MAPPING HEALTH RESOURCE PARTNER INSTITUTIONS (HRPIs):

Modeling a sustained approach for strengthening health governance and stewardship in low-income countries

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African Center for Global Health and Social Transformation (ACHEST)

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Mapping Health Resource Partner Institutions (HRPIs): Modeling a sustained approach for strengthening health governance and stewardship in low-income countries

Foreword

The global study on supporting the leadership of Ministers and Ministries of Health and its report "Strong Ministries for Strong Health Systems", undertaken by ACHEST and the NYAM recommended that countries develop effective governmental and non-governmental Health Resource Partner Institutions(HRPIs) to support health system stewardship and governance functions of the ministries of health. The study pointed out the importance of organizations both in and outside of government that can provide needed expertise and resources to ministries of health. The study noted that every country needs to cultivate and grow a critical mass of individuals, and institutions that interact regularly among themselves and with their governments, parliaments, and civil society as agents of change, holding each other and their governments to account, as well as providing support. These include professional associations, national academies of medicine and science, universities, free standing think tanks, research and development organizations, business, private sector, NGOs and the media.

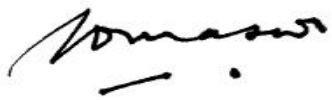
As a first step towards marshaling the HRPIs in the countries, a protocol and framework for mapping HRPIs, other governmental agencies and non-governmental organizations was developed and implemented in five countries namely Kenya, Malawi, Mali, Tanzania and Uganda. The purpose of these mapping studies was to identify and characterize HRPIs active in countries as a prelude to understanding how best they can work better with their respective governments especially the Ministries of Health to advance health system governance in sub-Saharan Africa in particular. As can be seen in the detailed country reports, it was found that while many such institutions were found in all the countries studied, they were strong in some countries and are used effectively by MOHs. In other countries, they were weak and rarely worked with the governments. In all countries these institutions need to be strengthened to provide the level of intellectual and human resources necessary to support effective health systems performance and governance. Ministries of health on the other hand were in some cases seen as insular and reluctant to collaborate with HRPIs.

During the 2nd Congress on Health Systems governance in March 2012, all the five countries presented and discussed their respective mapping study reports. It was unanimously agreed and recommended that all the five countries and ACHEST: 1) Develop mechanisms to link the work of HRPIs to Ministries of Health in order to utilize their expertise. 2) Make arrangements to develop the capacity of HRPIs so that they can play support roles to their governments more effectively. 3) Develop a new tool to be used for modeling a stronger working relationship between HRPIs and MoH as the next steps in implementing these recommendations. 4) The reports of the five countries to be widely disseminated. 5) Modify and adapt the mapping tool for use by other countries in mapping and collaborating with HRPIs.

We would like to recommend these reports to all who those who grapple with strengthening health systems in LMICs and welcome comments on the reports and are available to engage in further dialogue on how this stream of work can contribute to the achievement of better health outcomes.

In conclusion we wholeheartedly thank the Rockefeller Foundation, the government and people of Norway through NORAD for the financial grants that made it possible for this work to be undertaken.

We also thank the governments of Kenya, Malawi, Mali, Tanzania and Uganda for their willing participation in the study and commitment to strengthen their respective health systems.



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This work benefited immensely from the critique of the Second African Health Systems Governance Congress which took place in Kampala, March 2012.

ACHEST is immensely grateful to our development partners namely the Rockefeller Foundation and NORAD for the generous grants and encouragement that enabled this work to be carried out.

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Director of Health Systems
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Acronyms and Abbreviations

AAR		
AGM	-	Annual General Meeting
AGOTA	-	Association of Gynecologists and Obstetricians in Tanzania
AMREF	-	African Medical and Research Foundation
APHFTA	-	Association of Private Health Facilities in Tanzania
BFC	-	Basket Fund Committee
BMAF	-	Benjamin William Mkapa HIV/AIDS Foundation
BOG	-	Board of Governors
BOT	-	Board of Trustee
CHAI	-	Clinton Health Access Initiative
CSSC	-	Christian Social Services Commission
CUHAS	-	Catholic University of Health and Allied Sciences
DMO	-	District Medical Officer
EDCTP	-	European and Developing Countries Clinical Trials Partnership
ELCT	-	Evangelical Lutheran Church of Tanzania
ESRF	-	Economic and Social Research Foundation
FBO	-	Faith Based Organizations
FHI	-	Family Health International
GWRA	-	Global White Ribbon Alliance for Safe Motherhood
HESLB	-	Higher Education Students' Loan Board
HKMU	-	Hubert Kairuki Memorial University
HRH	-	Human Resources for Health
HRPIs	-	Health Resource Partner Institutions
HSSP	-	Health Sector Strategic Plan
ICT	-	Information and Communication Technology
IHI	-	Ifakara Health Institute
IMTU	-	International Medical and Technological University
JAHSR	-	Joint Annual Health Sector Review
KCMUC	-	Kilimanjaro Christian Medical University College
MAT	-	Medical Association of Tanzania
MCT	-	Medical Council of Tanganyika
MLC	-	Medical Laboratory Council
MeLSAT	-	Medical Laboratory Scientists Association of Tanzania
MEWATA	-	Medical Women Association of Tanzania

