MINISTRY OF HEALTH AND SOCIAL WELFARE

HEALTH AND SOCIALWELFARE SECTOR PUBLIC PRIVATE PARTNERSHIPS POLICY GUIDELINES

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LIST OF ABBREVIATIONS

APHFTA	ASSOCIATION OF PRIVATE HEALTH FACILITIES IN TANZANIA
BAKWATA	BARAZA LA KUU LA WAISLAM TANZANIA
BBO	BUILD-BUY-OPERATE
BLT	BUILD-LEASE-TRANSFER
BOO	BUILD-OWN-OPERATE
BOOT	BUILD-OWN-OPERATE-TRANSFER
BOT/DBFM	BUILD-OPERATE-TRANSFER/DESIGN-BUILD-OPERATE-MAINTAIN
CBHC	COMMUNITY BASED HEALTH CARE
CBOs	COMMUNITY BASED ORGANISATIONS
CCBRT	COMPREHENSIVE COMMUNITY BASED REHABILITATION IN TANZANIA
CCHP	COMPRHENSIVE COUNCIL HEALTH PLAN
CDH	COUNCIL DESIGNATED HOSPITAL
CHF	COMMUNITY HEALTH FUND
CHSB	COUNCIL HEALTH SERVICES BOARD
CIDA	CANADIAN INTERNATIONAL DEVELOPMENT AGENCY
CSO	CIVIL SOCIETY ORGANISATIONS
CSSC	CHRISTIAN SOCIAL SERVICES COMMISSION
DB	DESIGN-BUILD
DBFO/DBFM	DESIGN-BUILD-FINANCE-OPERATE/DESIGN-BUILD-FINANCE-MAINTAIN
DDH	DISTRICT DESIGNATED HOSPITAL
DP	DEVELOPMENT PARTNERS
ECD	EARLY CHILDHOOD DEVELOPMENT
EIA	ENVIRONMENTAL IMPACT ASSESSMENT
FBO	FAITH BASED ORGANIZATION
FBF	FAITH BASED FACILITY
FGC	FACILITY GOVERNING COMMITTEE
GIZ	DEUTSCHE GESELLSCHAFT FÜR INTERNATIONALE ZUSAMMENARBEIT (GERMAN AGENCY FOR INTERNATIONAL DEVELOPMENT)
GVT	GOVERNMENT
HC	HEALTH CENTER
HFGC	HOSPITAL FACILITY GOVERNING COMMITTEE
HQ	HEAD QUARTERS
HRH	HUMAN RESOURCE for HEALTH
HSSP III	HEALTH SECTOR STRATEGIC PLAN III (2009 – 2015)
ICT	INFORMATION AND COMMUNICATION TECHNOLOGY (TEKNOHAMA)
KCMC	KILIMANJARO CHRISTIAN MEDICAL CENTER
KIWAKUKI	KILIMANJARO WOMEN AGAINST AIDS
LGA	LOCAL GOVERNMENT AUTHORITIES
M&E	MONITORING AND EVALUATION
MDAs	MINISTRIES, DEPARTMENTS AND AGENCIES
MDG	MILLENIUM DEVELOPMENT GOALS
MKUKUTA	MPANGO WA KUKUZA UCHUMI NA KUPUNGUZA UMASIKINI TANZANIA
MMAM	MPANGO WA MAENDELEO WA AFYA YA MSINGI (PHSDP)
MOF	MINISTRY OF FINANCE
MOHSW	MINISTRY OF HEALTH AND SOCIAL WELFARE
MOI	MUHIMBILI ORTHOPAEDIC INSTITUTE
MOU	MEMORANDUM OF UNDERSTANDING
MTEF	MEDIUM TERM EXPENDITURE FRAMEWORK

NGO	NON-GOVERNMENTAL ORGANISATIONS
NHIF	NATIONAL HEALTH INSURANCE FUND
NSGRP	NATIONAL STRATEGY FOR GROWTH AND REDUCTION OF POVERTY
ORCI	OCEAN ROAD CANCER INSTITUTE
OVC	ORPHANS AND VULNERABLE CHILDREN
PHP	PRIVATE HEALTH PROVIDER
PHSDP	PRIMARY HEALTH SERVICES DEVELOPMENT PROGRAMME (MMAM)
PHS	PRIVATE HEALTH SECTOR
PMORALG	PRIME MINISTERS OFFICE REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT
PNFP	PRIVATE NOT FOR PROFIT PROVIDER
POW	PLAN OF WORK
PPA	PUBLIC PROCUREMENT ACT
PPC	PUBLIC PRIVARE COOPERATION
PPHF	PUBLIC-PRIVATE HEALTH FORUM
PPP	PUBLIC PRIVATE PARTNERSHIP
PPRA	PUBLIC PROCUREMENT REGULATORY AUTHORITY
PSFP	PRIVATE SELF-FINANCING (FOR-PROFIT) PROVIDER
RHMT	REGIONAL HEALTH MANAGEMENT TEAM
SA	SERVICE AGREEMENT
SIKIKA	FORMERLY YOUTH ACTION VOLUNTEERS
SDP	SOCIAL DEVELOPMENT PROGRAM
RAS	REGIONAL ADMINISTRATIVE SECRETARY
TAMP	TRADITIONAL AND ALTERNATIVE MEDICINE PRACTITIONERS
TASPA	TANZANIA SALT PRODUCERS ASSOCIATION
TFNC	TANZANIA FOOD NUTRITION CENTRE
TGPSH	TANZANIAN GERMAN PROGRAM TO SUPPORT HEALTH
TOT	TRAINING OF TRAINERS
TUCTA	TRADE UNIONS CONFEDERATION OF TANZANIA
TWG	TECHNICAL WORKING GROUP
VAF	VOLUNTARY AGENCY FACILITY
VCT	VOLUNTARY COUNSELLING AND TESTING

KEY CONCEPTS

Accountability
Being obliged and taking responsibility to give an explanation or justification for one's role, actions, outcomes, and use of resources; to relevant authorities, beneficiaries and communities, and other stakeholders.

Accreditation
A third party endorsement and assurance of the quality of services and care provided by a health and social welfare service provider; To be effective, the third party needs to be credible in the eyes of potential users.

Concession
The act of conceding or yielding; usually implying a demand, claim, or request, and thus distinguished from giving, which is voluntary or spontaneous.

Contract
A binding agreement between two or more parties for performing, or refraining from performing, some specified act(s) in exchange for lawful consideration.

Contractual Arrangement
Refers to either, a contract, agreement or memorandum of understanding, whichever shall be applicable in PPP

Contracting Authority
Means any Ministry, Government Department or Agency, Local Government Authority or Statutory Corporation

Contracting Parties
These are the Government Ministries, Departments and Agencies which enter into contractual obligations with the private sector to implement PPP arrangements as laid down by the PPP legislation, regulations and guidelines.

Fair Play
Sticking to agreed rules, not using unfair advantage, promoting equal opportunities, considerate behaviour, respect and acceptance of others.

Franchise
A form of business organization in which a firm which already has a successful product or service (the franchisor) enters into a continuing contractual relationship with other businesses (franchisees) operating under the franchisor's trade name and usually with the franchisor's guidance, in exchange for a fee.

Lease
A contract granting use or occupation of property during a specified period in exchange for a specified rent; A contract by which one party (landlord or lessor)

gives to another (tenant, or lessee) the use and possession of lands, buildings, property, etc. for a specified time and for fixed payments

Memorandum of Understanding (MoU)
A document describing a bilateral or multilateral agreement between parties; It expresses a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.

Non-state actors
These include financial institutions, academic institutions, Non-Governmental Organizations (NGOs), CBOs, FBOs, employees, trade unions, environmentalists, political leaders, community groups, sector interest groups and the public in general. This category is expected to support the implementation of PPPs through monitoring and evaluation, and dissemination of information in order to create an understanding of the nature and benefits of PPPs in their areas of interest.

Partner
One of two or more parties that have agreed to form a partnership and to provide health and social welfare services;

Partnership
The formal relationship between two or more partners who have agreed to work together in a harmonious and systematic fashion and being mutually supportive towards common goals, including agreeing to combine or share their resources, risks, rewards and skills for the purpose of achieving the common goals

Policy
A statement or a set of statements defining a desired direction of operations or actions that define the interests and values of the people it is meant to serve. Statements are conceived to address a theme, or purpose of actions to society, institutions, and individuals, for present and future guidance.

Policy Guideline
Any document and or statements that aim to streamline a plan or course of action, as of a government, political party, or business, intended to influence and determine decisions, actions, and other matters and they define operationalisation of the policy

Private Health and Social Welfare Sector
Any non-government health and social welfare business including private self financing (for profit), not-for-profit, voluntary agency or faith-based facilities involved in the direct delivery of health and social welfare services, the supply of inputs, or the training of health and social welfare professionals. This also incorporates the provision of traditional and alternative health services and services and goods by civil society organizations, academic institutions, employees, community groups, trade unions, special interest groups, pharmacies, laboratories, insurances and manufactures.

