in numbers, percentages, etc.

8. Expenditure Management

From the audit reports for the Ministry, there are queries raised with regard to their expenditure. Despite the efforts seen in the PHSDP to address the key areas of human resources for health, the expenditure of a large amount of funds has been questioned by the Controller and Auditor General. For example, in the FY 2007/08, FY2008/09 and 2009/10, salaries amounting to Tsh 326 mil, Tsh 78 mil and Tsh 83.8 mil, respectively, were paid to retirees, absconders and deceased employees. Also, for the year ended June 2009, payments amounting to Tsh 157 mil were lacking supporting documents, and imprests amounting to Tsh 313 mil issued to various officials were still outstanding. More efforts are needed managing the spending by the government rather than advocating more financial

resources. Has anybody been held accountable for all these queries which have been happening in almost every audit report?

Also, in recent years, the computerized inventory management system has not provided a reliable stock management. The budget allocation for better inventory software will improve the tracking of medicines and supplies and increase accountability in the case of misplaced and expiring drugs. There was a case in 2007, for instance, where ACTs with a value of 819,000 USD were found to be missing as they could not be accounted for by the computerized inventory system.[17]

9. Recommendations

As it has been discussed above, the allocation for the sector has never reached the Abuja target of 15% as the government committed. But to improve its performance, the health sector needs much more than a mere increase of financial resources. Sikika believes that an efficient and effective allocation and spending of resources is needed rather than just to increase the funding to the sector. However, the current trend of allocation and spending does not predict a bright future for the sector.

Improve Budget Planning

Good planning is something that may help the sector to move forward. We recommend that when the planning process for the 2011/12 budget begins, the health sector's needs should be given a priority for the purpose of overcoming the challenges that the sector faces. Individually, the various health policies in place are well constructed. But the different policies that guide the sector still need to be aligned. Targets have to be realistic and clearly defined so that, at the end, their achievement can be objectively measured. Moreover, these policies and guidelines are to be consulted to ensure that resources are allocated according to the stated priorities. The planning for public expenditures without focusing on the real needs of the people does not only jeopardize the development of the health sector, but is also against the monetary regulations guiding public expenditure. A budget that is planned without focusing on the needs of the people does not help to solve their problems and, thus, such a budget does not lead to sustainable development of the Tanzanian health sector.

It is important that the government does its best to ensure that the planning aims at allocating funds to tackle the root problems, rather than symptoms. There is no point in trying to rectify a specific problem when the underlying issues that are causing this problem are not being addressed. By looking at Human Resources for health, for instance, there is no point of just allocating more money for the recruitment of health workers to cater to the shortage of health workers if the reasons why some do not report to their duty stations, or issues such as the long waiting time to receive salaries which increases the attrition rate in healthcare facilities, are not addressed.

17 OIG (2009), p.7.

Improve Budget Oversight

It is also recommended that the budget process becomes more transparent than it is now. Currently, Members of Parliament who are to oversee all public expenditures are not provided with key budget documents like the Medium Term Expenditure Frameworks which relate allocations to objectives and targets. As this analysis shows, it was not possible for Sikika to meaningfully analyze the allocation of funds that are channelled to the LGAs without the availability of the PMO-RALG MTEF. The permanent secretary of the MoHSW should make sure that the MTEF is prepared in time and distributed to the Parliamentary Committee for Social Services to enable them scrutinizing the budget before it is tabled in the Parliament for approval.

Financial discipline needs to be strengthened. The findings by the Controller and Auditor General (CAG) concerning MDAs, including the MoHSW, provide strong evidence that a significant amount of public funds is being abused and misused. However, his recommendations have not been taken seriously. His queries are being raised year in year out. As per article 63.3 of the Constitution, and on behalf of the National Assembly, the Social Services Committee has the mandate to raise issues concerning public affairs. We advise the Committee to monitor and make follow ups on whether audit recommendations have been implemented or not. Also, it should take time to go through the CAG reports of the Ministry and identify the major issues and steps to be taken in order to address poor performance by demanding an explanation from the Minister regarding how the CAG's findings were acted upon, who was found to be responsible, and what action has been taken against them.

The Accounting Officers (these are the Permanent Secretaries to the Ministries) have the responsibility of preparing the action plan in response to the CAG report and they submit those to the Paymaster General (Permanent Secretary for the Ministry of Finance and Economic Affairs) who also must submit responses and action plans to the Minister who presents them to the National Assembly. Article 10(iii) of the Public Finance Act requires the Paymaster General and Accounting Officers to make good on losses or deficiencies by applying legal measures and disciplinary actions against the persons who have misused or abused public resources. The public would like to see measures taken against those who are proved to have misused or abused public funds.