MoHSW	-	Ministry of Health and Social Welfare
MU	-	Mzumbe University
MUHAS	-	Muhimbili University of Health and Allied Sciences
NACOPHA	-	National Council of People Living with HIV/AIDS
NHIF	-	National Health Insurance Fund
NIMR	-	National Institute for Medical research
NGO	-	Non Governmental Organizations
NTD	-	Neglected Tropical Diseases
OC	-	Optometry Council
PAT	-	Pediatric Association of Tanzania
PC	-	Pharmacy Council
PER	-	Public Expenditure Review
PF	-	Policy Forum
PI	-	Plan International
PPP	-	Public Private Partnership
PRINMAT	-	Private Nurses and Midwives Association of Tanzania
SWAp	-	Sector Wide Approaches
TANA	-	Tanzania Nurses Association
TDA	-	Tanzania Dental Association
TEC	-	Tanzania Episcopal Conference
TPHA	-	Tanzania Public Health Association
TWG	-	Technical Working Group
UDOM	-	University of Dodoma
UMATI	-	Family Planning Association of Tanzania
UNICEF	-	United Nations Children's Fund
UNFPA	-	United Nations Population Fund
WD	-	Women's Dignity
WRATZ	-	White Ribbon Alliance for Safe Motherhood Tanzania

Executive Summary

Following the study, ***"Strong Ministries for Strong Health Systems"*** which pointed out the importance of organizations, both in and outside government, that can provide needed expertise and resources to ministries of health, a study was done in Tanzania as part of an international study, to identify and characterize such organizations, termed as Health Resource Partner Institutions (HRPIs), in terms of what they are, their areas of focus and the way they work and interact with the ministry of health and among themselves. Their contribution towards development of governance and stewardship of the health sector was also assessed. The outcome of the study would be to design a mechanism for involving them more effectively with the Ministry of Health and Social Welfare so as to enhance health and health systems governance and stewardship.

41 HRPIs and their contact addresses were identified by the principal researcher, basing on his knowledge and through consultation with heads of department at the MoHSW and the Health Resource Secretariat at the Ministry which coordinates meetings of the Ministry with development partners and stakeholders. Such meetings include the Annual Joint Health Sector Review, SWAP Meetings, and Basket Fund Committee Meetings. Another source of information was coordinators of the 13 TC SWAp Technical Working Groups of the MoHSW. More information of the HRPIs was sourced from their websites.

20 out of the 41 HRPIs identified were studied in detail. Data was collected during the second week of November 2011 through the second week of January 2012. The questionnaire was sent by e-mail to some HRPIs while others were visited for face to face interview by the researcher. The information was coded and data analyzed using Microsoft Office Excel 2007.

The study found out that, the 20 HRPIs that were studied in detail, have been established for many years, they are legally established entities, established either by law or registered as NGOs with the Ministry of Home Affairs and have well established governance structures.

The HRPIs studies were involved in key areas of governance and stewardship such as health policy development, health systems research, monitoring and evaluation, human resources, health financing, economic policy, trade and health, and policy advocacy. They have been involved by the Ministry in policy and legal review meetings, and in SWAp TWG, PER and the JAHSR meetings. Apart from interacting and working with the MoHSW, they have been interacting with the Parliamentary Groups for legislative issues, and among themselves in areas of common interest. The HRPIs studied have been assessed strong and can be relied upon in their specific areas of interest.

The major areas of frustration of HRPIs were that, the Ministry has not established and communicated a formal mechanism for their involvement and there is no seriousness in implementing the PPP strategy. Information sharing between the Ministry and HRPIs is not adequate and the Ministry has at times been unresponsive and that they would like to see more implementation and outcome of developed policies and strategic plans.

The conclusion of the study is that, HRPIs play a crucial role in governance and stewardship of the health sector. Identifying them, recognizing their work, supporting them and building mechanisms for collaboration and networks for information sharing are crucial if the government is to effectively utilize the great potential that HRPIs possess.

The following recommendations are made out of this study.

1. Conduct a thorough study to identify as many more HRPIs as possible, characterize them and identify their strengths and opportunities and build and maintain a database of HRPIs in Tanzania.

2. There is a need to assess the existing mechanisms of involvement of HRPIs and other stakeholders in order to develop a structure that will effectively ensure participation of all stakeholders in the development of the health sector. The structure should be supported by some policy and legal framework to ensure guidance and commitment of all players to use it.

3. The Ministry should ensure that policies, plans, budgets, guidelines, protocols and all kinds of information that is crucial is properly repackaged and shared through different means, such as distribution of hard copies of documents, organized meetings, through different departments of MoHSW and the use of the MoHSW website, continuously being updated.

4. The MoHSW leadership should make deliberate efforts to change the negative attitude of all its staff working at the headquarters and the LGAs to change their negative attitudes towards DPs, NGOs and other stakeholders and fully implement the PPP Policy. The Ministry should also implement its ***Clients Service Charter*** and be more responsive so that stakeholders get what the ministry has promised to deliver to its clients.