Public Sector
A Government Ministry, Department or Agency, Local Government Authority and any other person acting on behalf of the Government Ministry, Department or Agency or Local Government Authority

Public Private Partnerships
The term Public Private Partnership describes a spectrum of possible relationships between the public and private actors for integrated planning, finance, provision and monitoring of services. The essential prerequisite is some degree of private participation in the delivery of traditionally public domain services.

Public Private Partnership in the Health Sector can take a variety of forms with differing degree of Public and Private sector responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public.

Public Goods
Are goods that are non rival (service consumption by one person does not reduce the service consumption available to others) and non exclusive (one cannot exclude others who have not paid for the services from benefiting from it). Examples are vector control, water and sanitation services and EPI.

Risk
Effect of uncertainty on objectives, is the potential that a chosen action or activity will lead to undesirable outcomes.

Service Agreement
A legally binding agreement stating clearly: the responsibilities of the parties to the contract, the range of services to be provided, time span, the performance standards to be achieved, procedures for performance monitoring, terms of payment and costs, quality, arbitration and exemptions.

Umbrella Organization
Coordination structure established with the function to represent, coordinate, provide support services and accredit their members. It does not have authority over the individual member

PREFACE

The Government of the United Republic of Tanzania intends to improve the partnership with the Private Health and Social Welfare Sector in the provision of health and social welfare services. Following the development of the National Public Private Partnerships (PPP) Policy in November 2009, the PPP Act of 2010 and PPP Regulations of June 2011, it is imperative that Health Sector PPP Guidelines be developed and put into operation. To fulfill this requirement, the Health Sector PPP Policy Guidelines contained in this document have been developed in collaboration with health and social welfare sector stakeholders.

The purpose of these Guidelines is to provide guidance for mainstreaming, establishing, implementing, coordinating, mobilizing, monitoring and evaluating partnerships between the Government of Tanzania and the private health and social welfare sector within existing laws, policies and plans. These guidelines seek to support broader national health objectives. More specifically, the guidelines aim to promote recognition and understanding of the complementarities between the public and the private sectors in the provision of health and social welfare services. Furthermore, the guidelines define an institutional framework within which the coordination, implementation, monitoring and evaluation activities enrich these partnerships. The guidelines will foster development of the specific policies for partnership with the different private sub-sectors; and provide the policy makers and stakeholders in the health sector with guidelines for identifying and addressing partnership concerns when taking policy decisions.

The first two sections of the document are foundation sections, describing the core policy framework for the health and social welfare sector and components of the overarching health care system. The various ways of collaborating with the private sector in the health and social welfare sector are explained in the third section, where PPP is elaborated. The fourth section deals with the overall vision of public private partnership, defining rationale, guiding principles, goal, challenges, roles and functions of key stakeholders and objectives. The fifth section describes organizational framework of PPP in the Health and Social Welfare Sector, while the sixth section is on the envisaged implementation framework, explaining various steps to follow in implementing PPP. This section concludes with the monitoring and evaluation of public private partnerships in the health and social welfare sector as well as the expiry of the PPP.

These Health and Social Welfare Sector Public Private Partnerships Policy Guidelines confirm the Ministry of Health and Social Welfare's commitment to collaborate with private sector stakeholders in creating the right regulatory and institutional framework for the implementation and monitoring of public private partnerships in the health and social welfare sector.

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In particular we would like to thank colleagues from the PMO, PMO-RALG, MOHSW, CSSC, APHFTA, BAKWATA, Ifakara Research Institute, CEDHA, CIDA, GIZ/TGPSH (former GTZ) for participating in the preparation, reviewing of drafts, editing and finalising this document. Their discussions and input were exemplary of the genuine interest that currently exists for Public Private Partnership in health and social welfare in Tanzania.

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1 Introduction

1.1 Historic Background

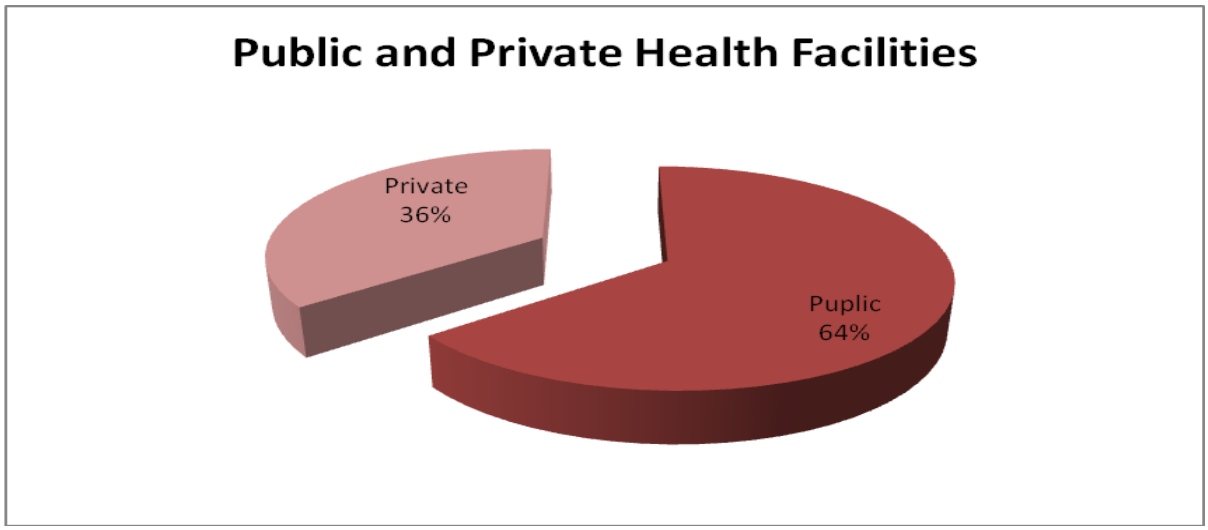
In pre-colonial Tanzania, traditional healers and birth attendants were the main providers of health care. This changed during the colonial period, when the government became the major health provider, a position it has retained to-date. During the colonial era, health care providers in the private sector were classified into three categories, namely the 'private-not-for-profit' healthcare providers, 'private-for-profit' healthcare providers and providers of traditional and alternative medicine. The not-for-profit providers comprised mostly religious organizations and voluntary agencies registered under the auspices of Christian or Islamic organizations. Although the 'private-for-profit' and the traditional and alternative health providers have been in existence since the colonial and pre-colonial times, respectively, they suffered government-imposed restrictions that took effect in 1977 and pertained until 1991.

Due to the growing demand for health care services, both in terms of physical and human resources, the Government lifted the restrictions on private healthcare providers in 1991. The new policy allowed doctors and dental surgeons to start private-for-profit practice. However, individuals who were not doctors were not allowed to start private practice on their own. In 1996 the Ministry of Health and Social Welfare (MOHSW) introduced guidelines and standards for health facilities, obliging private health facilities to undergo registration and to fulfil certain requirements. This was aimed at ensuring that private health services complemented heath care services provided by the Government in efforts to narrow the gap in demand and supply. In addition, contractual arrangements between the Government and Faith-Based Organisations were carried out in terms of subsidies (Grant-in-Aid); the Government provided, according to a formula, bed and staff grants to FBO-owned hospitals that were providing affordable health service to their surrounding communities. In districts without any government hospital the Government designated FBO hospitals to serve as Council Designated Hospitals (formerly also known as District Designated Hospitals) whereby the Government supports the operational costs of the private hospital.

In order to improve the availability and quality of health services in the country it is acknowledged that the cooperation between various active stakeholders in the health sector needs to be strengthened and intensified by exploring and developing new forms of partnership arrangements.

1.2 Role of Public and Private Sectors in Health Services Delivery

Currently the Government of Tanzania owns 64% of all health facilities while the remaining 36% are owned by the private health sector which comprise; Faith-Based Organizations (FBOs), NGOs (National and International), Civil Society Organizations (CSOs) and other for-profit Private Health Service Providers. Traditional and alternative health service providers are also still present in all districts, operating according to the Traditional Medicine Act of 2002. Overall, the government hospitals and faith-based hospitals are the main healthcare providers in the country



Source: MOHSW 2011

The 'private-for-profit' health service providers, started as self-financing providers, and are growing, particularly in urban areas since 1991. These providers (the private sector), initially provided mainly curative services, but in the recent years they have become more engaged in the provision of public health services, especially in reproductive child health, vaccinations, TB and HIV care and treatment. There are also a small but growing number of private diagnostic centres, providing x-ray and laboratory services. There are also a number of private health facilities that have invested in the establishment of healthcare training schools. Although these private self financing health providers remain largely active in urban areas, the government has supported their registration under the Registrar of Private Health Facilities at the MOHSW. As of August 2011, there were 249 hospitals, 687 health centres, 6571 dispensaries and 400 independent laboratories registered.

