A Report on RMNCAH Resources Mapping for Tanzania One Plan III and a Roadmap for Harmonization of Resources mapping and National Health Accounts (NHA).

The financial year 2021/2022.

November 2021

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1. List of Acronyms

BoT	Bank of Tanzania
CAD	Canadian Dollar
CHAI	Clinton Health Access Initiative
DFA	Department of Foreign Affairs Ireland
DPP	Directorate of Policy and Planning
FCDO	Foreign, and Commonwealth Development Office
GAC	Global Affairs Canada
GFF	Global Financing Facility
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit
GoT	Government of Tanzania
HSSP	Health Sector Strategic Plan
JICA	Japan International Cooperation Agency
KOICA	Korea International Cooperation Agency
LGA	Local Governments Authority
MMR	Maternal Mortality Rate
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NHA	National Systems of Accounts
PoLARG	Presidents Office Regional Authority and Local Governments
RCHS	Reproductive and Child Health Section
RM	Resources Mapping
RMET	Resources Mapping and Expenditure Tracking
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SHA	Systems of Health Accounts
TZS	Tanzania Shillings
UNFPA	The United Nations Population Fund
UNICEF	The United Nations Children's Fund
USAID	The United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization

2. Executive Summary

Background: Tanzania's investments in health have not managed to reach 15% of the total budget despite efforts to increase domestic resources for health financing. On budget donor financing has been declining, and there is a rise in off-budget donor which accounts for 84% of donor support[1]. These challenges have impacted visibility into the financing of Reproductive Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N) intervention in the country. To get the best out of the limited resources, Tanzania needs to track all resources available, understand where they are allocated, and improve efficiency in its spending. This resource tracking exercise is intended to improve visibility in the financing of the RMNCAH in line with the One Plan III.

Methods: This exercise was split into two parts; the first part was to improve the tool for resource mapping (budget) and expenditure tracking on reproductive health conditions in line with the new One Plan III and aligned with disease classifications in the national health account (NHA). The second part involved using the tool to conduct resource mapping and expenditure tracking for RMNCAH interventions for the One Plan III. Data was collected from both government and development partners.

Results: The overall budget of **746,000,000,000** TZS has been estimated as a requirement for implementation of year one (2021/2022) intervention for One Plan III. Out of this amount, a total of **281,316,196,568** TZS representing a 38% was reported as secured commitment from the Government of Tanzania (GoT) and development partners. The GoT budget allocation amounts to **124,312,357,707** TZS representing **44%** of the total mapped RMNCAH resources, while donor allocations account for 52%. The GoT funding includes the health basket fund. The financial gap for year 1 is estimated to be **463,683,803,432** TZS.

MNH (Maternal and Newborn Health) is the health area with the highest allocation (as commitment) at **82,153,369,627** TZS in terms of absolute numbers, representing **29%** of the total available commitments, while cross-cutting interventions were the area with the lowest allocation at 2,931,108,218 TZS, representing 1% of the total available budget.

The highest financial gap in terms of what is required against what has been mapped/available was observed under the child health area with nearly 95% of child health interventions outlined within One plan III not funded. In practice this gap might be lower than predicted because part of the 29,680,544,4000 TZS allocated to maternal health and child health secured commitment for which is yet to be split per health areas. Cross-cutting interventions and family planning interventions were over committed by 93% and 2% respectively

Geographically, Simiyu region was identified with the highest resources committed per capita where Rukwa region had the least at 3,613 TZS and 876 TZS respectively.

Out of the total mapped resources, **86,758,560,000** TZS (34% of total commitment) was reported as a lumpsum hence could not be assigned into specific strategic objectives and individual geographical areas (National and/or regions), however this has been captured as part of the TZS **281,316,196,568** I,e total committed funds for year 1. However the team was able to identify that **29,680,544,400** TZS from the said 86,758,560,000 TZS has been committed funds for maternal and child health interventions and the remaining amount as commitment for family planning interventions. Such situations, has limited the estimation of the financial gap for strategic objectives and some health areas.

[1] Tanzania Health Sector Public Expenditure Review 2020

The exercise also noted there is an ongoing dialogue for 75,480,600,000 TZS for RMNCAH (accounting 10% of total financial need for year 1). This amount has not been included as part of what is currently available. Once the dialogue is finalized, total mapped resources will reach 356,796,796,568 TZS, equivalent to 48% of the requirements for year one of One Plan III.

Recommendation: This study recommends the following: -

- With the One plan III in place, future RMNCAH Resource Tracking exercise should begin early to allow a for comprehensive data collection from both Donors and their implementing partners. The exercise should be conducted yearly to inform the budgeting process within the Ministry of health and health facilities.
- If possible, there should be an alignment between the objective, strategies, and intervention across the different national guiding documents intended to improve RMNCAH services in Tanzania for easy mapping of resources and financial gap analysis. Currently, the list of interventions and objectives for RMNCAH between health facilities' plans and One Plan III do not match
- Future exercise should provide a visibility into equity aspects of resources allocation and distributions. This will assist in distribution of resources in a more equitable manner by aligning RMNCAH resources distribution with the burden of RMNCAH challenges faced by different regions.

3. Background

For the past ten years, Tanzania has witnessed a decline in under-five mortality reaching 53 deaths per 1,000[2] live birth, slightly surpassing its target of 54 deaths per 1,000[3] live births by 2020. The country fell short of attaining its target in reducing maternal mortality to 192 per 100,000[4] live birth by 2020 with 2017 estimates showing 524 per 100,000[5] live birth, a 6% drop from the numbers observed in 2015/2016 (MMR, 556/100,000 live birth)[6] The One Plan II helped accelerate efforts towards maternal mortality rate and child mortality rate targets by mobilizing and allocating resources to high impact RMNCAH programs.