5. The Ministry should formulate guidelines for operationalization of policies at different levels.

6. Facilitate the creation of Think Tanks among HRPIs that would be relied upon to monitor health sector development and provide feedback to the MoHSW on an annual basis or as need arises.

7. For enhancing effective partnership between the MoHSW and HRPIs, there is a need for the MoHSW to assist in capacity building for HRPIs as well as for the MoHSW itself. Training in health systems and operations research and monitoring and evaluation is essential to enable HRPIs and MoHSW generate evidences for effective development of policies, strategies and plans and ensure their implementation.

I. Background of the Study

During the late 80s and early 90s, the health sector in Tanzania experienced significant deterioration characterized by dilapidated health infrastructure, inadequate medicines, medical supplies and equipment, heavy work load due to shortage of health workers coupled with a heavy burden of diseases contributed mainly by malaria, HIV and AIDS and tuberculosis, resulting into low morale of health workers. As a result, most of the people could not access health services and the quality of the services deteriorated.

The World Development Report 1993 published by the World Bank had the following major recommendations regarding the global economic, health and nutrition situation:

1. That, countries needed to foster an economic environment that will enable households to improve their own health. Policies for economic growth that ensure income gains for the poor are essential,

2. Redirect government spending away from specialized care and toward such low-cost and highly effective activities such as immunization, programs to combat micronutrient deficiencies, and control and treatment of infectious diseases. By adopting the packages of public health measures and essential clinical care described in the report, developing countries could reduce their burden of disease by 25 percent, and

3. Encourage greater diversity and competition in the provision of health services by decentralizing government services, promoting competitive procurement practices, fostering greater involvement by nongovernmental and other private organizations, and regulating insurance markets. These reforms could translate into longer, healthier, and more productive lives for people around the world, and especially for the more than 1 billion poor.

In response to the World Development Report, Tanzania started to implement some health sector reforms aimed at improving access to health services to the population. These reforms were directed in the following areas.

- Organizational reforms including redefining the role of the government, decentralization, the health referral system
- Managerial reforms - coordination of health services, management support systems, capacity building, human resources management
- Health Financing – resource allocation, role of donors, cost sharing health insurance scheme
- Public/Private mix
- Population and health – population policy, family planning,
- Food and Nutrition
- Health systems research
- Legal Reform
- Primary health care

(***Proposals for Health Sector Reform, December 1994***)

To operationalize the recommendations in the Health Sector Reform document, the Ministry of Health and Social Welfare (MoHSW) developed a series of programs of work, the "***Action Plan for 1996-1999***", the ***Health Sector Reform Program of Work July 1999 – June 2002***), then by strategic plans, the ***Medium Term Strategic Plan 2002 –2004***, followed by ***Medium Term Strategic Plan 2004 – 2009*** and the current one, the "***Health Sector Strategic Plan III (July 2009 to June 2015).***

The MoHSW developed some mechanisms for involvement and coordination of different stakeholders, the local governments, NGOs, faith based organizations, the private sector, the community and Civil Society Organizations (CSOs), the Basket Fund Committee (BFC), Sector Wide Approaches (SWAp) and the Technical Committee of SWAp with its various Technical Working Groups (TWG) and the Joint Annual Health Sector Review (JAHSR).

II. Summary of the Terms of Reference

The terms of reference for the study were

1) To participate in the development, modification or country adaptation of the study tool in consultation with the ACHEST Project Coordinator of the study
2) To identify, locate and administer questionnaire to all indigenous HRPIs that are involved or have the potential to participate in national health stewardship and governance
3) To draw a table listing all possible HRPIs in the country including information on their location, their key areas of work, how they have worked in health stewardship and governance, and how they can be supported to strengthen national health stewardship and governance.
4) To carry out a pre-test of the tool and revise the tool in consultation with the Project Coordinator
5) To carry out detailed study and follow-up of 10 – 15 HRPIs by administering the tool, collecting and recording data using the questionnaire
6) To compile data from the core 10- 15 HRPIs and from other HRPIs which manage to submit reasonably well completed questionnaires, analyse and present the data for easy interpretation
7) To write a clear and concise report
8) To present the report at a joint workshop.

III. Data Collection and Analysis Methods

According to the report ***Strong Ministries for Strong Health Systems*** Health Resource Partner Institutions (HRPIs) are individuals, groups and institutions that interact regularly among themselves and with the government, parliament and civil society agents of change, providing support and holding each other accountable. HRPIs have the potential for supporting the health system stewardship and governance functions of the ministries of health.

Possible HRPIs and their contact addresses were identified by the principal researcher in Tanzania, basing on his knowledge and through consultation with heads of department at the MoHSW and the Health Resource Secretariat at the Ministry which coordinates meetings of the Ministry with development partners and stakeholders. Such meetings include the JAHSR, SWAp, and BFC. Another source of information was coordinators of the 13 TC SWAp Technical Working Groups of the MoHSW. More information of the HRPIs was sourced from their websites.

Data was collected during the second week of November 2011 through the second week of January 2012. The questionnaire was sent by e-mail to some HRPIs while others were visited for face to face interview by the researcher.

Some top executives had to assign their subordinates to respond to the questionnaire. Face to face interviews were conducted with 12 top executives of the HRPIs. In two instances they involved their subordinates as a team in the interviews. Interviews with the teams proved to be very effective.