List of References

MoHSW (2008), Human Resource for Health Strategic Plan (HRHSP) 2008-2013, MoHSW, Dar es Salaam.

MoHSW (2009a), Health Sector Performance Profile Reports Mainland Tanzania July 2007-June 2008, MOHSW, Dar es Salaam.

MoHSW (2009b), Health Sector Strategic Plan III (2009-1015), MoHSW, Dar es Salaam.

MOHSW (2009c), Medium Term Expenditure Framework for the Year 2009/10, MoHSW, Dar es Salaam.

MOHSW (2010a), Medium Term Expenditure Framework for the Year 2010/11, MoHSW, Dar es Salaam.

MoHSW (2010b), Health Sector Performance Profile Report 2010 Update, MoHSW, Dar es Salaam.

Ofisi Ya Bunge (2010a), Hansard 10th of June, 2010, Ofisi ya Bunge, Dodoma.

Ofisi Ya Bunge (2010b), Hansard 28th of June, 2010, Ofisi ya Bunge, Dodoma.

OIG (2009), Audit Report on Global Fund Grants to Tanzania, The Global Fund.

TACAIDS (2008), Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08, Dar es Salaam.

URT (2007), Primary Health Service Development Programme (PHSDP) 2007-2017, Government Printer, Dar es Salaam.

URT (2008), Volume II Estimates of Public Expenditure Consolidated Fund Services (Section I) and Supply Votes (Ministerial), Government Printer, Dar es Salaam.

URT (2009), Volume II Estimates of Public Expenditure Consolidated Fund Services (Section I) and Supply Votes (Ministerial), Government Printer, Dar es Salaam.

URT (2010a), Volume II Estimates of Public Expenditure Consolidated Fund Services (Section I) and Supply Votes (Ministerial), Government Printer, Dar es Salaam.

URT (2010b), Volume III Estimates of Public Expenditure Supply Votes (Regional), Government Printer, Dar es Salaam.

URT (2010c), Volume IV Estimates of Public Expenditure Development Votes, Government Printer, Dar es Salaam.

Annex

Table 2: Budget Allocation for the MoHSW

Fund	Financial Year			Change 2009/10 to 2010/11
	2008/09	2009/10	2010/11	
Recurrent	198,157,615,000	218,393,211,000	229,978,968,000	5%
Development	242,067,318,100	260,599,867,000	448,442,515,000	72%
Total	**440,224,933,100**	**478,993,078,000**	**678,421,483,000**	**42%**

Sources: URT (2010a), and URT(2010c).

Table 3: Development Allocations of the MoH

Fund	Financial Year			Change 2009/10 to 2010/11
	2008/09	2009/2010	2010/11	
Local Funds	13,029,173,000	13,029,173,000	9,873,761,000	-24%
Basket Funds	163,996,057,927	93,223,320,000	319,791,389,187	243%
Others	65,042,087,173	154,347,374,000	118,777,364,813	-23%
TOTAL	**242,067,318,100**	**260,599,867,000**	**448,442,515,000**	**72%**

Source: URT (2010c).

Table 4: Budget Allocation Share across Departments for FY 2010/1

Sub Vote	Recurrent Budget	Development Budget	Total Budget	Share of MoHSW Budget
Preventive Services	28,896,218,252	304,022,804,007	332,919,022,259	49.07%
Curative Services	159,486,499,336	70,247,573,233	229,734,072,569	33.86%
Policy and Planning	884,507,760	67,345,289,760	68,229,797,520	10.06%
Human Resources Dev	21,787,173,950	4,971,570,000	26,758,743,950	3.94%
Chief Medical Officer	8,877,971,890	-	8,877,971,890	1.31%
Social Welfare	3,891,251,338	1,355,278,000	5,246,529,338	0.77%
Admin. and General	4,772,188,004	-	4,772,188,004	0.70%
Finance and Accounts	704,590,000	-	704,590,000	0.10%
Tanzania Food and Drugs A.	-	500,000,000	500,000,000	0.07%
Info., Edu. and Comm.	268,175,470	-	268,175,470	0.04%
Procurement	236,342,000	-	236,342,000	0.03%
Internal Audit	91,850,000	-	91,850,000	0.01%
Legal Services Unit	82,200,000	-	82,200,000	0.01%
Total	**229,978,968,000**	**448,442,515,000**	**678,421,483,000**	**100%**

Sources: URT (2010a), and URT (2010c).