Tanzania has made efforts to increase its domestic financing for RMNCAH services but is yet to meet the Abuja declaration requiring African countries to spend 15% of their total budget on health[7]. There has also been an overall decline in donor contribution. The 2020 public expenditure review showed an increase in off budget donor contribution to 84%. The decline in donor contributions and an increase in off-budget support calls for efforts to increase visibility into resources allocation and coordination of these resources to improve efficiency and expected outputs.

Provision of health services is coordinated between the Ministry of Health Community Development, Gender, Elderly and Children (MoHCDGEC) and the President's Office Reginal Authority and Local Governments (PORALG). The MoHCDGEC has a responsibility of developing policy, guidelines, standards, planning, overseeing the progress of implementation, and providing supportive supervision while PORALG is mandated with translation and implementation of health policy and relevant guidelines at Regional Administration and Local Government Authorities deliver services including quality health services.

The government employs the Decentralization by Devolution approach to delegate provision of services by LGAs. This allows lower-level facilities to plan and budget for health interventions they want to implement in each budgetary cycle. Successful implementation of planned activities requires adequate financing. The sources of funding for the Health Sector and Operational plans include domestic (Government of Tanzania, GoT) and external (donors), global health initiatives, and financial loans. The key financing instruments for the National Development include the General Budget Support (GBS), the Health Basket Fund (HBF), Direct Program Funding (DPF), Technical Assistance/Capacity Building (TA/CB), Public-Private Partnership (PPP), and Financing through Aid for Trade.

The Reproductive and Child Health Section of the MoHCDGEC just launched its third strategic document, the One Plan III (2021-2025) to guide the implementation of the RMNCAH interventions

[2] UN Inter-agency Group for Child Mortality Estimation (UN IGME) Report 2019

[3] The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016 - 2020) - One Plan II

[4] The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016 - 2020) - One Plan II

[5] Trends in Maternal Mortality 2000 to 2017, Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division

[6] Tanzania Demographic Health Survey and Malaria Indicator Survey, 2015/2016

[7] WHO, The Abuja Declaration: Ten years on

to improve the quality of Tanzania's RMNCAH services in line with the HSSP V. The strategy focuses on:

1. Creating an enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and nutrition services.
2. Strengthening the capacity of health systems for planning, management, and service delivery of RMNCAH services.
3. Increasing access and utilization of quality RMNCAH services.
4. Improving the quality of care for RMNCAH services

This exercise builds from the previously conducted resource mapping exercises (2013/2014 and 2019/2020) and is intended to provide visibility into resources available for implementation of One Plan III interventions and improving collection of RMNCAH expenditure data for the NHA.

4. Objectives.

The main objectives of this exercise were to (i) review and improve the One Plan resource mapping and expenditure tracking (RMET) tool and optimize the tool for harmonization with NHA in the future (ii) to conduct resource mapping of the One Plan III using that RMET tool.
Specifically, this exercise:

- Developed a tool (RMET) for the collection of RMNCAH expenditure and budget data
- Assessed the financial resources available for implementation of first year's (2021/2022) One Plan III interventions
- Quantified financial gaps for the first year of One Plan III implementation

5. Methodology

Resource Mapping for One Plan III

Overview

Resource mapping (RM) is a country-specific and flexible annual exercise that tracks domestic, donor, and implementing partner budget data to inform joint annual planning, resource allocation, and spending. It sometimes includes expenditure data as well; in which case the exercise is termed resource mapping and expenditure tracking (RMET). RM/RMET is tailored to each country's strategies and context and is used to inform annual planning and budgeting, including coordination between governments and donors against national plans. It is also used to identify gaps for resource mobilization and improve efficiency and equity in resource allocation and spending.

To date, the GoT has conducted two rounds of RMNCAH RM collecting budget data only, one for the One Plan II and the other for One Plan I as part of the East African Community efforts to improve visibility and planning for RMNCAH activities. In the latest round, we have integrated expenditure mapping into the data collection tool to optimize the tool for potential harmonization and mapping with health accounts classifications in the future.

The process

This RMET exercise was conducted to provide visibility into available financial resources from the GoT and Donors involved in financing and provision of RMNCAH services in Tanzania. The exercise involved charting the program/health areas and objectives covering RMNCAH services in line with the One Plan III and mapping the available resources against these health areas and objectives.

Target group

The target group included the Government (MoHCDGEC and PORALG), Donors, and Implementing Partners working to improve RMNCAH services in the country. The list was provided by the reproductive and child health section of the MoHCDGEC reflecting the members of the RMNCAH technical working group who provide most of the funding for RMNCAH programs and services in Tanzania.
The government (MoHCDGEC and PoLARG) and a total of eleven (11) donors were contacted and requested to share their budget data for the implementation of 2021/2022 RMNCAH interventions. Donors were requested to share the tools with their implementing partners for them to also fill in their information. Of the 11 donors contacted, 6 provided complete programmatic information, while 2 provided partial information as grants have not been finalized yet. Three donors were unable to provide data during this round.

Tools for data collection

An Excel-based data collection tool was developed and used for this RMET exercise. This tool was informed by the tool that was used in 2019/2020 for a similar exercise with a few changes made on budgetary data collection part to reflect the One Plan logical framework and costing. The tool also integrates expenditure tracking against the One Plan III strategies and interventions, to allow for the collection of expenditure data each year through the implementation of the plan. This data may be

mapped and optimized for production of health accounts in the future, based on interest from the government and donors.

Data Collection

Key stakeholders representing MoHCDGEC, PORALG and donors supporting the implementation of RMNCAH services were oriented on the RM tool, there inputs collected and needed modifications were done. Donors were asked to forward a partner specific tool to their implementing partners for completion. Additional training was provided to those who had challenges in filling data in the tool and those who missed the first training session.