Some problems were encountered during data collections. Repeated phone calls had to be made to remind the respondents to complete the questionnaire and mail it back to the researcher. Most of the people were away on holiday during the month of December to the second week of January 2012.

The information was coded and data analyzed using Microsoft Office Excel 2007.

IV Findings

Basing on the definition of HRPIs provided in the ***Strong Ministries for Strong Health Systems*** report, 40 HRPIs were identified, out of which 20 were selected for detailed analysis. The list is definitely not exhaustive, as there are many more non-governmental organizations that could fulfill the definition that have not been included due to the limited time of study. For example, there are many NGOs, local and international, which are working in Tanzania in various disease specific programmes such as HIV/AIDS, tuberculosis, non-communicable diseases and neglected tropical diseases such as trachoma, onchocerciasis, elephantiasis that have not been included in this study. These NGOs absorb a significant health workforce and are doing a great job in provision of services to those afflicted with the diseases and in controlling the diseases. They are also a source of information, evidence and innovations and provide opportunity for professional development and growth.

a. Location

Of the 20 HRPIs studied, 16 of them are based at Dar es Salaam, the commercial capital of Tanzania and practically where the government operates. Of the 4 HRPIs that are located outside of Dar es Salaam, one of them, Ifakara Health Institute still has a strong base in Dar es Salaam though its official headquarters is located at Ifakara, Morogoro Region.

The HRPIs are operating in established office premises with permanent physical and mailing addresses except some professional associations, the offices of which were difficult to locate.

b. History

Of the 20 HRPIs studied, 4 (IHI, AMREF, TEC and UMATI) were established before independence of Tanganyika in 1961. Between 1965 and 1993 (28 years), only 6 HRPIs were established while from 1994 to 2006 (12 years only) 10 HRPIs were established. It is to be noted here that Tanzania began to implement health sector reforms in 1994 and adopted an open door policy for private and NGOs to operate within the spirit of public/private partnership. Another factor that lead to the growth of NGOs in the health sector is HIV/AIDS.

Table 1 shows the historical perspective of the establishment of HRPIs.

Table 1: Establishment of HRPIs in Tanzania

PERIOD	HRPI ESTABLISHED
Before Independence in 1961	IHI, AMREF, TEC, UMATI
1965-1993	MAT, NIMR, TPHA, MeLSAT, CSSC, PSI
1994 – 2006	APHFTA, KCMUC, PRINMAT, SIKIKA, WD,CUHAS, CHAI, WRATZ, BMAF, MU

c. Geographical Scope

5 HRPIs are based at Dar es Salaam and have no branches. CUHAS and KCMUC also having no branches are based at Mwanza, along Lake Victoria and Moshi, Kilimanjaro region respectively. The remaining 3 HRPIs which have no branches in Tanzania operate globally with their main headquarters in Washington DC, U.S.A. while operating from Dar es Salaam in Tanzania. CHAI operates in 70 countries, PSI in 60 countries while WRA operates in 15 countries, WRATZ being the counterpart in Tanzania.

10 HRPIs have branches in Tanzania and they are all based at Dar es Salaam except IHI which has its headquarters at Ifakara in Morogoro Region. Though the headquarters of AMREF in Tanzania is Dar es Salaam, it also operates in Kenya, Uganda, South Africa, South Sudan, and Senegal and has 13 other offices in Europe and North America. The headquarters of AMREF is at Nairobi, Kenya. See Annex 1 for the full list of HRPIs.

d. Legal Status

The 20 HRPIs can be categorized into service, university, research, professional and advocacy according to their main function. They can also be categorized as government or non-governmental institutions, and according to their legal status. The Table 2 below provides these categories accordingly.

Table 2: The Legal Status of Different Types of HRPIs

TYPE OF INSTITUTION	REGISTERED		ESTABLISHED BY LAW		NO LEGAL STATUS		TOTAL
	GOVT.	NGO	GOVT.	NGO	GOVT.	NGO	
Service	-	CSSC, TEC, BMAF, CHAI, APHFTA, PRINMAT,	-	-	-	-	**6**
University	-	-	MU	CUHAS, KCMUC	-	-	**3**
Research	-	AMREF, IHI	NIMR	-	-	-	**3**
Professional. Associations	-	MAT, MeLSAT, TPHA	-	-	-	-	**3**
Advocacy	-	UMATI, WD, SIKIKA, PSI	-	-	-	WRATZ	**5**
TOTAL	**0**	**15**	**2**	**2**	**0**	**1**	**20**

There were 6 HRPIs whose main function is service provision which are all NGOs with registration by the Ministry of Home Affairs as their legal status. One university is government and two are non-governmental, all being faith based, one owned by the TEC and the other one by the ELCT. All universities are established by law according to their university charter. There are 3 research institutions, two of which are registered as NGOs and the other one is a government institution. All

the 3 professional associations and the 4 of the 5 HPRIs whose function is mainly advocacy are registered as NGOs. WRATZ, being an alliance formed of a number of institutions, some of which are multi lateral organization, is neither established by law or registered.

e. Governance of the Institution

The governance of HRPIs presented a very variable picture. There are HRPIs that are only governed by a single organ, such as Board of Trustees (2), Governing Council (1), General Assembly/Annual General Meeting (5), and Board of Directors (3). There are RPIs that are governed by two levels of organs, such as Board of Trustees and Governing Council (4), Annual General Meeting and Governing Council (1), Annual General Meeting and Board of Directors (1) and International Board of Directors and Local Advisory Board (1). There are two HRPIs that are governed by three levels of organs; the Board of Trustees, Annual General Meeting and Board of Directors (1) and the Annual General Meeting, Board of Directors and Advisory Board (1). Table 3 shows the different governance organs of the HRPIs.