1.3 The National Policy and Institutional Framework for Public Private Partnership

The **National Public Private Partnership Policy**, endorsed in November 2009, confirms the Government's commitment to collaborate with private stakeholders by setting out a regulatory and institutional framework conducive for the policy's implementation. It focuses on putting in place a collaborative mechanism to ensure implementation through win-win strategies for the public and private sectors and other stakeholders involved in PPP.

It addresses constraints and challenges that have prevented the beneficial use of public-private health sector collaboration in terms of financial, human, and technological resources to deliver health and social welfare services. The National PPP Policy identifies PPP as a viable means to effectively address constraints of financing, managing and maintaining public goods and services. Additionally, it acknowledges that PPPs can enable the government to fulfil its responsibility of ensuring the efficient delivery of socio-economic goods and services; by ensuring efficiency, effectiveness, accountability, quality and the outreach of services.

Most PPPs implemented in Tanzania thus far have been concessional arrangements for running existing enterprises, with limited provisions for rehabilitation and new investments. Notably, such PPPs have been successfully implemented by Faith-Based Organizations (FBOs) in the education, health and water sectors for many years. The National PPP Policy advances that the participation in PPPs may take place in both productive and socio-economic service sectors including, but not limited to: Agriculture, Infrastructure, Manufacturing, Education, Health, Natural Resources, Tourism, Energy, Mining, Water, Land development, Environment and Solid Waste Management, appropriate Defence Infrastructure, Sports, Communication, Information and Communication Technology (ICT), Trade, Entertainment and Recreation and Irrigation.

The Government, in collaboration with other stakeholders, will develop an **Implementation Framework** that will includes and provides for the enactment of the new legislation, review of related legislation, and adoption of appropriate regulations and operational guidelines.

The scope of the implementation framework will include five key components:

1. An **implementation strategy** defining and detailing activities to be implemented over a time-frame of an initial five year period, functions and responsibilities of implementing institutions and resource requirements.

2. An **institutional framework** for implementation including the PPP Coordination Unit under the Ministry responsible for investment and private sector development, PPP Finance Unit under the Ministry responsible for finance and PPP Managers in implementing Ministries, Departments and Agencies (MDAs). Clear linkages amongst the PPP Units, Project Managers in the implementing Ministries and appropriate bodies at the Local Government will be observed.

3. **Legislation** to be reviewed and enacted to support implementation of PPPs.

4. A Provision for specific **regulations and operational guidelines** including:
   a) Formulation, Appraisal, Approval and Negotiation of PPPs
   b) Enabling Environment for PPPs
   c) PPP technical committees such as transaction advisors
   d) Sources of finance for PPPs
   e) Tendering procedures for both solicited and unsolicited bids
   f) Risk management;
   g) Monitoring and Evaluation of PPPs
   g) Public Accountability and Reporting requirements and
   h) PPPs Investors' guide

5. A **Communication Strategy** for sensitization and raising awareness of the general public, beneficiaries and other stakeholders.

Regarding the identification of potential PPPs, the National PPP Policy mentions that PPPs can be initiated by Government MDAs, the private sector, individuals and non-state actors.

The regulatory framework as exemplified by the **Public Private Partnership Act no. 18 of 2010** and the accompanying **Public Private Partnership Regulations of 2011** will encourage review of existing legislations as well as adoption of regulations and operational guidelines. These legal documents provide for the institutional framework for the implementation of public private partnership agreements between public sector and private sector entities. They also set out rules, guidelines and procedures governing public private partnership development, procurement, implementation, and other related matters.

The PPP Act 2010 is divided into five Parts:

Part I provides for preliminary matters including the title of the proposed law, the provision for its commencement, and the interpretation of terms used in the Act.

Part II deals with the establishment of the Public Private Partnership Co-ordination Unit within the Tanzania Investment Centre and the Finance Unit within the Ministry of Finance. This part defines the functions of the coordination unit and the financial aspects of the projects.

Part III of the Act defines the roles and functions of both the Public and Private sector actors entering into a contracting relationship, with the contracting authority being defined as the Ministry, government department or agency (MDA), local government or statutory corporation that enters into a partnership agreement.

The contracting authority shall make consultation with the relevant regulatory authorities prior to submission of feasibility study of the proposed project to the coordination unit (pre-feasibility study).

Part IV of the Act contains miscellaneous provisions which include powers of the minister, sector ministries, government departments, agencies and local government to monitor all public private partnership projects as well as manage conflict of interest; penalties; powers of the minister to make regulations, and saving provisions.

Part V makes proposals for consequential amendments to the Tanzania Investment Act, Cap.38 in order to add, to the current functions of the Tanzania Investment Centre, the functions of promoting private sector participation in the public private partnership projects.

The **PPP Regulations 2011**, to be cited as the *"Public Private Partnership Regulations of 2011",* shall apply to all projects undertaken in partnership between the public sector and the private sector. The Regulations are divided into eight Parts;

Part I provides for preliminary provisions including the title of the proposed regulations, the provision for its commencement, and interpretation of terms used in the Regulations.

Part II deals with the identification of PPP projects, the feasibility of pre-identified and unsolicited projects, the project concepts, and the selection and determination of tendered projects by the contracting authority.

Part III deals with the approval of projects by the Coordination Unit of the Tanzania Investment Centre after submission by a contracting authority as well as the assessment and the registration processes.

Part IV deals with the financial arrangements that guide the Finance Unit of the Ministry of Finance, after receiving approval from the Coordination Unit.

Part V guides the procurement process that the contracting authority will employ once a project has been approved.

Part VI describes the process that the contracting authority and a private party will employ in the implementation of a partnership once an agreement has been negotiated, agreed and awarded.

Part VII describes the termination of the project

Part VIII is about the general provision to deal with monitoring and evaluation.

1.4 National Health Sector Policy and Strategies Relevant to PPP

The Government has a number of enabling policies and strategies to strengthen health and social welfare services in Tanzania. These policies and strategies target both national and international commitments, such as the Millennium Development Goals. Summary of main health and social welfare related policy and strategies as follows;

i. **The National Development Vision 2025:** requires supporting and stimulating various actors participating in economic growth by encouraging the private sector to undertake investments in socio-economic goods and services. One of its objectives is the achievement of high quality livelihood for all Tanzanians through public health interventions and primary health services.

ii. **National Strategy for Growth and Poverty Reduction (MKUKUTA):** recognizes the health sector as a key factor in economic development, with the ultimate goal being improved quality of life and social well being.

iii. **National Health Policy 2007:** aims at implementing national and international commitments and seeks to facilitate the provision of basic health services, which are proportional, equitable, of good quality, affordable, sustainable and gender sensitive. It goes further to suggest that, public private partnership projects are to be promoted for the delivery of reliable and affordable socio-economic services.

iv. **Health Sector Reform Program**: aims at improving the health sector in terms of provision of quality health services through strategies including PPP.

v. **The Health Sector Strategic Plan 2009-2015 (HSSP III);** focuses on "Partnership for delivering the Millennium Development Goals". As a key guiding reference document for the health and social welfare sector, it mentions that its overall focus will be on partnership. The sixth of its eleven specific strategies, is 'to continue mainstreaming Public Private Partnerships at all levels' and proposes three key strategies: 1) ensuring conducive policy and legal environment for management of PPPs; 2) ensuring effective operationalisation of PPPs and; 3) enhancing PPPs in the provision of health and social welfare services. The HSSP III mentions that PPP is key to achieving increased accessibility and quality of health and social welfare services. The HSSP III states that PPP forums will be installed at national, regional and district levels, and that service agreements will be used in all Local Government Authorities to contract private providers for service delivery. Private training institutions will also be increasingly involved in production of human resources for health (HRH), based on their specific competencies.

vi. **Primary Health Services Development Program, 2007-2017 (PHSDP);** focuses on strengthening the health system, rehabilitation, human resource development, referral system, and increased health sector financing by 2017. The **PHSDP** mentions that private sector participation at the district level needs to be strengthened through establishment of PPP fora that, amongst other objectives can facilitate recognition, organization and representation of private service providers within the district as partners to the public service providers and managers in the delivery of essential services. These fora are also intended to facilitate delivery of non-core services, promote communications and dialogue, ensure effective working of Service Agreements, facilitate processes towards self-regulation by private service providers of various categories, and ensure quality, public safety and adherence to agreed norms and standards.

vii. **Human Resources for Health Strategic Plan (2003-2013);** guides the health sector in efficient planning, development, management and utilization of human resource for health.

viii. **Public Service Reform Program:** aims at transforming the public services into a service that has the capacity, systems and culture for the continuous improvement of services, and includes the provision of adequate staff.

ix. **Local Government Reform Program:** denotes devolution of powers and establishment of a holistic local government system to achieve a democratic and autonomous institution.