Completed tools by both MoHCDGEC, PORALG, and Donors/ Implementing partners were sent to the resource mapping team for compilation and analysis. The resources mapping team did extract health facilities data from PlanRep, a planning system managed by the PORALG and used by all health facilities for planning and budgeting of health interventions.

Data Processing and Analysis

The completed tools were returned for data extraction and analysis. This involved reviewing the completed tools in line with the One Plan III health areas, objectives, and interventions and aggregating data into one master file for analysis. The team omitted any data shared by implementing partner which was also available for the donors, to avoid double-counting. Only partner's data that wasn't received from donors were included in the analysis.

The PORALG data was activity-based and was slightly different from the health areas and objectives of the One Plan III, and therefore the activities were reviewed and mapped to reflect the health areas and strategic objectives of the one plan III health areas and objective for alignment and to facilitate analysis.

Assumptions used in data analysis

- The exchange rates used are: -
  1 USD = 2,283.12 TZS (BoT, 23 November 2021)
  1 CAD = 1,808.27 TZS (BoT, 23 November 2021)
  1 EURO = 2,574.90 TZS (BoT, 23 November 2021)

Potential for Mapping with System of Health Accounts

Overview

The System of Health Accounts is an internationally standardized expenditure tracking methodology used to produce National Health Accounts (NHA) to monitor funds from source to point of delivery to inform policy development, answering critical questions including progress on efficiency, equity, and financial protection goals. Data includes government, donor, and private expenditures, including household out-of-pocket payments. NHA exercises address four basic questions: where resources come from; where they are consumed; what kinds of services and goods they purchase; and whom they benefit. In Tanzania, an NHA exercise is expected to be conducted every year, however, there have been some years in which the exercise was not conducted, or its results were not published.

This exercise differs to resource mapping. While NHA looks at the expenditures data (flow of funds from source to point of delivery) within the health sector, the resources mapping looks at what has been budgeted for health sector interventions from different funding sources.

The Process

To align the data collected for RMNCAH from the RMET exercise with the NHA exercise, we integrated a sheet for the collection of expenditure data against the One Plan objectives and interventions in future years (after Year 1). This expenditure data can be mapped to NHA disease classifications. However, it is important to note that other NHA data elements could not be included, such as Health Care Function, Health Care Provider, and Factors of Provision as the One Plan III does not provide detailed information on these elements. These may limit the utility of the data for NHA purposes. It is recommended to conduct further discussions with the WHO and Directorate of Policy and Planning for improved integration of NHA elements into the tool and/or for development of a sector-wide RMET-NHA harmonized tool for use in future years, as described in the Harmonization Roadmap below.

The expenditure tracking part of the tool was developed in consultation with an Economist from the University of Dar es Salaam who has experience in collecting NHA data. The RMNCAH interventions from the One Plan III were mapped against the NHA reproductive health conditions (maternal, neonatal, perinatal, contraceptive management, and unspecified reproductive health conditions) to enable expenditures from the One Plan III to be tracked per NHA reproductive health conditions.

6. Results

The analysis considered budget data from the government and major donors for the fiscal year 2021/2022 for RMNCAH interventions across health areas prioritized in the One Plan III. All budget data was adjusted to reflect the GoT fiscal year of July to June.

Total resources available

The overall budget of **746,000,000,000** TZS has been estimated as a requirement for implementation of year one (2021/2022) intervention for One Plan III. Out of this amount, a total of 281,316,196,568 TZS was mapped as committed funding from the government and major development partners for the implementation of RMNCAH interventions in line with the plan for the 2021/2022 fiscal year

The GoT through the MoHCDGEC and the PORALG reported to allocate a total of 124,312,357,707 TZS representing a 44% of total allocations. This includes resources from the basket fund, own sources, health insurance, other charges, user fees etc. (See Fig 1. below). The remaining amount has been allocated by donors supporting RMNCAH interventions. (See Annex 4 for a breakdown of individual donor's contributions)

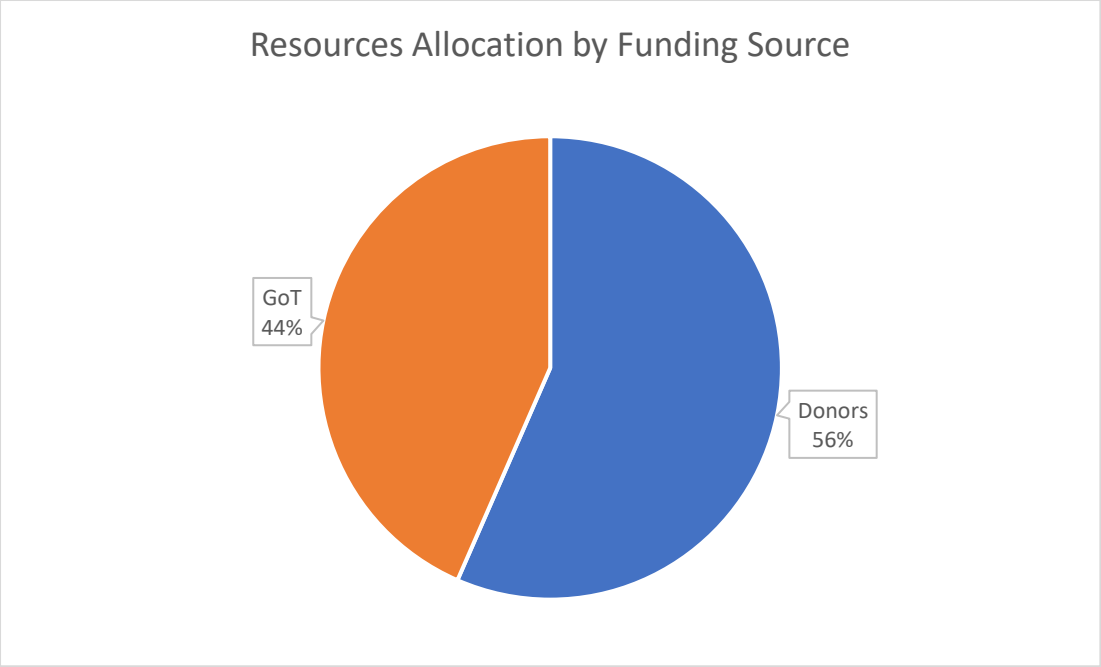

Fig 1. Resources allocation by Funding Source

Reported commitments for different health areas.