Table 5: Allocations for Human Resources for Health

Expenditure	Financial Year			Change 2009/10 to 2010/11
	2008/09	2009/10	2010/11	
Recurrent	16,341,507,472	17,398,135,400	21,787,173,950	25%
Development - Local	0	635,820,700	800,000,000	26%
Development - Foreign	3,774,197,477	5,395,998,600	4,171,570,000	-23%
Total	**20,115,704,949**	**23,429,954,700**	**26,758,743,950**	**14%**

Sources: URT (2010a), and URT (2010c).

Table 6: LGA Allocations for Health in the FY 2009/10 and 2010/11

Fund	Financial Year		Change 2009/10 to 2010/11
	2009/10	2010/11	
Recurrent*	41,992,072,300	42,933,122,800	2.2%
Development	122,281,973,100	116,309,338,600	-4.9%
Total	**164,274,045,400**	**159,242,461,400**	**-3.1%**

*Recurrent expenditures imply the allocations for Preventive Services and for Regional Hospitals.

Sources: URT (2010a), and URT (2010c).

Table 7: Budget of Regions in FY 2009/10 and FY 2010/11

Region	2009/10			2010/11		
	Recurrent	Development	Total	Recurrent	Development	Total
MBEYA	1,336,565,000	10,149,337,900	11,485,902,900	1,266,786,000	5,870,451,000	7,137,237,000
LINDI	1,729,523,000	3,447,630,000	5,177,153,000	867,922,000	2,969,307,000	3,837,229,000
KIGOMA	1,646,092,000	6,971,088,000	8,617,180,000	1,735,124,000	5,596,052,000	7,331,176,000
MANYARA	115,739,000	5,617,102,600	5,732,841,600	231,938,000	4,852,866,000	5,084,804,000
KAGERA	2,062,044,000	6,753,611,000	8,815,655,000	2,330,523,000	5,529,054,000	7,859,577,000
DAR ES SALAAM	0	6,526,051,000	6,526,051,000	0	6,062,438,000	6,062,438,000
MARA	2,318,372,300	4,438,559,000	6,756,931,300	2,340,118,000	3,938,816,000	6,278,934,000
SINGIDA	1,881,642,000	5,731,834,000	7,613,476,000	1,922,938,000	5,154,256,000	7,077,194,000
MOROGORO	3,772,888,000	5,955,848,000	9,728,736,000	3,966,273,000	5,213,343,000	9,179,616,000
MTWARA	1,870,213,000	5,298,617,000	7,168,830,000	1,884,950,000	5,001,384,000	6,886,334,000
ARUSHA	3,237,932,000	5,161,641,600	8,399,573,600	3,073,330,000	5,249,486,000	8,322,816,000
TABORA	1,944,473,000	5,886,254,000	7,830,727,000	1,986,986,000	5,886,169,000	7,873,155,000
TANGA	2,876,942,000	5,885,656,000	8,762,598,000	3,089,596,000	5,831,398,000	8,920,994,000
IRINGA	2,531,551,000	5,936,078,000	8,467,629,000	2,826,031,000	5,815,657,000	8,641,688,000
RUVUMA	3,022,183,000	4,431,584,000	7,453,767,000	3,113,522,000	4,511,321,000	7,624,843,000
MWANZA	2,299,300,000	9,632,380,000	11,931,680,000	2,170,218,000	10,133,876,000	12,304,094,000
DODOMA	2,790,320,000	5,813,278,000	8,603,598,000	3,032,454,000	6,033,684,000	9,066,138,000
COAST	155,900,000	3,278,300,000	3,434,200,000	202,798,000	3,549,837,000	3,752,635,000
SHINYANGA	2,165,153,000	7,125,963,000	9,291,116,000	2,016,868,000	8,393,074,600	10,409,942,600
KILIMANJARO	2,414,921,000	6,569,466,000	8,984,387,000	3,261,182,000	7,377,061,000	10,638,243,000
RUKWA	1,820,319,000	1,671,694,000	3,492,013,000	1,613,565,800	3,339,808,000	4,953,373,800
TOTAL	**41,992,072,300**	**122,281,973,100**	**164,274,045,400**	**42,933,122,800**	**116,309,338,600**	**159,242,461,400**

Sources: URT (2010b), and URT (2010c).

Table 8: Changes in Development Votes for Regions from 2009/10 to 2010/11

Fund	Financial Year		Change 2009/10 to 2010/11
	2009/10	2010/11	
Health Sector Funding	76,121,461,100	74,266,975,030	-2.4%
HIV/AIDS	8,891,364,000	11,264,508,000	26.7%
Primary Health Care	4,392,046,000	8,082,397,000	84.0%
Rehabilitation of Hospitals	7,776,783,000	7,446,932,000	-4.2%
Child Survival	5,988,426,000	5,828,736,000	-2.7%
Construction of Hospitals	4,971,893,000	5,012,755,000	0.8%
Global Fund	14,140,000,000	4,407,035,570	-68.8%
Total	**122,281,973,100**	**116,309,338,600**	**-4.9%**

Source: URT (2010c).