Additionally, the government has developed a number of legal and regulatory instruments and established an enabling institutional environment in an effort to strengthen PPPs in the health and social welfare sector (see Annex 2).

2 THE HEALTH AND SOCIAL WELFARE SYSTEM

2.1 Health and Social Welfare Services System

Health service delivery in Tanzania is provided through a decentralized three tier pyramidal referral system which broadly falls into six functional levels: community level, ward level, District level, Regional Level, Zonal level and National Level. All these levels offer curative, preventive, promotive and social welfare services, more specifically; the health service delivery system is a referral system starting with community health services, dispensaries, health centres, district hospitals, regional and zonal hospitals up to the referral/consultant hospitals. Different government departments work together to ensure access and quality health care in the country; The Ministry of Health and Social Welfare is responsible for policy, governance, financing and quality assurance (delivery of specialist/referral services at national level), while the Prime Minister's Office - Regional Administration and Local Government (PMO-RALG) is the implementer from regional level down. At the national level, Executive Boards manage hospitals while at the regional and district levels there are Regional and Council Health Boards respectively where private health service providers have representation.

Regional referral and consultant hospitals serve as referral points for hospitals at district level; these hospitals have more specialization than hospitals at district level. Regional referral hospital serves a population of the region. At the national level is the Muhimbili National Hospital with its network of five super special hospitals, namely the Ocean Road Cancer Institute (ORCI), Muhimbili Orthopaedic Institute (MOI), Mirembe Mental Health Hospital (MMHH), Kibongoto Infectious Disease Hospital (KIDS), and Comprehensive Community Based Rehibilitation in Tanzania (CCBRT). Next in level to the national referral hospital are the zonal referral hospitals, namely KCMC, Mbeya Referral Hospital, Bugando Medical Centre (BMC), Mtwara hospital and Lugalo Military Hospital.

According to 2007 data (PHSDP 2007) the available health facilities were 5,379, of which 4,679 were dispensaries, 481 were health centres and 219 were hospitals. The private facilities totalled 809, or 15% of all health facilities, and voluntary agencies owned 952 facilities, or 17.6% of all health facilities in the country. However, by 2011 the total number of health facilities reached 7,507 with the private health facilities (both private for profit and private not for profit) contributing 2677 facilities, which is 36% of all health facilities. Table 1 below also shows the distribution of the health facilities according to their categories in the referral system.

Table No 1: Private Health Facilities by Levels Source: MOHSW 2011

	Public	Private	Total
National Hospitals & its Network	5	0	5
Zonal Referral Hospitals	2	3	5
Regional Referral Hospital	23	10	33
Hospitals at Council levels	78	128	206
Health Centers	491	196	687
Dispensaries	4231	2340	6571
Total	4830	2677	7507

Similarly to the healthcare services, the Social Welfare services are coordinated nationally. There is a Social Welfare officer at each regional and council level as well as in each hospital. At the level of dispensary and community, the government has a plan to deploy social and welfare community officers to provide social welfare services at the community level; a role that is currently played by community health workers and dispensary staff. The plan is to have a community social welfare officer at the community level, and each village will have a community social welfare officer.

Traditional services do complement conventional health services at the community level, in each district and region.

2.2 Human Resources

Despite efforts by the MOHSW to staff health facilities at all levels, there is a human resources deficit in the health and social welfare sector. It is estimated that the available health care workers in the public health sector are approximately 35,202 and that the deficit is 90722 (HSSP III 2009). The general shortage of qualified staff is at all levels, but the shortage is most evident at the lower levels and in remote and hard to access areas. According to the Health Sector Performance Profile Report 2010, the medical doctor/patient ratio is 1:72,000, assistant medical doctor/patient ratio is 1:27,000 and nurse/patient ratio is 1:4,000. The shortage is mainly caused by, among other factors, low output of qualified staff, mal-distribution, poor remuneration, poor infrastructure, and lack of attractive retention schemes. Given that the number of health facilities increases as Regions and Districts implement the MMAM program the demand for more human resources is inevitable, necessitating increased training and absorption of skilled health and social welfare workforce. is necessary.

2.3 Financing

Tanzania follows a mixed type of financing within the public health sector. This consists of government support (mainly tax-based), finances from external sources, such as donor support, and complementary domestic financing (fees-for-services, pre-payment schemes e.g. health insurance). Government budget and donor support accounts for about 43% of health financing, with households contributing 47% through out-of-pocket expenditures, and other sources such as the Community Health Funds (CHF) and National Health Insurance Funds (NHIF) covering approximately 10%. The percentage of GOT expenditure on health is around 10% of total expenditures, below the Abuja target of 15%.

Development Partners (DPs) indirectly support the health and social welfare sector through the General Budget Support managed by the Ministry of Finance (MOF). In addition, some Development Partners provide direct support through the Health Basket Fund arrangement that provides the health sector with needed financial and technical support.

The disbursement of the Health Block Grant and Health Basket Fund are also channelled through the local government authorities (LGAs). Since 1999, Councils and LGAs prepare Comprehensive Council Health Plans (CCHPs) for improving the delivery of health services and ensuring the cost effective utilization of funds. It was envisaged that all partners in the health sector, including Local Government

Authorities, Faith Based organizations, Voluntary Agencies, Health Institutions, Civil Societies, Local and International organizations and all Private Health Sector Providers will participate in making use of the CCHP to guide their performance in planning, implementing, monitoring and evaluation of all health services within the council area.

3.0 PUBLIC PRIVATE PARTNERSHIP

Public Private Partnership (PPP) in the health sector has been promoted by the government since the colonial period. This is because the government realised that it could not provide all the needed health and social welfare services without complementary input from the private sector. In recent years, the government has been working towards creating a good institutional environment to facilitate public-private collaboration. There are various ways of collaboration between the public and private sectors, and the scope of collaboration also varies. Indeed all ministries and government institutions have been collaborating with the private sector in various ways for many years. The Public Private Partnership Act recognises the PPP arrangements that existed before the enactment of the Act.

3.1 Categories of Public Private Partnership

There are two categories of PPP; PPP for operation of existing public assets and PPP for development and operation of new facilities.

3.1.1 PPP for Operations of existing public assets

In this category there are four PPP options as described in Table 2.

Table 2: Options of PPP for the Operations of existing public assets

Options	Description
Service Contract	The government contracts with a private entity to provide services previously performed by the government Example: Councils contract private health facilities to provide some services e.g. baby delivery, child care, and mortuary services. The Government can contract the private sector to provide some services e.g. security, cleaning, laundry etc.
Management contract	The private entity is responsible for all operational aspects and maintenance of the facility under contract. Example: Government can contract a private firm to manage a public health organisation.
Leasing contract	Provides an alternative arrangement whereby the government grants a private entity leasehold in an asset and the private partner operates and maintains the asset in accordance with the term of the lease.
Concession	The government grants a private entity the exclusive right to provide, operate and maintain an asset over a long period of time in accordance with the performance requirements set forth by the government.

3.1.2 PPP for development and operation of new facilities.

In this category there are various options as shown in Table 3.

Table 3: Options of PPP for the development and operation of new facilities

OPTIONS	Description
Design-Build (DB)	The Government contracts with a private partner to design and build a facility in accordance with the requirements set by the Government. After completing the facility, the Government assumes responsibility for operating and maintaining the facility.
Design-Build-Operate (DBO)	The Government contracts with the private partner to design and build a facility in accordance with the requirements set by the Government. After completing the facility, the ownership of the facility remains with the public sector while the private partner operates the facility according to public performance requirements. The operator is also responsible for replacing the assets whose life has expired.
Design-Build-Operate-Maintain (DBOM) or **Build-Operate-Transfer (BOT)**	This combines the responsibilities of design-build procurements with the operations and maintenance of a facility for a specified period by private sector partner. At the end of that period, the facility is transferred back to the Government.
Build-Lease-Transfer (BLT)	After building the asset, the concessionaire rents or leases it from the Government and eventually transfers it back to the Government.
Design-Build-Finance-Operate (DBFO) or Design-Build-Finance-Maintain (DBFM)	The private sector designs, builds, finances and operates or maintains a new facility under a long term lease. At the end of the lease term, the facility is transferred to the Government.
Build-Own-Operate (BOO)	The Government grants the right to finance, design, build, operate and maintain a project to a private entity, which retains ownership of the project. The private entity is not required to transfer the facility back to the Government.
Build-Own-Operate-Transfer (BOOT)	The Government grants a franchise to a private partner to finance, design, build and operate a facility for a specified period of time. Ownership of the facility is transferred back to the Government at the end of that period.
Buy-Build-Operate (BBO)	This is a form of asset sale that includes a rehabilitation or expansion of an existing facility. The Government sells the asset to the private sector entity, which then makes the improvements necessary to operate the facility in a profitable manner.