The One Plan III has outlined a total of seven (7) **health areas** namely Adolescent Health, Child Health, Family Planning, Nutrition, Immunization, Maternal and Newborn Health, and a Cross-Cutting health area. MNH is the health area with the most resources at 82,153,369,627 TZS representing 29% of the total reported/committed resources and the least financed area is the one with cross-cutting interventions with a total of 2,931,108,218 TZS representing 1% of the total available resources.

This exercise was not able to apportion 29,680,544,400 TZS between MNH or child Health as this funding has been reported collectively to maternal and child health interventions. (See Table 1. Below). Because of this, the mapped resources for both MNH and Child Health will be slightly underestimated.

Table 1. Distribution of reported commitments as per the One Plan III Health Areas

Heath Area	**Reported commitments (TZS)**	**Percentage Split**
Adolescent Health	10,335,832,181	4%
Child Health	9,305,414,868	3%
Cross cutting	2,931,108,218	1%
Family Planning	75,632,115,016	27%
Immunization	60,296,855,179	21%
MNH	82,153,369,627	29%
Nutrition	10,980,957,079	4%
Allocated to MCH	*29,680,544,400*	*11%*
Grand Total	**281,316,196,568**	**100%**

Reported commitments for different strategic objective.

In addition to health areas, One Plan III has outlined four main strategic objectives of which three are costed (refer to table 2 below). These are: -

- To create an enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and Nutrition services (Strategic Objective 1)
- To strengthen the capacity of health systems for planning, management, and service delivery of RMNCAH services (Strategic Objective 2)
- To increase the access and utilization of quality RMNCAH services (Strategic Objective 3)
- To improve the quality of care for RMNCAH services (Strategic Objective 4), which is not costed

Table 2. Distribution of reported commitments as per the One Plan III Strategic Objectives

Strategic Objective	**Reported Commitments (TZS)**	**Percentage Split**
Strategic Objective 1	1,506,858,596	1%
Strategic Objective 2	70,955,436,931	25%
Strategic Objective 3	122,095,386,642	43%
Not Allocated to specific Strategic Objective	*86,758,514,400*	*31%*
Grand Total	**281,316,196,568**	**100.0%**

Strategic objective 3 had the highest amount of resource allocation at 122,095,386,642 TZS, representing 43% of Committed resources. This is also in line with the costed One Plan III where objective 3 is the one with the highest financial requirement and is related to services delivery.

This exercise was not able to allocate a total of 86,758,514,400.00 TZS between these three strategic objectives as the submitting institution did not break this amount down for each objective. Table 2 above shows the distributions of resources between the three strategic objectives.

At the regional level, RMNCAH interventions are financed by both the GoT and its development partners. Collectively, Mwanza region has the highest amount allocated for RMNCAH at 12,489,020,085 TZS representing 4% of total resources and Njombe region has the least amount with 948,171,876 TZS representing 0.3%. When estimating resource allocation per capita, Simiyu receives the highest per capita allocation at 3,613 TZS while Rukwa receives the lowest at 876 TZS per capita. The One Plan III does not provide estimates of funding need by region, and therefore we cannot estimate whether allocations across regions are equitable. Annex 5 provides an estimate of funding by region, both in absolute and per capita terms.

It should be noted that 86,758,514,400 TZS was yet to be allocated to any region at the time of conducting this analysis. Therefore, the resource mapping team decided to have this amount at the national level. Revised estimates may be provided by donors and implementing partners as these resources are being allocated to specific regions.

Commitments under discussion.

The exercise also noted that there is ongoing dialogue between one development partner and the government for a support worth 75,480,600,000 TZS (10% of total financial need for year 1) to support RMNCAH. Since the breakdown of this prospective support is yet to be finalized the resource mapping team did not include this amount in the analysis. However, once these dialogues are finalized, total mapped resources will reach 356,796,796,568 TZS, equivalent to 48% of the requirements for year one of One Plan III.

Financial Gap Analysis

This exercise also estimated the financing gap for the first year of One Plan III (July 2021 to June 2022) both for health areas and strategic objectives. The gap was calculated by looking at the total resource requirement for 2021/2022 from the costed One Plan III against the total budget/allocated resources from both GoT and Donors. The total resource gap is estimated to be 464,683,803,432 TZS. Table 3 and 4 below provides a detailed breakdown of the funding gap in each health area and strategic objectives respectively. Notably, 1,632,115,016 TZS more than the costed need is allocated to family planning, while 1,931,108,218 TZS more than the costed need is allocated to cross-cutting interventions. Child Health and MNH have the largest funding gaps, at 178,694,585,132 TZS and 147,846,630,373 TZS, respectively in terms of absolute numbers. Percentage wise (what is allocated against what is required), child health and nutrition are the health areas with the largest financing gap at 95% and 91% respectively. Contributing to this apparent gap is a large portion of funding allocated to MCH that could not be apportioned to each of these health areas.