Table 3: Governance of HRPIs

NUMBER OF LEVELS	GOVERNING ORGAN(S)	HRPI	NUMBER
ONE LEVEL	Annual General Meeting	TEC, PRINMAT, MAT, MeLSAT, TPHA	5
	Board of Trustees	BMAF, CHAI	2
	Governing Council	NIMR	1
	Board of Directors	AMREF, WRATZ, SIKIKA	3
TWO LEVELS	Board of Trustees & Governing Council	CUHAS, KCMUC, MU, IHI	4
	Annual General Meeting & Governing Council	UMATI	1
	Annual General Meeting & Board of Directors	CSSC	1
	International Board of Directors & Local Advisory Board	WD	1
THREE LEVEL	Board of Trustees, Annual General Meeting & Board of Directors	PSI	1
	Annual General Meeting, Board of Directors & Advisory Board	APHFTA	1
TOTAL			**20**

g. Founding Institutions/Individuals

The HRPIs that were studied were established by the Government, faith based organizations, foreign institutions and individuals. The National Institute for Medical Research and Mzumbe University were established by the Government. The Catholic University of Health and Allied Sciences (CUHAS) was established by the Tanzania Episcopal Conference (TEC), which is a Roman Catholic Institution formed under the Cannon Law of the Roman Catholic Church comprising of 33 bishops, each heading a diocese. TEC has established and supports a network of other health and educational institutions all over the country. The Evangelical Lutheran Church of Tanzania (ELCT) is the founder of the Kilimanjaro Christian Medical University College (KCMUC). The ELCT and the Christian Council of Churches jointly established the Christian Social Services Commission (CSSC) for the purpose of establishing, coordinating and supporting the provision of health and

education services in the country.

Ifakara Health Institute (IHI), White Ribbon Alliance Tanzania (WRATZ) and Population Service International (PSI) have their origin outside Tanzania. IHI started as a Swiss Tropical Institute field laboratory established by Dr. Rudolf Geigy in 1956. PSI and WRATZ were both founded in Washington DC, USA and later established their operations in other countries globally.

The following HRPIs were established by individuals.

1. African Medical and Research Foundation (AMREF)
2. The Family Planning Association of Tanzania (UMATI)
3. Medical Association of Tanzania (MAT)
4. Tanzania Public Health Association (TPHA)
5. Medical Laboratory Scientists Association of Tanzania (MeLSAT)
6. Association of Private Health Facilities in Tanzania (APHFTA)
7. Private Nurses and Midwives Association of Tanzania (PRINMAT)
8. Sikika
9. Womens' Dignity (WD)
10. Clinton Health Access Initiative (CHAI)
11. Benjamin Williama Mkapa HIV/AIDS Foundation (BMAF)

Appendix I provides the full list of HRPIs.

g. Funding for the HRPIs

The mostly mentioned source of funding for HRPIs is donors (40%) followed by members' contributions and revenue from projects (each 19%) and government grants (12%). Other sources of funding were research grants, consultancy, banks and fund raising, each of them mentioned by only 1 HRPI. Most of the HRPIs could not provide the details on the exact proportion of funding from each source.

The government, mainly through the Ministry of Health and Social Welfare has been providing funds to government established HRPIs and some professional associations, especially for organizing their annual conferences. The Ministry of Education and Vocational Training is providing funding to some universities as grants.

Donors provide funding to HRPIs to support them in carrying out their programmes as part of bilateral or multilateral agreements with the government. Some donors are international foundations such as the Bill and Melinda Gates Foundation and Touch Foundation, the Global Fund, Church institutions and NGos abroad, international research institutions such as the European and Developing Countries Clinical Trials Partnership (EDCTP), individual donors from within and outside Tanzania.

Members' contributions apply mainly in associations, church institutions whereby dioceses or churches make contributions to their HRPIs and alliances, such as the WRATZ, where members of the alliance contribute funding for some specific activities.

HRPIs also generate revenue from fees paid for their services such as universities. The fees can be paid by individual students or their sponsors who may include the government through the Ministry of Health and Social Welfare and the Ministry of Education and Vocational Training and the Higher Education Students' Loan Board. HRPIs also generate revenue from overheads for carrying out some donor funded projects with specific agreements or from some income generating activities such as renting conference facilities.

Table 4 shows the different sources of funding for HRPIs.