Public Private Partnership (PPP) is one form of Public Private Cooperation (PPC) which is currently gaining popularity as it facilitates win-win situations and invites investors to provide public services. Formal PPP arrangements are currently not common in the health and social welfare sector. However due to ongoing efforts to improve the institutional framework and create investor confidence in the country generally, more investors are interested in partnering with the government in various areas like health facilities or the manufacture of pharmaceuticals and equipment. It is therefore important to guide and orient public health officials to facilitate the implementation of formal PPP arrangements.

4.0 PPP in the Health and Social Welfare Sector

4.1 Vision, Mission and Objectives

The national legal and policy framework for PPP in the Health and Social Welfare Sector states the following:

Vision
All categories of health service providers in Tanzania optimally use their comparative advantages to contribute to universally available, affordable, accessible, appropriate and effective health services in view of attaining the MDGs.

Mission
Maximize use of comparative advantages of all stakeholders to facilitate the delivery of reliable and affordable health and social welfare services by engaging both the public and private sectors.

Goal of the Partnership
Improve accessibility and quality of health services through effective and efficient utilization of public and private resources

Partnership Aims
Establish a functional integration and to support the sustained operation of a pluralistic health care delivery system by optimizing the rational use of available resources from public and private sectors and investing in the comparative advantages of partners.

Partnership Objectives
Three strategic areas define the way forward:

1) Ensure a conducive environment for operationalisation of PPP

a. Strategic Objective: Review of legal, regulatory and administrative obstacles to PPP at all levels
   Specific objectives:
   - Review of CCHP planning manual to accommodate PPP implementation
   - Support countrywide advocacy on Service Agreement in relevant regions and councils'. Review of service agreement with regard to its suitability to include private-for-profit providers
   - Review of legal issues regarding the secondment of health and social welfare staff between public and private providers and other human resources for health and social welfare issues
   - Review of legal issues on PPP and health insurance (CHF, NHIF), like uniform accreditation criteria applied to all categories of providers
   - Review Health Management Information System (including disease surveillance) issues that ensure full participation of all categories of providers
   - Review pharmaceuticals and supplies procurement procedures and issues that unequally affect some categories of providers

- Review quality assurance issues that would hamper the implementation of one uniform mechanism applied to all categories of providers
- Formulate and operationalise PPP policy guidelines
- Ensure political support

b. Strategic Objective: Effectively advocate possible policy and regulatory changes at opportune moments and fora
c. Strategic Objective: Facilitate operational research on PPP in collaboration with national and international research institutions
d. Strategic Objective: Address legal and administrative constraints identified, e.g.:
    - Support participation of all four private universities in HRH policy development
    - Support review of Nursing Council guidelines on private practice
    - Support Registrar's office initiatives to change legislation on private practice by Enrolled Nurse-Midwives and Nursing Officers
    - Address other issues to be determined
e. Strategic Objective: Assist all categories of health and social welfare providers with obtaining the necessary legal status to optimally participate in PPP

2) Ensure effective operationalisation of PPP

a. Strategic Objective: Establish and maintain PPP technical working group (TWG) within the MOHSW ~~and the PPPSC Secretariat~~
b. Strategic Objective: Strengthen the MOHSW to lead the PPP policy implementation, ~~assisted by the PPPSC~~in collaboration with the Public-Private Health Forum
c. Strategic Objective: Identify the capacity needs of the RMO offices and ZRHCs relating to PPP and;
    i. Conduct capacity needs assessment and prepare capacity building plan
    ii. Document lessons learned in TGPSH supported regions and lake Zone on PPP ~~committees~~fora at zonal, regional and council level
    iii. Support the institution of PPP fora~~committees~~ in all regions
d. Strategic Objective: Identify the capacity needs of the relevant private organisations and address these to allow them to play their role effectively in PPP (CSSC, BAKWATA, APHFTA, Professional apex organisations)

3) Enhance PPP in provision of health and nutrition services

a. Strategic Objective: Promote effective PPP inclusion in CCHPs
b. Strategic Objective: Address capacity needs of partners in the field of costing services and effective negotiations
c. Strategic Objective: Facilitate peer review mechanisms
d. Strategic Objective: Document and share lessons learned

4.2 Guiding principles for PPP in the Health and Social Welfare Sector -

The scope and level of the partnership will depend on the extent to which public and private partners' aims and missions coincide and are mutually respectful of one another. Additional guiding principles for health sector partnerships shall include:

i. Overall responsibility for health policy formulation and for the health status of the population is maintained by the government who will consult and seek consensus with the partners in all cases of common concern.

ii. National policies will guide the provision of health services to the population at different service delivery levels while plans and operations of the private health sector will support the available national policies and strategies and be integrated into respective plans.

iii. The Government and private sector partners will strive to optimize and complement services rather than duplicating them.

iv. The distinct identity and autonomy of each partner will be respected.

v. The public sector partners will ensure the equitable allocation of resources for health in accordance with the needs of the population and according to the volume and quality of services rendered.

vi. Inputs, outputs and outcomes relating to achievement of available health strategies' goals and objectives will be agreed, reported by and shared among the partners in an accountable and transparent manner.

vii. Each of the partners brings some sort of resource (material or ~~im~~non-material) to the partnership. In addition to straightforward material resources other resources may also be leveraged.

viii. Partnership implies mutual shared responsibility for the outcomes of its activities. In other words, the risk for the provision of a service is shared between the public and private entities and is not the sole responsibility of one or the other.

ix. Partnerships follow the principles of fair play.

4.3 Benefits

According to the National PPP Policy of 2009, PPP arrangements are beneficial to the health sector and are justifiable in view of the potential benefits that accrue to all parties. The potential benefits include:

(i) Facilitating creative and innovative approaches in stimulating the private sector to engage in specific PPPs, through the utilization of the service agreement with

Local Government Authorities (LGA) for supporting improved public and private health and social welfare services.

(ii) Enhancing LGA capacity to develop integrated solutions that effectively address the needs of the public in health and social welfare.

(iii) Reduced costs of implementation and realization of quality products and services attributable to economies of scale and operating efficiency;

(iv) Accessing technical and managerial expertise, financial resources and technology from both the public and private sector;

(v) Facilitating financial capital injections while reducing public debt and dependency on aid;

(vi) Better responsiveness to consumer needs and satisfaction of those needs;

(vii) Fostering economic growth by developing new investment opportunities and increasing provision of public goods and services;

(viii) Ensuring fulfilment of the best interest of the public and private sectors through an appropriate allocation of risks and returns, as defined in the service agreement template;

(ix) Allowing bidders to compete on the basis of their ability to develop unique and creative approaches to the delivery of a required output;

(x) Tapping all comparative advantages of private practice towards contribution to health and social welfare services.

4.4 Challenges

While Tanzania is contemplating private sector participation in areas previously treated as the domain of the public sector, it is facing significant challenges in adapting these measures within the current health sector. The key challenges faced include:

i. Lack of analytical capacity and health related data for the assessment of potential proposals leading to weak project designs and service agreement implementation and output

ii. Inadequate enabling environment which includes lack of financial resources, cost and price setting mechanisms and appropriate risk sharing modalities

iii. Insufficient human resources capacity within both the private and public sectors in terms of design, negotiation, procurement, implementation and management of PPP arrangements

iv. Inadequate information exchange forums, coordination mechanisms and monitoring and evaluation standards for appropriate participative discussion

v. Lack of public awareness on PPP concept and benefits in general

4.5 Scope of PPP in Health and Social Welfare Sector;

In the Health and Social Welfare Sector, Public-Private Partnerships are seen as a multi-dimensional concept that should be pursued from the perspective of both national and local governing authorities with the emphasis on:

i. Establishment of an enabling legal and policy framework for the promotion of targeted PPPs
ii. An implementation strategy that outlines, amongst others, interventions, activities, roles of stakeholders, resource requirements, outputs, quality requirements and time frame
iii. Development and review of PPP arrangements and related operational guidelines, standards and instruments
iv. Identification of the nature of private sector participation, extent and conditions for Government support, and risk-sharing mechanisms
v. Mechanisms for coordination, information exchange and promotion of PPPs
vi. Identification of appropriate control mechanisms, performance indicators, skills and competencies required to achieve effective PPPs
vii. An effective monitoring and evaluation system
viii. Participation in PPPs may take place through the development of a service agreement with any private sector health provider by a council LGA in both health and social welfare services including, but not limited to the following; Curative Services, Reproductive and Child Health Services, Diagnostic Services, Preventive services, Human Resources, Pharmaceutical Services, Traditional and Alternative Medicine, Environment and Solid Waste Management, Information and Communication Technology (ICT), Orphans and Vulnerable Children (OVC), Early Childhood Development (ECD), Rehabilitation Centres, Mental Health (MH), Elders and Disabled, logistics, vocational training, health insurance, quality management and many non-core health related activities.