Table 3. Funding Gap by Health Areas

Heath Area	One Plan III 2021/22 Cost Estimates (TZS)	Allocated Resources (TZS)	Funding Gap (TZS)	Funding Gap (%)
Child Health	188,000,000,000	9,305,414,868	178,694,585,132	95%
MNH	230,000,000,000	82,153,369,627	147,846,630,373	64%
Nutrition	117,000,000,000	10,980,957,079	106,019,042,921	91%
Immunization	120,000,000,000	60,296,855,179	59,703,144,821	50%
Adolescent Health	15,000,000,000	10,335,832,181	4,664,167,819	31%
Family Planning	74,000,000,000	75,632,115,016	- 1,632,115,016	-2%
Cross cutting	1,000,000,000	2,931,108,218	- 1,931,108,218	-193%
Allocated to MCH		*29,680,544,400*	*(29,680,544,400)*	
Grand Total	**746,000,000,000**	**281,316,196,568**	**464,683,803,432**	**62%**

Table 4. Funding Gap by Strategic Objectives.

Strategic Objectives	One Plan III Cost estimates	Allocated Resources (TZS)	Funding Gap (TZS)	Funding Gap (%)
Strategic Objective 1	12,000,000,000	1,506,858,596	10,493,141,404	87%
Strategic Objective 2	37,000,000,000	70,955,436,931	-33,955,436,931	-92%
Strategic Objective 3	697,000,000,000	122,095,386,642	574,904,613,358	82%
Available not allocated to an objective		*86,758,514,400*		
Grand Total	**746,000,000,000**	**281,316,196,568**	**464,683,803,432**	**62%**

This analysis observed that strategic objective 2 is over funded by approximately 92% while the two remaining objectives are underfunded. There is also 86,758,514,400 TZS which is not allocated to any objective which affected the estimation of financial gap between the strategic objectives.

7. Limitations

a. This resource mapping exercise was conducted for 100 days which limited the ability to reach all institutions during data collection. Not all reached donors were able to submit their budget data during the data collection period which might lead to underreporting of the resources committed for RMNCAH interventions. Also, only those who participated in RMNCAH technical working group meetings were reached, this leaves a possibility that there could be some donors who might not have been reached.
b. Expenditure data was not collected this year as this is the first year of implementation but will be collected for Year 1 alongside Year 2 budgets.
c. Additional data collection would be needed for NHA for all other conditions and other data elements not included in this tool (in addition to private sector/household data collection
d. Some organizations were not able to break down their data as per One Plan III health areas and interventions, which made it challenging to map resources to respective health areas and objectives. For instance, this exercise was not able to apportion 86,758,560,000 TZS into the respective One Plan III strategic objectives. This limited the ability in estimating the financial gap for each strategic objective. It was also not possible to apportion 29,680,544,400 TZS between the MNH and Child Health which limited the estimation of the financial gap for these health areas.
e. This exercise did not collect data on the cost of human resources (HR). HR-related costs were beyond the scope of the One Plan III

8. Recommendation

a. Several donors and implementing partners were not able to provide allocations disaggregated by strategic objective, region, etc. as allocation decisions have not been finalized. Additional data collection, or revision of data collection tools, on a quarterly or six-monthly basis may provide more disaggregated information. Alternatively, the MOH could engage with partners to identify a suitable timeline for annual data collection based on when allocations decisions are usually finalized.
b. The resource mapping and financial gap analysis may be used in budgeting and planning discussions with the Ministry of Finance and donors to mobilize new funds and re-allocate existing funds from overfunded to underfunded areas.
c. RMNCAH Resource Tracking exercise should be done yearly and begin early to inform the budgeting process within the Ministry and health facilities. This will also allow for comprehensive data collection from both Donors and their implementing partners. The Ministry of Health may require that all partners submit data through the resource tracking tool and provide a clear timeline and detail on data needs and use.
d. If possible, there should be an alignment between the objective, strategies, and interventions between the guiding documents intended to improve RMNCAH services in Tanzania for easy mapping of resources and financial gap analysis. Currently, the list of interventions and objectives for RMNCAH between the health facilities' plans and One Plan III do not match.
e. If a sector-wide RM/RMET exercise is desired to better track, allocate and mobilize resources across the health sector, there may be potential for integrating routine resource tracking for the One Plan within a sector-wide exercise and fully aligning this tool with data needs for the National Health Accounts from government and development partners. Further details on this process, and a roadmap for initial exploration, is provided below.

9. Next Steps

- In addition to this report, the following deliverables from CHAI will support data use:
    - **PowerPoint presentation** to be discussed and validated with the MOHCDGEC and partners that will include a description of the objectives, methodology, results, limitations, and next steps.
    - **Provision of technical inputs in workshops** to discuss and validate results and use analyses in prioritizing and finalizing the One Plan III.
- In future years, expenditure data may be mapped to reproductive health conditions for the HA exercise

10. Harmonization Roadmap

Sector-wide RM/RMET

While RM/RMET in Tanzania has historically been sector-specific to RMNCAH, the MOHCDGEC has expressed interest in developing a sector-wide exercise. This would go beyond a focus on mapping RMNCAH budget data against the One Plan and extend to all actors funding activities across the health sector. An exercise like this would allow the MoHCDGEC to have more comprehensive visibility into the total funding available for health and enhance joint planning and budgeting between government and partners in line with the Health Sector Strategic Plan (HSSP). Depending on the government's needs and intended use cases for the data, this exercise could vary along the following dimensions: data sources (donors, implementing partners, and/or government agencies); scope (expenditure and/or budget data); data elements and alignment to plans (typically mapped against government cost categories, regions, strategies, etc.); frequency and timeline (typically a routine exercise aligned to the government fiscal year to inform policy and planning). While a sector-wide RM/RMET exercise is still to be determined in Tanzania, the data collected for the NHA and RM/RMET exercises would likely overlap in data sources and scope.