Table 4: Main Source of Funding for HRPIs

SOURCE OF FUNDING	HRPI AND LEVEL OF FUNDING IN BRACKET	FREQUENCY	% FREQUENCY
Government	KCMUC, MU, NIMR(40%), MAT, MeLSAT	5	12
Member Contributions	CSSC, TEC, WRATZ, APHFTA, PRINMAT, MAT, MeLSAT, TPHA	8	19
Revenue from Projects/Fess	CUHAS, KCMUC, MU, CSSC, BMAF, UMATI(12%), APHFTA, TPHA	8	19
Donors	CUHAS, KCMU, MU, AMREF, IHI (100%), NIMR(60%), CSSC, BMAF(95%), CHAI, UMATI(88%), WD(100%), WRATZ, SIKIKA(100%), PSI(100%), PRINMAT, MeLSAT, TPHA	17	40
Research Grants	CUHAS	1	2.5
Consultancy	APHFTA	1	2.5
Banks	APHFTA	1	2.5
Fund Raising	PRINMAT	1	2.5
TOTAL		**42**	**100**

h. Partner Institutions, Institutional Links and Networks

All HRPIs had links with the government and some links with other HRPIs, universities, other academic institution, research institutions, foreign governments, multilateral organizations and affiliated institutions within and outside Tanzania.

Research institutions were the second most linked institutions with the HRPIs (75%). They were seen to be sources of information and technical advice as well as partners for doing joint research with.

11 out of 20 HRPIs (55%) are linked with universities. Universities provide to them training opportunities, technical expertise through consultancy, sharing of information and partners for undertaking joint research. The same applies to a lesser extent, to non university academic institutions.

Affiliate institutions are institutions with shared mission. For example, the White Ribbon Alliance for Safe Motherhood Tanzania (WRATZ) is linked to GWRA as well as to professional associations that have interest or play a role in safe motherhood such as Tanzania Midwives Association (TAMA), Association of Gynecologists and obstetricians in Tanzania (AGOTA), Medical Women's' Association (MEWATA) and Pediatric Association of Tanzania (PAT). Linkage of this kind was mentioned by 12 out of 20 HRPIs (60%) that were studied in detail.

Foreign governments and multilateral organizations were linked to HRPIs mainly for their funding. Apart from funding, multilateral organizations were also a source of information and guidelines.

Table 5 shows the linkage and networking of HRPIs.

Table 5: Institutional Links

LINKED INSTITUTION	HRPIs WITH LINKS	NATURE OF LINKS
University	11 (55%)	Under same ownership, training opportunities, consultancy services, sharing information, joint research
Other Academic Institutions	6 (30%)	Training opportunities, sharing information, joint research
Research Institution	15 (75%)	Joint research, source of information, technical advice
National Government	20 (100%)	Recognition, program implementation, funding, regulation, source of information, technical advice, source of HRH, policy advocacy
Foreign Government	9 (45%)	Funding,
Multilateral Organization	8 (40%)	Funding, guidelines
Affiliate Institution	12 (60%)	Shared missions

i. Technical details, and areas and types of work

The HRPIs studied can be categorized as institutions whose main purpose is service provision, academic and/or research, professional associations, professional regulatory bodies and advocacy.

Health Policy:

10 out of 20 HRPIs (50%) indicated that they were somehow involved in health policy, directly or indirectly. They undertake research to generate evidence for publication and dissemination to facilitate policy advocacy. Almost all of the HRPIs who mentioned health policy development as one of the areas of focus of their work, have been involved by the Ministry of Health and Social Welfare in development of some health policy documents. Ifakara Health Institute and Mzumbe University have played the role of expert adviser for the Ministry on malaria policy and organization and management of collaborative HIV/AIDS. HRPIs are also involved in health policy development through their participation in SWAp and TWGs meetings.

WD, WRATZ, SIKIKA have been heavily involved in researching, policy analysis and advocacy on budget, resource allocation, auditing, accounting and matching resources and output against targets. They have also been concerned with equity issues and service to the poor.

Health Systems:

13 0ut of 20 HRPIs (65%) mentioned health systems as one area that they have been preoccupied with. They have been undertaking research on the performance of the health system to identify areas and interventions to improve performance. Specific monitoring and evaluation exercises have been conducted as part of health system assessment to provide feedback to the government

and other health providers. As part of their intervention in improving attraction, motivation and incentive to health workers, BMAF has gone as far as undertaking construction and renovation of health infrastructure including staff houses.

Health Care Programs:

13 out of 20 HRPIs (65%) are implementing some Health Care Programs such as voluntary counseling and testing, Prevention of Mother to Child Transmission (PMTCT) of HIV, family planning, care of women with fistula resulting from prolonged labour and the safe motherhood. Other health care programs are concerned with alcohol, tobacco and substance abuse.

Disease Specific Programs:

Disease programs that are being implemented by some HRPIs are malaria, HIV/AIDS, non communicable diseases, in particular diabetes and the Neglected Tropical Diseases (NTDs). AMREF was one of the pioneering institution in initiating and scaling up of HIV voluntary counseling and testing through its famous program known as ANGAZA. NIMR has been leading the fight against the neglected tropical diseases, such as elephantiasis, onchocerciasis and trachoma.