4.6 Roles and Functions of PPP Stakeholders

As mentioned under section 1.3, the National PPP Policy of 2009 defines broadly the roles and functions of various stakeholders and actors. Within the diverse health and social welfare sector, the categorisation by ownership can be outlined as follows;

a) Public Health and Social Welfare Services

Health and Social Welfare services belonging to the Government (public sector) at all levels and includes parastatal companies which are government public owned enterprises.

b) Private Health Services

Health and Social Welfare services which operate outside Government ownership are subdivided into facilities and services provided by;

i. Faith Based Organizations (FBOs)
ii. Civil Society Organizations (CSOs)
iii. Non–Governmental Organizations (NGOs)
iv. Individual Private Service Providers
v. Providers of Traditional and Alternative Medicine

vi. Professional Associations/Societies (APHTA, TPHA, TARENA, MAT, MELSAT, etc.)

vii. Private Health Insurance

5.0 ORGANIZATIONAL FRAMEWORK OF PPP IN THE HEALTH AND SOCIAL WELFARE SECTOR

5.1 Levels of PPP Implementation

National Level

The PPP office at the Ministry of Health and Social Welfare will coordinate PPP implementation in the Health Sector. The PPP office will support coordination mechanisms that maximize the distinctive competencies of private and public service providers, and facilitate all stakeholders to deliver effective, affordable, reliable, and equitably distributed health and social welfare services. At the National level there will be a national level **Public-Private Health Forum (PPHF).** Members of the forum will be from both Private and Public sectors. The public sector will have a total of eight representatives, MOHSW (2), PMO-RALG (2), PMO-TIC (1), MOF (1), NHIF (1), other Ministry (1). The Private sector will have 12 members; private health service providers (6), health professionals' associations (2), private sector related to health 4). Private sector representatives will include drug manufactures, private insurance, private medical training institutions, umbrella organizations, etc. Development Partners will have one representative. Members, who will not exceed twenty two in number, will be appointed by the Permanent Secretary of the MOHSW. The chairperson will be elected among the members, and he/she will serve for three years. If the Chair is from the Public sector then the Co-Chair will be from the Private Sector. The PPHF will be supported by a Secretariat housed in a PPP Health Resource Centre.

Public-Private Health Forum member's Roles and Responsibilities

- Determine *Public-Private Health Forum in Tanzania's* vision and mission. The Board Members will be responsible for monitoring how well *Public-Private Health Forum in Tanzania* is reaching its mission and for assessing and updating the vision and mission as the environment changes over time.
- Support to the Public Private Health Forum Resource Centre. Tasks include helping shape the Resource Centre's work program, monitoring how the Resource Centre is implementing *Public-Private Health Forum in Tanzania's* workplan, and monitoring its resources.
- Ensure coordination and communication between Board Members on health issues and PPPs. The Board Members—assisted by the Resource Centre—will coordinate and inform each other on each of the sector's priority issues and PPP in health. This process will also help to ensure that there is no unnecessary overlap of activities and to avoid duplication of effort or competition between partners.

- Represent *Public-Private Health Forum in Tanzania* in a variety of venues and forums to a wide range of audiences to raise awareness on *Public Private Health Forum in Tanzania's* vision, mission and purpose, to promote the concept of PPPs in health within their own constituencies, and to leverage opportunities to create PPPs that will address Tanzania's health priorities.
- Mobilize resources for *Public-Private Health Forum in Tanzania*. All the partners have a shared responsibility to ensure that adequate resources are mobilized for the planned activities. This is in line with the partners' interest in creating a sustainable entity.

At the **regional level** (RMO's office), there will be a PPP focal person appointed by RAS, who will be a member of the PPP forum. Other members of the forum will be from the private and public sectors (members will come from which levels?), and the chairperson will be elected from among themselves. The number of committee members will not exceed twenty. The RMO will be the secretary, assisted by the PPP focal person,.. The forum will meet quarterly, and a summary of the annual report will be forwarded to the national level.

At the **council level** (DMO's office), there will be a PPP focal person, appointed by the Council Director, who will be a member of the PPP forum at the council level. Other members of the forum will be from the private and public sectors (members will come from which levels?),. The members of the forum, who will not exceed twenty in number, will elect one of them as the chairman of the forum.. w. The DMO, assisted by the PPP focal person, will be the secretary of the forum. The forum will meet quarterly, and a summary of its annual report will be forwarded to the regional level, where reports will be collated and forwarded to the national level. .
The district level will coordinate PPP fora at **lower levels** where they will meet not less than once per year. The updating of the PPP forum at all levels will be done yearly and will be discussed by the members. The diagram illustrating organizational structure and implementation arrangements of PPP fora at different levels are presented in see annexes 1 and 4.

5.2 The PPP Forums

As underlined in many policy documents, PPP forums are seen as a strategic measure for ensuring effective operationalisation of PPP at the national, regional and district levels. They serve the following objectives:

a) Strengthening working relations between public and private sector participants to increase access and choice to health and social welfare service users
b) Facilitating recognition, organization and representation of private service providers within the district as partners to public service providers and managers
c) Ensuring participation by private sector representatives in the implementation of the PHSDP/MMAM program
d) Strengthening private sector involvement and participation in the provision of non-core services

e) Developing more effective and sustainable mechanisms for partnership-based interventions and implementations through joint planning, trainings and capacity building
f) Facilitate interfaith forums at district level to ensure working partnerships among health and social welfare service providers of all faiths and denominations in matters of communication, dialogue and negotiations with the government
g) Improving effective working of Service Agreement clauses towards increased accountability and transparency for allocated health resources
h) Facilitating processes towards self regulation by members of locally established associations of private service providers of various categories, to ensure quality, public safety and adherence to agreed norms and standards
i) Encouraging regular review of monitoring systems, and joint development of guidelines for monitoring of private health and social welfare services.

6.0 PPP IMPLEMENTATION

In implementing project appraisal the roles and functions of the public sector and the private sector **are defined as follows:**

1) The **public sector** shall facilitate the implementation of the public private partnership projects by;
   a) Identifying projects
   b) Carrying out feasibility studies
   c) Monitoring and evaluation
   d) Risk sharing
   e) Putting in place an appropriate enabling environment including favorable policies, implementation strategies, and the legal and institutional framework

2) The **private sector** shall play the role of identifying and implementing public private partnership projects by;
   a) Carrying out feasibility studies
   b) Mobilizing resources
   c) Risk sharing
   d) Monitoring and evaluation
   e) Providing technical expertise and managerial skills

3) The **public sector and private sector** shall have the duty to develop a communication strategy for awareness creation, consensus building, and acceptance of the outcomes, benefits and associated costs and risks by all stakeholders of public private partnerships.

6.1 PPP Project Appraisal and Implementation

The appraisal and implementation of PPP projects in the Health and Social Welfare Sector will take into account the following procedures;

1) Identification of the project
2) Conducting pre-feasibility study

3) Conducting feasibility study
4) Approval of project
5) Procurement for the project
6) Implementation of the project
7) Monitoring and evaluation of the project
8) Expiry of the project agreement

6.1.1 Identification of the Project

A potential PPP project may be identified by a public or private party. The identified project will be submitted to the Ministry of Health and Social Welfare for consideration. The Accounting Officer of the MOHSW will submit the project to the Ministry responsible for investment for Gazetting.

The identified projects shall conform to the following criteria:

1) Address the health and social welfare sector priorities
2) Compliance with value for money requirement
3) Affordable
4) Ensure cost-effectiveness in project implementations
5) Ensures net benefits and savings as a result of private sector participation in the project compared to government financing
6) Adherence to the Public Private Partnership Act and other relevant laws
7) Adequate risk analysis and sharing

6.1.2 Conducting pre-feasibility study

A pre-feasibility study may be done by the public or private party (in case of unsolicited project). The report of the pre-feasibility study shall be submitted to both the Coordination unit and the Finance unit by the Accounting Officer of the MOHSW for approval. For an unsolicited proposal, the pre feasibility study will be conducted by the private party.

6.1.3 Conducting Feasibility study

Upon approval of the pre-feasibility study report, the public or private party as the case may be, will conduct a feasibility study. For an unsolicited proposal, the feasibility study will be conducted by the private party.

6.1.4 Approval of the project

The Ministry of Health and Social Welfare will review the feasibility study report to determine whether the project is viable or not viable. In so doing an accounting officer will form a committee of experts for every specific project, to review the feasibility study report and make the appropriate recommendation or advice on the implementation of the project. The approved project will be submitted to the finance unit and the coordinating unit for review and recommendation of the report.

6.1.5 Procurement for the project

Procurement for the approved PPP project shall be done through an open and competitive bidding process in accordance with the relevant Public Procurement Law.

6.1.6 Implementation of the project

The contracting authority shall initiate the process of entering into written agreement with the successful bidder. This will include forming a negotiating team, drafting of agreement, approval of draft agreement by the Finance Unit, submission of the agreement for vetting by the Attorney General and signing of the agreement.