RM/RMET- NHA harmonization

In several countries with routine sector-wide RM/RMET and NHA exercises, governments have harmonized processes for completing these exercises. The data requirements for the exercises are similar and their use cases complementary, despite each exercise having different objectives and methodologies and answering different questions. Where processes have been harmonized, complementary parts of both exercises are aligned to form a single tool, process, and timeline for data collection from governments, donors and implementing partners. Data analysis and report writing remain separate processes to meet the unique needs and use cases from RM/RMET and NHA for government and development partners. In these countries, harmonization has helped to conserve human and financial resources, minimize the burden of data provision for overlapping pieces of RM/RMET and NHA, and expand the potential for new and complementary use cases. In turn, these benefits have advanced demand and use of data for decision-making and promoted institutionalization of both exercises.

The potential for harmonization in Tanzania

In general, there is likely potential for harmonization of RM and NHA data collection from government sources, donors and implementing partners. If processes were harmonized, a single team within the Directorate of Policy and Planning would collect sector-wide budget and expenditure data using one integrated tool aligned to the government fiscal year, with coordinated timelines, trainings, funding and supporting team. The collection of data from other sources for the NHA (including households and the private sector) would continue to be collected separately. Given the exercises serve distinct purposes within the MOHCDGEC's resource tracking and planning functions, a harmonized tool

would be optimized to collect expenditure and budget data at the level of granularity required for both exercises. Analysis, report writing, and dissemination would be completed separately for each exercise.

It is important to note that the feasibility and benefit of harmonizing data collection hinges on harmonizing sector-wide exercises. As processes currently stand, RMET in Tanzania is sector-specific to RMNCAH, limiting the utility of expenditure data that would be collected for NHA (which requires sector-wide data). NHA also requires classification of expenditures by health care provider, health care function, factors of provision, and multiple other data elements which are not collected in the current tool. Even if these data requirements were to be built into the current tool, parallel and duplicative data collection efforts would be necessary from many of the same partners to track expenditures for the rest of the sector (outside of RMNCAH). This limits the applicability of data collected in a sector-specific exercise aligned to a specific plan (the One Plan) to the NHA exercise.

Recommended harmonization roadmap for Tanzania

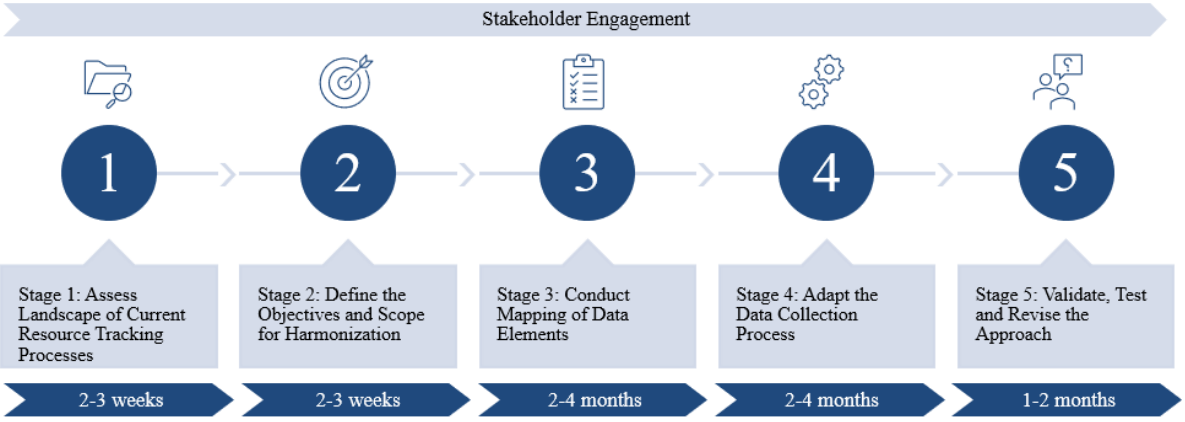

Figure 2. Harmonization roadmap

Figure 2 outlines the process most countries have followed to achieve harmonization. In the initial two stages, the main goals are to assess the potential and scope for harmonization based on the landscape of existing resource tracking processes and areas of overlap, as well as objectives for a harmonized process and dataset. In Tanzania, these processes would require dedicated engagement and buy-in from the Directorate of Policy and Planning and other departments across MOHCDGEC that would be using RM/RMET and NHA data, as well as technical partners like CHAI, the University of Dar es Salaam, and the WHO.

Stage 1 would involve an initial step to define the scope of a sector-wide RM/RMET exercise based on the demand and need for budget and expenditure tracking across the health sector and by different actors. In this step, the MOHCDGEC would need to consider what data sources would be included, whether the exercise would track both budget and expenditure data, data elements that would be included, the team that would be responsible for carrying out the exercise and the timeline that would be used. The MOHCDGEC may consider consulting programmatic stakeholders including major donors and implementing partners, and technical stakeholders such as CHAI and WHO in defining the scope for RM/RMET.

Stage 2, which may occur simultaneously, would involve a discussion of the objectives and anticipated advantages of harmonizing some or all parts of the process to produce the annual RM/RMET and NHA exercises. This would include assessing demand for, as well as potential efficiencies from, harmonizing training, data collection, data analysis, and use cases from the perspective of different

stakeholders, which would inform decisions on the scope for harmonization—including what types of data and level of detail would be collected through a harmonized process, who would be responsible for the process and what timelines would be used.

After determining the scope and objectives for harmonization and securing buy-in from government and technical stakeholders, Stages 3-5 involve deliberations on the format and content of the tool and harmonized process, and piloting with a diverse set of partners. In Tanzania this would include determining which data elements would be included based on intended use cases, and cross-walking data elements that are different across the exercises (for example, RM strategies and interventions with NHA disease classifications) to ensure relevant data elements at the appropriate level of detail are captured in a harmonized tool. In Stage 5, a revised tool and training would be piloted with providers/users of data and revised accordingly. The goal would be to ensure the tool provides sufficient guidance, data quality checks and granularity so that it is both user-friendly and meets the needs of both exercises.