Human resources:

14 out of the 20 HRPIs (70%) identified human resources for health as one of the areas of focus for their institution. The universities are involved in the training aspect of human resources development and undertake research in human resources development. Apart from universities and research institutions, WD, WRATZ and SIKIKA also carry out some research activities to generate evidence to advocate for policy change. 4 of the HRPIs are members of the TC-SWAp TWG on human resources for health. BMAF, SIKIKA and CHAI have been actively involved in researching and piloting some innovations to improve recruitment, deployment, motivation and retention of human resources for health. BMAF have been at the forefront in piloting an incentive package for young health professionals to work in remote districts. SIKIKA undertook a tracking study for new recruits posted to work in different work station to find out the report rate and if they stayed on to assess retention.

Health Financing:

Notable among HRPIs which have been involved in the area of health financing are MU, IHI, CSSC, TEC, CHAI, WD, SIKIKA, APHFTA and TPHA. Among others, they have been following up the efforts of the government to reach the Abuja Declaration in budget allocation, tracking up allocation in different health priority areas, accountability and achievement of set targets.

Community Participation:

Half of the studied HRPIs have been undertaking intervention in the community with the community participation.

Economic Policy, Trade and Health:

Only 3 out of 20 HRPIs (15%) have been involved in issues of economic policy, trade and health. These are MU, IHI and SIKIKA.

Advocacy:

HRPIs have also been involved in health advocacy to the community, educating them so that they value health and utilize health services. They have been training members of the community to provide health services and advocating to the government to adopt and develop appropriate policies.

Table 6 below shows the different areas of focus for the HPRIs.

Table 6: Areas of Focus of HRPIs

AREA OF FOCUS	HRPIs	NUMBER	%	MECHANISM
Health Policy	MU, IHI, CSSC, TEC, WD, WRATZ, SIKIKA, APHFTA, MeLSAT, TPHA	10	50	1. Undertake research and publication (MU, IHI, WD,WRATZ, SIKIKA, TPHA) 2. Participate in policy development and review (All) 3. Advocate for policy (WD, WRATZ,SIKIKA, TPHA) 4. Dissemination of Policy (All) 5. Policy expert adviser (IHI, TPHA) 6. Participate in SWAP/Network Policy meetings (All)
Health Systems	MU, AMREF, IHI, NIMR, TEC, WD, BMAF, CHAI, WRATZ, SIKIKA, APHFTA, MeLSAT, TPHA	13	65	1. Undertake research (AMREF, IHI, NIMR, SIKIKA) 2. Evaluation and Monitoring (IHI, AMREF, NIMR,TPHA) 3. Renovation of rural health infrastructure (BMAF)
Health Care Programs	KCMUC, MU, AMREF, NIMR, CSSC, BMAF, CHAI, UMATI, WD, WRATZ, APHFTA, PRINMAT, TPHA	13	65	1. Voluntary Counseling and Testing for HIV (AMREF) 2. Family Planning 3. Care of women with fistula (WD) 4. Safe motherhood (WD, PRINMAT, WRATZ) 5. Alcohol, tobacco and Drug Abuse (TPHA)

Disease Specific Programs	AMREF, IHI, NIMR, CSSC, CHAI, PSI, APHTA	7	35	1. Malaria (NIMR, PSI) 2. Voluntary Counseling and Testing for HIV (AMREF) 3. Non communicable diseases (APHFTA) 4. Neglected Tropical Disease (NIMR)
Human Resources	CUHAS, MU, AMREF, IHI, NIMR, CSSC, TEC, BMAF, CHAI, WD, WRATZ, SIKIKA, APHFTA, MAT	14	70	1. Training of postgraduate students in health management and administration (CUHAS, MU,) 2. Undertake research (CUHAS, MU, AMREF, WD, WRATZ, SIKIKA) 3. Participate in HRH-TWG (AMREF, IHI, CSSC, BMAF) 4. Tracking of new recruits posted to work in district councils (BMAF, SIKIKA, CHAI)
Health Financing	MU, IHI, CSSC, TEC, CHAI, WD, SIKIKA, APHTA, TPHA	9	45	Tracking budget process, PER, allocation of budget, expenditures against target (WD, WRATZ, SIKIKA
Community Participation	CUHAS, AMREF, IHI, CSSC, CHAI, WRATZ, PSI, APHTA, MeLSAT, TPHA	10	50	1. Training of community health workers (TPHA, IHI) 2. Distribution of insecticide treated nets (PSI) 3. Annual safe motherhood rallies (WRATZ)
Economic Policy, Trade and Health	MU, IHI, SIKIKA	3	15	Pharmaceutical and trade policy development (SIKIKA)
Technical Assistance	CUHAS, IHI, AMREF, IHI, NIMR, CSSC, CHAI, UMATI, MeLSAT, TPHA	10	50	Development of national policy on collaborative TB/ HIV activities (MU)

Advocacy	AMREF, CSSC, UMATI, WD, WRATZ, SIKIKA, APHFTA, MAT, MeLSAT, TPHA	10	50	1. Public information and debate 2. Advocacy for planning, public budget, budget transparency, expenditure reporting and accountability (IHI, SIKIKA, WD, WRATZ) 3. Advocacy of policy on safe motherhood to high profile leadership (WRATZ, WD, UMATI)

Participation in health stewardship and governance

Table 7 shows the involvement of HRPIs in various areas of health governance and stewardship.