Table 9: Regional Development Votes for HIV/AIDS in 2010/11

Region	Per Capita Spending on HIV/AIDS	HIV Prevalence (%)
ARUSHA	328	2
DAR ES SALAAM	257	9
DODOMA	263	3
IRINGA	286	16
KAGERA	409	3
KIGOMA	237	2
KILIMANJARO	236	2
LINDI	242	4
MANYARA	227	2
MARA	275	8
MBEYA	246	9
MOROGORO	307	5
MTWARA	295	4
MWANZA	267	6
PWANI	306	7
RUKWA	246	5
RUVUMA	354	6
SHINYANGA	411	7
SINGIDA	267	3
TABORA	246	6
TANGA	273	5
Average	**285**	**6**

Sources: URT (2010c), and TACAIDS (2008).

Table 10: Regional Development Votes for Hospitals in 2010/11

Region	OPD Attendance	Per Capita Dev. Exp. of Hospitals
ARUSHA	1.07	720
DAR ES SALAAM	1.2	0
DODOMA	0.52	464
IRINGA	0.67	0
KAGERA	0.23	41
KIGOMA	0.82	175
KILIMANJARO	0.72	1016
LINDI	0.65	798
MANYARA	0.46	1565
MARA	1.45	364
MBEYA	0.44	266
MOROGORO	0.66	365
MTWARA	0.57	706
MWANZA	0.78	105
PWANI	1.35	232
RUKWA	0.47	194
RUVUMA	0.77	154
SHINYANGA	0.64	35
SINGIDA	0.79	2195
TABORA	0.68	196
TANGA	0.8	270
Average	**0.74**	**356**

Sources: URT (2010c), and MoHSW (2010b).

Table 11: Unnecessary Expenditures in the MoH

Budget Item	Financial Year			Change 2009/10 to 2010/11
	2008/09	2009/10	2010/11	
Allowances (all kinds)	6,612,453,500	6,499,189,970	4,438,866,302	-32%
Training - Domestic	1,098,043,500	4,250,143,120	5,562,906,200	31%
Training - Foreign	684,781,700	1,823,130,000	846,348,930	-54%
Travel - In - Country	2,502,831,494	2,717,741,148	2,405,789,784	-11%
Travel Out of Country	1,198,567,800	1,773,560,900	1,061,641,600	-40%
Fuel, Oil and Lubricants	1,079,404,900	1,214,929,200	1,401,832,000	15%
Acquisition of vehicles	0	194,400,000	33,000,000	-83%
Hospitality Supplies and Services	2,429,139,900	576,733,000	376,738,000	-35%
Total	**15,605,222,794**	**19,049,827,338**	**16,127,122,816**	**-15%**

Sources: URT (2008), URT (2009), and URT (2010a).

Table 12: Participation of the MoHSW Staff at the Parliamentary Session

Department	Financial Year		Change 2009/10 to 2010/11
	2009/10	2010/11	
Administration and Personnel	0	78,620,000	-
Policy and Advocacy	116,800,000	0	-100%
Procurement Management Unit	1,600,000	1,600,000	0%
Legal service Unit	21,950,000	19,650,000	-10%
Curative services	0	11,350,000	-
Chief Medical Officer	14,670,000	15,760,000	7%
Preventive	16,380,200	0	-100%
Human Resource Development	0	16,100,000	-
Social Welfare	13,270,000	0	-100%
Total	**184,670,200**	**143,080,000**	**-23%**

Sources: MoHSW (2009c), and MoHSW (2010a).

Table 13: On-Budget Allocations for Drugs & Pharmaceuticals

Fund	Financial Year		Change 2009/10 to 2010/11
	2009/10	2010/11	
Local	26,124,341,297	31,075,172,172	19%
Basket Fund	14,899,782,000	30,600,000,000	105%
Total	**41,024,123,297**	**61,675,172,172**	**50%**

Sources: Ofisi Ya Bunge (2010b).

Table 14: Treatment Abroad

Activity	Financial Year			Change 2009/10 to 2010/11
	2008/09	2009/10	2010/11	
Support India Health Desk	200,000,000	140,000,000	350,000,000	150%
Support Health Geneva	400,000,000	50,000,000	345,667,192	591%
Provide Funds for Patients Treatment Abroad	3,958,440,000	8,987,243,500	7,201,000,000	-20%
Total Treatment Abroad	**4,558,440,000**	**9,177,243,500**	**7,896,667,192**	**-14%**

Sources: MoHSW (2009c), and MoHSW (2010a).



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