After signing of the agreement, the Contracting Authority together with the private party shall commence the process for implementation of the project. The Accounting Officer of the Contracting Authority shall ensure that the agreement is properly implemented, managed, enforced, monitored, and reported on from inception to expiry or termination.

6.1.7 Monitoring and evaluation of the project

The project shall be monitored and evaluated by the Contracting Authority to ensure that the project is implemented in accordance with the agreement. The Contracting Authority shall, in collaboration with the private party, prepare a monitoring and evaluation framework which shall be comprised of;

1) Project management plan
2) Performance criteria
3) External audit and reporting requirements
4) Submission of progress reports
5) Verification of project assets and value
6) Stakeholders' communication

All PPPs shall be coordinated and monitored by MOHSW and LGA's. The ministry will monitor the progress of the PPP projects through quarterly progress implementation and financial reports. The ministry will establish a mechanism of monitoring and evaluation of PPP activities.

The PPP office at MOHSW will monitor and evaluate all PPP activities related to health and social welfare in public and private sectors at national, regional and district levels. The ~~National PPP Coordinating Committee and~~ PPP Technical Working Group (TWG) will also track the operationalisation and implementation of PPP activities in the health and social welfare sector at national, regional and district levels. Furthermore, the established fora at regional, council and community levels will monitor and evaluate PPP activities at their respective areas and submit quarterly progressive reports.

The proposed **M&E checklist** includes tracking the following

A: Output-Orientation;

1) The number, type and location of PPP projects/services in the health sector
2) The number of functioning PPP fora at the various levels in the health and social welfare system
3) The number, type and location of signed Service Agreements

B: Process-Orientation;

1) The process of formulation, appraisal, approval and negotiation of PPP projects
2) The financing and expenditure practices

3) The process of capacity building and supervision.

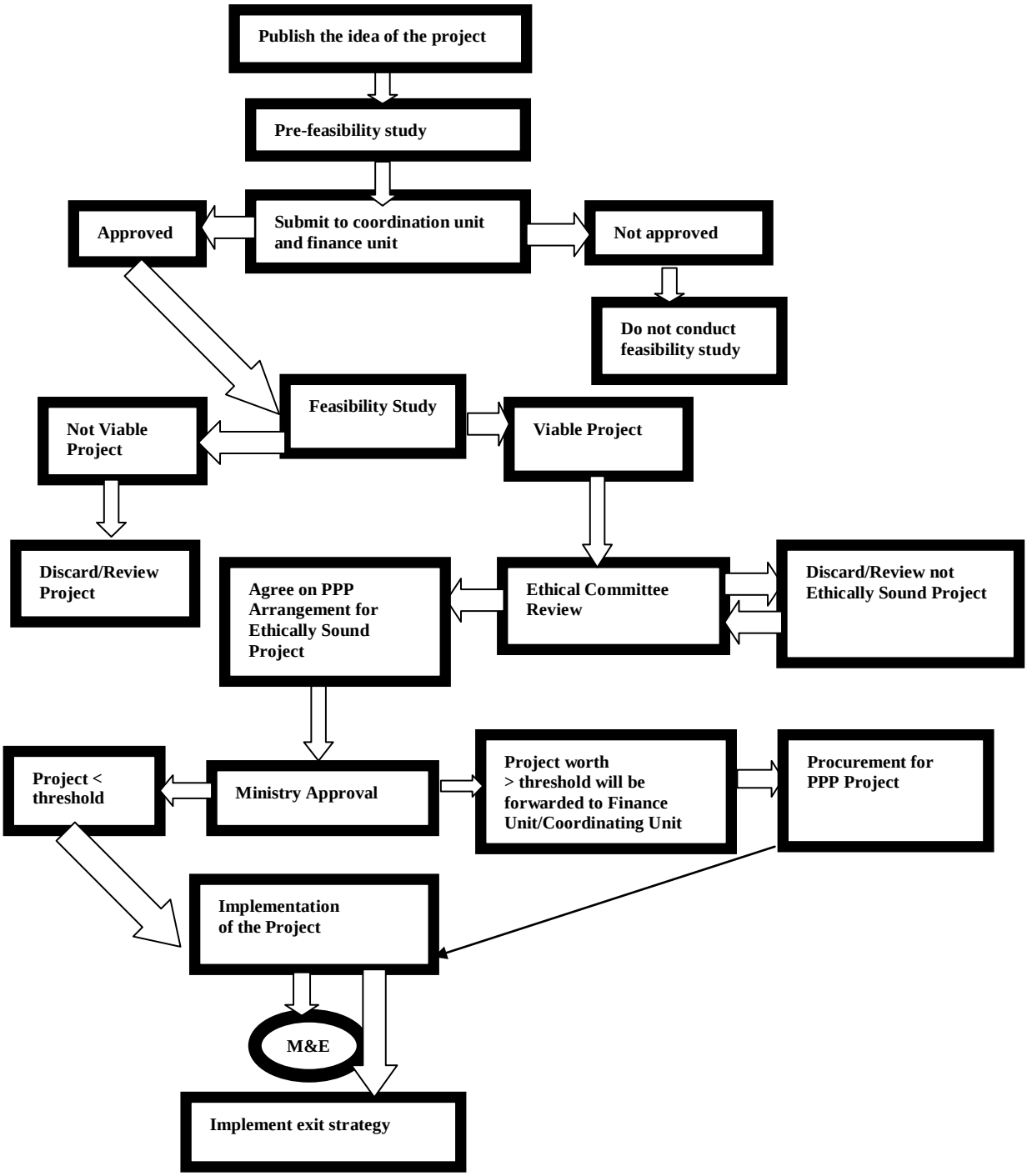
Evaluation modalities will depend on the type of project.

6.1.8 Expiry of the project agreement

In case of expiry of the agreement period, the handing over of the project and its facilities to the public/private will be arranged as per agreement. However, the parties shall decide and agree on the way forward. The owner may decide to enter into another agreement or come up with another option.

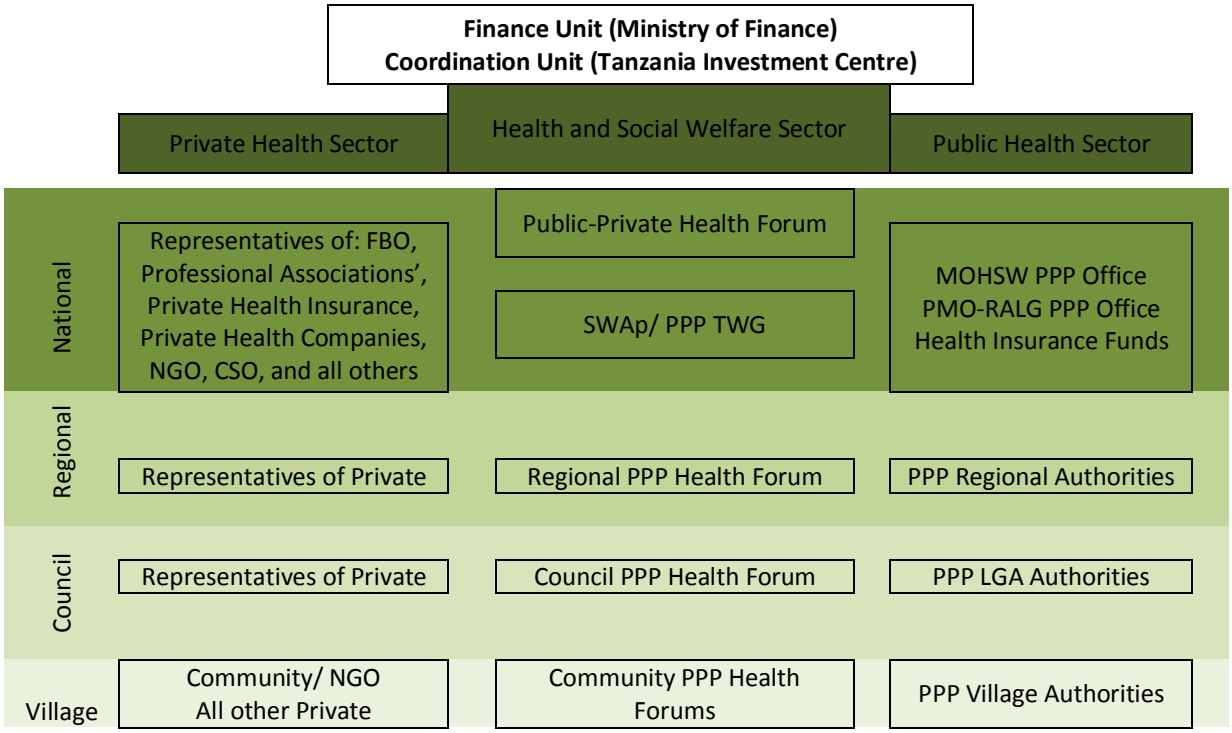
The following flowchart illustrates the processes requested for a project approval till implementation:

Flowchart for project appraisal process and implementation



Source: Own illustration, 2011

Annex 1: Organizational Framework for PPP Health and Social Welfare Service



Source: Own illustration, 2011.