This process for developing and harmonizing sector-wide RM and NHA would require 6-12 months of dedicated bandwidth and engagement from the MOHCDGEC, the WHO and relevant technical partners that lead the NHA process in-country (including the Directorate of Policy and Planning and the University of Dar es Salaam) to deliberate on the format and content of the tool and ensure resulting data meets the needs of both exercises; and donors, implementing partners, and government agencies that would be filling out the tool and using data, to provide feedback on the scope of RM/RMET and harmonization, as well as test the subsequent harmonized tool and processes for relevance, ease and use of data in routine budgeting and planning.

11. Annexes

Annex 1. Scope of Work

Background

To address the elevated maternal health challenges, the government of Tanzania continues to strengthen its internal systems and work with partners for improving the quality and coverage of health services aligned with the Tanzania investment case - One Plan II. The investment case aims to provide guidance on the implementation of maternal, newborn, and child health programs across different levels of service delivery and ensure coordination of interventions and quality services across the continuum of care. The GFF partnership played a critical role in mobilizing financiers to increase funding in support of Tanzania's investment case and supports the improvement of data for decision making, including identifying data quality bottlenecks, developing a data visualization platform, and improving resource tracking. It also supports the government in implementing a five-year Health Financing Strategy which focuses among others in the introduction of a single national health insurance bill.
Tanzania is in the process of developing a new One Plan (One Plan III) which will continue to focus on RMNCHA while fostering health system functions to improve the provision of RMNCAH services at the facility level as well as the resilience of the health system and its capacity to address epidemics outbreak.

An essential component to the operationalization of the One Plan III will be the financing of the plan, including service delivery costs and related systems investments to reach coverage targets over time. Given the diverse set of financiers, purchasers, and implementers in a complex health system, it is critical that investments in health are not duplicative and well-coordinated on the most pressing gaps in the One Plan roadmap implementation. Additionally, there is a need to assess resource sufficiency to meet the ambitions which will be outlined in One Plan III; where funding shortfalls are projected, the government may choose to mobilize additional resources, assess opportunities for further efficiency savings, and/or choose to scale back the One Plan III targets to ensure the feasibility of implementation.

To that end, the Ministry of Health will need to conduct a resource mapping (RM) of One Plan III, providing funding gaps at national and decentralized levels on key priority areas. In this context, **RM** refers to the collection and analysis of forward-looking budget data from key health sector financiers and the ministry of health, captured along the framework of One Health Plan III's interventions. The comparison of RM budget data against One Plan III costing data will produce a financial gap analysis for the new One Plan. This will enable the assessments of: 1) overall funding sufficiency of the new One Plan, and the scale of the funding gap, if any; 2) areas of anticipated over-investment (i.e. duplication) or under-investment (i.e. shortfalls) in the One Plan III, and therefore opportunities for greater allocative efficiency; and 3) opportunities for greater coordination and efficiency in One Plan implementation across various health sector stakeholders who have related activities planned in their budgets (e.g. same intervention area, common geographic coverage, etc.).
The resource mapping of One Plan II for 2019 and 2018 shows an improvement in domestic resource mobilization which increased in absolute and relative terms between 2018 and 2019. The Gov of Tanzania financed 20% of the IC in 2018 and 39% of it in 2019. The number of donors remains identical between the 2 years and donors' contributions seem to have decreased both in absolute and relative terms. The cost of the One Plan II also decreased in 2019 which may explain lower needs and contribution. Data from the updated resources mapping were also used to understand the equity and efficiency of resource allocation around RMNCAH priorities and provinces. Given the MOH is in the

planning phase of developing a One Plan III, the RM could support the prioritization process of this document.

Given the MOH in Tanzania is well advanced on the NHA and RM of the previous One Plan, this scope of work will also encompass activities related to reviewing the existing NHA-RM data collection and analysis process and applying it to collect data in the context of the RM of the new One Plan.

Objectives

1. To review and improve the national health account (NHA) and One Plan resource mapping and expenditure data harmonization tool.
2. To conduct resource mapping of the One Plan III using that NHA-RMET harmonization tool

Tasks

A firm is needed to support the following activities:

1. Review and implementation of One Plan Resource Mapping and Expenditure Tracking and NHA Harmonization tool

- **Conduct an assessment of the current processes and develop a roadmap for harmonization between the One Plan III RMET and NHA.** This assessment will describe current/envisioned processes for each exercise and highlight complementarities towards considering a harmonized data collection process. It will present a potential for alignment of RM/NHA harmonized process with national health strategies, routine budgeting and expenditure tracking needs, and investment cases for resource mobilization for the health sector. A roadmap of key decisions will highlight MoH resources, stakeholders, training, and timelines necessary to integrate the RM and NHA tools and manage harmonized data collection.
- **Review the existing Excel-based tool for harmonizing data collection between One Plan III RMET and NHA.** Last year, the Ministry of Health started harmonizing the data collection process between the One Plan II resource mapping and the NHA exercise. Building on this activity, this task will consist in conducting an initial crosswalk of RM cost categories with NHA factors of provision to ensure the latter have all been captured in the existing harmonization tool. Additionally, once this review is completed, the team or consultant will update the harmonization tool if needed and engage with stakeholders for sensitization and testing of the tool.
- **Data collection, cleaning, and validation**
    - Conduct c data collection RM work and develop data analysis.
    - Where possible, process previous resource mapping on the One Plan III and migrate them into the RMT and NHA harmonization tool.
    - Collect, clean, and validate data with submitting entities according to the data management plan.
    - Consolidate database and deliver a final set of data.
- **Data analysis and report writing.** The following analysis will be conducted where deemed appropriate for the One Health III RMET:
    - Map planned government, donors, and other partners' contributions to the priorities of One Plan III (by priority and by region) and compare it with the cost of these priorities

at national and regional levels in order to determine the funding gap by priority area at national and decentralized levels.
    - Assess flows of funding by region and compare them with health indicators to assess whether resources have been allocated at a decentralized level in correlation with health/population needs.
    - The deliverable should include an excel sheet with summary statistics and a graphical representation of the results, specifically budget commitments, and financial gap analysis per year. The analysis should be disaggregated, where possible, by data elements such as priorities and interventions, geographic region, financing source type (e.g., government or partner), cost category, fiscal year, and any other variables deemed relevant.

- **Present findings in a PowerPoint presentation and written report, to be discussed and validated with partners.**

    - **Coordination**
        - Meet with government and partners (if any) that work on National Health Accounts and/or preparation of the health budgets, to assess the feasibility of linking the One Plan III resource mapping with existing health planning, budgeting, and expenditure tracking exercises. One key aim will be to assess the feasibility of routinely monitoring planned commitments and expenditures on the new One Plan III.
        - Support the Government through a short training and written materials to understand and eventually independently update the data collection tool and analysis, such that resource mapping for the One Plan III can be updated in future years.
        - Support the use of financial gap analysis results in the finalization of the One Plan III, including the provision of technical inputs to workshops and prioritization discussions.
        - Provide any additional support that may be needed on the resource mapping, as discussed, and agreed to between consultant, GFF Focal Point, GFF Liaison Officer, and World Bank.

Annex 2. List of contacted Donors/Funders

S/N.	**Donors/Funders**
1	Department of Foreign Affairs Ireland
2	Foreign, and Commonwealth Development Office (FCDO)
3.	Global Affairs Canada (GAC)
4.	GIZ
5.	KFW
6.	USAID
7.	UNICEF
8.	UNFPA
9.	WHO
10	JICA
11.	KOICA

Annex 3. Breakdown of Donor's contributions

Donor	Amount in TZS
USAID	86,758,514,400
GAC	21,067,850308
UNFPA	15,077,713,379
Irish Aid	26,521,484,420
Foreign, and Commonwealth Development Office (FCDO)**	3,234,899,776
Global Alliance for Vaccines & Immunization-GAVI*	1,775,971,211
German Government (BMZ)	1,252,486,487
Other Donors/IPs at LGA*	654,325,227
United Nations Children's Fund (UNICEF)*	473,767,126
Global Fund*	177,024,433
WHO*	9,802,095
Grand Total	**157,003,838,861**

*This data was extracted from health facilities plans received from the PORALG
** This data was extracted from one of the implementing partners who submitted their data

Annex 4. Regional/Geographical RMNCAH resources allocations

Geography	Allocated Resources (TZS)	Percentage Split	Population 2021*	Allocation (TZS) per capita
National	167,766,777,552	59.6%	57,724,380	2,906
Mwanza	12,489,020,085	4.4%	3,983,793	3,135
Dar Es Salaam	10,564,379,267	3.8%	5,526,638	1,912
Kigoma	9,160,835,703	3.3%	2,898,568	3,160
Simiyu	8,738,223,188	3.1%	2,418,495	3,613
Mbeya	7,880,745,659	2.8%	2,274,236	3,465
Dodoma	7,488,888,449	2.7%	2,729,668	2,744
Shinyanga	5,843,243,712	2.1%	2,054,229	2,844
Morogoro	5,537,462,374	2.0%	2,799,260	1,978
Songwe	4,298,060,795	1.5%	1,319,064	3,258
Tabora	3,780,825,132	1.3%	3,191,194	1,185
Pwani	3,710,909,803	1.3%	1,357,271	2,734
Arusha	3,686,818,671	1.3%	2,156,511	1,710
Kagera	3,517,287,686	1.3%	3,353,241	1,049
Geita	3,505,531,130	1.2%	2,539,114	1,381
Mara	3,358,385,507	1.2%	2,490,155	1,349
Tanga	3,270,603,584	1.2%	2,509,439	1,303
Iringa	2,789,491,657	1.0%	1,177,327	2,369
Kilimanjaro	2,172,338,674	0.8%	1,996,952	1,088
Manyara	1,854,065,631	0.7%	1,937,450	957
Ruvuma	1,809,432,044	0.6%	1,695,057	1,067
Singida	1,722,249,437	0.6%	1,754,370	982
Lindi	1,673,347,000	0.6%	1,047,783	1,597
Mtwara	1,547,167,079	0.5%	1,507,426	1,026
Rukwa	1,147,748,829	0.4%	1,310,007	876
Katavi	1,054,186,045	0.4%	842,200	1,252
Njombe	948,171,876	0.3%	854,932	1,109
Total	**281,316,196,568**	100%		

* Data was obtained from District Health Management System (DHIS-2)

Annex 5. Resource Tracking Team

S/N.	Name	Institution
1	Mr. Martin Magogwa	MoHCDGEC-RCHS
2	Ms. Laura Kateti	MoHCDGEC- DPP
3	Ms. Elizabeth Gibaseya	MoHCDGEC-DPP
4	Dr. Yahya Hussein	POLARG
5	Mr Raymond Kiwesa	PoLARG
6	Ms. Sarah Hussein	PoLARG
6	Mr. Simon Mvunabandi	CHAI
7	Mr. Gilbert Mateshi	CHAI
8	Dr. Esther Mtumbuka	CHAI
Leadership		
9	Mr. Lusajo Ndagile	MoHCDGEC-DPP
10	Dr. Ahmad Makuwani	MoHCDGEC-RCHS