Annex 2: Legal and policy documents related to PPP in Health and Social Welfare

National Strategy for Growth and Poverty Reduction (MKUKUTA) 2005/2010
Vision 2025

Local Government Reform Program Decentralization by Devolution 2009-2014 (LGRP II)

Primary Health Services Development Program 2007-2017 (MMAM) 2007

National Health Policy (2007)

The Health Services Scheme (2009)

The Private Hospitals Act Cap 151 , the Private Hospital Regulations (2002)

The Private Laboratories Act Cap 136,

The Traditional and Alternative Medicine Act Cap 244

The National Health Insurance Fund Act Cap (2002)

The Medical Practioners and Dentist Act Cap 152

The National Public Private Partnership Policy (2009)

The Public Private Partnership Act No 18 of 2010

The Community Health Fund Cap 409

The Law of Child Act No 21 of 2009

The Person with Disabilities Act No 9 2010

The Pharmacy Act No 1 of 2011

The HIV/AIDS (Prevention and Control) Act No. 2 of 2008

The Public Service Act (2002)

Nurses and Midwifes Act No. 1 Of 2010

The Local Government Reform Program II of 2009-2014

Annex 3: References

National Bureau of Statistics, United Republic of Tanzania (1996) Demographic Health Survey Tanzania: Maryland: MEASURE DHS ORC MACRO

Prime Minister's Office, Dar es Salaam (2009), National Public Private Partnership (PPP) Policy

Ministry of Health and Social Welfare (2009), Health Sector Strategic Plan III

Prime Minister's Office, Dar es Salaam (2010), National Public Private Partnership (PPP) Act

Prime Minister's Office, Dar es Salaam (2011), National Public Private Partnership (PPP) Regulations Ministry of Health and Social Welfare (2010) Public Private Partnership Strategic Plan 2010-2015

Ministry of Health and Social Welfare (2008) Human Resource for Health Strategic Plan 2008-2013

Ministry of Health and Social Welfare (2007) Primary Health Care Development Program 2007-2015

Annex 4: PPP Implementation at decentralised level: Comprehensive Council Health Plan

In terms of implementation of PPP in the Health and Social Welfare Sector, a complex construct of several public institutions as well as non-governmental stakeholders at national, regional and district levels is in place. This composite sector governance system which requires effective management arrangements falls under the general guidance of the MKUKUTA, Vision 2025 and the Decentralization by Devolution program (the D by D program). In this context the Local Government Reform Program II of 2009-2014 envisages that the D by D program will achieve devolution of central government's role and functions, and transform LGAs to competent strategic leaders and coordinators of socio-economic development, accountable and promoting transparent service delivery and poverty reduction interventions in their areas of jurisdiction. This includes the delivery of social services such as those by the health sector. To support this process and advise LGAs, the development of planning guidelines for critical areas of service delivery including improved implementation by outsourcing was recommended, ensuring joint planning and collaboration between LGAs, non-state health providers and civil society organizations as well as other relevant sectors. Hence, all Councils are asked to produce an annual **Comprehensive Council Health Plan:**

- It covers 3 aspects: technical, financial and structural aspects
- It includes all activities of the District Health Services and all sources of funding at the council level (government funds, locally generated funds, local donor funds, etc.).
- The Council Health Management Teams are responsible to produce the CCHP with inputs from the health facilities, the non-state actors and other co-opted members.
- It has to be approved by the Council Health Services Board (CHSB), which consists of community representatives, officers from other departments, and representatives from the private sector.
- The Regional Health Management Teams approve the CCHPs and forward these to the national level. The PMO-RALG together with the MOHSW assesses the CCHPs and gives final approval, before funds can be disbursed to the LGAs.
- The services of all providers have to be considered, including public and parastatal providers, FBOs, private self financing providers, NGOs, community-based initiatives for health promotion, as well as traditional and alternative medicine providers
- The Essential Health Package (EHP) contains priority areas that have to be covered in the CCHPs, and includes the main diseases and health conditions.
- The CCHP will be following the structure outlined in the HSSP III - 11 Strategies

Funds such as the Health Basket Fund which are allocated annually from the Central Government to LGA are based on a resources allocation formula. The funds allocated

through this mechanism are translated into action through the CCHP and its six cost centres, guided by laid down rules. It is recommended to revise the guidelines in order to ensure adjustment to recent developments in the area of PPP and efficient implementation of arrangements.

Additionally, private hospitals can enter an arrangement to be devolved as Council Designated Hospital (CDH). Through these arrangements, the Government provides running costs of the hospital, while the owner maintains the infrastructure and the required resources including human resources. There about 40 such hospitals currently in operation countrywide.

Annex 5: The Service Agreement

The MOHSW, the PMO-RALG, BAKWATA, CSSC and APHFTA developed a Service Agreement Template in 2007 that provided a contractual arrangement for private providers of health services to render health services on behalf of the government. The Service Agreement Template was designed in order to increase the availability of quality health services to the general population in accordance to the National Health Policy and its related Guidelines.

The benefits expected from this contractual arrangement include:

i) Allowing the government to determine and monitor the use of funds disbursed to the private sector

ii) Allowing the private providers of health services receiving government monies to justify their demands

iii) Providing to the private providers a reliable means of income

(iv) Increasing the availability of quality and affordable health services to the general population in accordance to the national policy and regulations

(v) Strengthening the partnership between the government and the private health service providers

(vi) Using the template for various types of PPP agreements

The document is divided into two main parts: a formal agreement template and a second part made up of six schedules that cover the implementation process and include:

Schedule 1: Services to be provided by the Service Provider
Schedule 2: Services Outputs and Costs
Schedule 3: Quality Standards
Schedule 4: Management Outputs
Schedule 5: Financing of Health Services
Schedule 6: Exemption Process and Mechanism for Reimbursement

In case of a need to contract out health services to the private sector, the existing service agreement template will be used. A negotiation between public and private parties will be conducted. During the negotiation, the service to be contracted out will be mentioned. The two parties will agree on the price of or modality of paying the intended services to be contracted out. It is recommended to use the existing prices to negotiate and the scope of the service has to be mentioned. The public party is advised to enter into Service Agreement after securing funds for reimbursing the private party, and the mode of reimbursement has to be agreed upon. There will be a termination of contract in case of not fulfilling the terms and conditions of the agreement. Dispute resolution should be conducted using an agreed mediator prior to the termination of the contract.

Annex 6: LIST OF STAKEHOLDERS WHO CONTRIBUTED IN THE DEVELOPMENT OF THE HEALTH SECTOR PPP POLICY GUIDELINES

S/N	NAME	ORGANIZATION
1	Dr Edwin Mung'ong'o	Dept Curative Services -MOHSW
2	Dr Mariam Ongara	PPP Office –MOHSW
3	Dr Mary Kitambi	PPP Office -MOHSW
4	Dr Adeline Kimambo	CSSC
5	Dr Obelin Kisanga	GIZ
6	Dr E. Nangawe	Ifakara Research Institute
7	Dr Saidi Mpendu	BAKWATA
8	Dr Peer Sieben	Planning Dept-MOHSW
9	Mr Steven Lanjouw	PPP Office-MOHSW
10	Ms Mariam Ally	Planning Dept-MOHSW
11	Mr Joseph Kelya	Planning Dept-MOHSW
12	Mr Maganga	PMORALG
13	Mr Mboya	PMO
14	Ms Muumin Mkwizu	PMO
15	Mr Mramba	PMO
16	Dr Meshack Mmasi	Mwanza
17	Dr Leornad Subi	Kahama
18	Dr Fransis Bangi	Kigoma
19	Dr Merikior Massatu	CEDHA
20	Dr Samuel Ogillo	APHFTA
21	Dr Berez Makaranga	APHFTA
22	Dr Paul Mhame	Traditional Medicine-MOHSW
23	Ms Siana Mapunjo	Pharmaceutical Unit- MOHSW
24	Ms Claudia Kowald	GIZ
25	Mr E Bandio	Diagnostic Services – MOHSW
26	Dr John Paul Kaswija	Lake Zone Training Centre
27	Ms Romana Sanga	Hospital Reforms- MOHSW
28	Mr Simon Ernest	Dept. Curative Services - MOHSW
29	Mr Rahibu Abdulrahman	State Attorney – MOHSW
30	Mr January Soko	Eastern Zone Training Centre
31	Mr Andy O'Connell	PPP Office- MOHSW
32	Mr Edwin P Bisakala	Kinondoni Municipal Council
33	Dr Dismas Vyagusa	Singida Rural District Council
34	Mr Paul M Nandrie	Wajibika
35	Ms Feliciana Mmasi	TECDEN/ COTC Tumbi
36	Dr Meshack Shimwela	Ilala Municipal Council