Policy: Health Policy Development

17 out of 20 institutions (85%) indicated that they were involved in policy review and development, mainly by participating in policy development meetings and SWAp/Network Policy review and development meetings. They also got involved in policy development by undertaking research in health policy. 2 HRPIs have been acting as policy expert advisers, and there are HRPIs which are strong advocates of policy. All HRPIs have been involved in policy dissemination. The policy concerns for the HRPIs have mainly been family planning, reproductive health and safe motherhood, health equity, health financing, budget, allocation, accountability and their comparison with output, outcome and targets. Other areas of policy concern for HRPIs were environmental health, alcohol and substance abuse.

Oversight: Legislation process and development

9 out of 20 HRPIs (45%) have been involved in the legal review process, either through meetings or reviewing of draft bills. Some of the HRPIs managed to foster strong ties with the law makers, the parliamentary legal committees or groups.

Research: Health systems and development

8 out of 20 HRPIs (40%) were involved in conducting research in health policy and health systems, seating in the NIMR Advisory Board and presenting papers in scientific conferences.

Regulation: Rules and procedures of management

Some of the areas that HRPIs have contributed in are the development and refinement of operational guidelines, guidelines for conducting supportive supervision and health centre regulation, banking procedures for private health facilities and the development of service level agreements between faith based health facilities and local governments on provision of health services.

Incentive development and application: Staff payments, and retention strategies

HRPIs have been very active in the area of human resources development and in particular, staff payments and development and testing and applying retention strategies. Some of the strategies that have been applied are provision of salary grants and scholarships for students with some form

of bonding, development of national definition of underserved difficult and hard to reach areas and their recommended incentives, development of the national orientation package for new recruits. HRPIs have also been participating in HRH TWG meetings.

Partnership with other stakeholders: SWAP and networks

9 out of 20 HRPIs (45%) studied have been participating in the JAHSR Meeting and the SWAp TWGs meetings. HRPIs have also been networking among themselves. There is a very strong network linking HRPIs that are concerned with equity on health, budget analysis, and allocation of resources, accountability on expenditure and their relations to outputs as compared to targets. Safe motherhood and reproductive health has also been linking a number of HRPIs together.

Organization: Organizational reforms, including restructuring and decentralization

7 out of 20 HRPIs (35%) were involved in the health sector reform process lead by the MoHSW. They were also involved in building capacity of CSOs and LGAs and private health facilities, thus facilitating decentralization and growth of the private sector.

Accountability: Consultancy or research to track funds with outputs or amount of work done

7 HRPIs focused on budget analysis, participation in public expenditure review meetings, health financing and tracking budget trends for the health sector. They are also concerned with the way financial resources are allocated and accounted for as well as linking expenditures with outputs as related to the set targets. As part of their consultancy work they also trained DMOs in budgeting.

Monitoring and evaluation: Assessing the level of performance against program objectives and planned targets

Some HRPIs were involved in monitoring and evaluation, for example, impact assessment of some projects. They also participate in the Monitoring and Evaluation SWAp TWG.

Coordination: Alignment of individuals and institutions to nationally agreed goals and processes

Strong coordination role was noted in HRPIs concerned with safe motherhood, faith based institutions and private health facilities where one of the HRPIs assumed the coordination role.

Table 7: HRPI Involvement in Health Governance and Stewardship

HRPI PARTICIPATION IN NATIONAL OR REGIONAL HEALTH GOVERNANCE	HRPIs N (%)	HRPIS INVOLVED	COMMENTS ON HOW/WAYS HRPIs INVOLVED
Policy: Health Policy Development	17 (85%)	CUHAS, KCMUC, MU, AMREF, IHI, NIMR, CSSC, TEC, UMATI, WD, WRATZ, SIKIKA, PSI, APHFTA, MAT, MeLSAT, TPHA	1. Undertake research (MU, IHI, WD,WRATZ, SIKIKA, APHFTA, MeLSAT, TPHA) 2. Participate in policy development and review (All) 3. Advocate for policy (UMATI, WD, WRATZ, SIKIKA, APHFTA,TPHA) 4. Dissemination of Policy (All) 5. Policy expert adviser (IHI, MU) 6. Participate in SWAP/Network Policy meetings
Oversight: Legislation Process and development	9 (45%)	TEC, WD, WRATZ, SIKIKA, APHFTA, PRINMAT, MAT, MeLSAT, TPHA	1. Participate in health sector legal reviews (All) 2. Collaboration with Parliamentary Group (WRATZ, WD, SIKIKA)
Research: Health policy and systems development	8 (40%)	CUHAS, NIMR, CSSC, WD, WRATZ, SIKIKA, MAT, MeLSAT	1. Conduct Research (CUHAS, NIMR, CSSC, WD, WRATZ) 2. Participate in NIMR Advisory Board (MAT) 3. Present papers in scientific conferences (All)
Regulation: Rules and procedures of management	7 (35%)	IHI, NIMR, CSSC, WD, APHTA, MAT, TPHA	1. Development and refinement of operational guidelines (IHI) 2. Development of Service Level Agreement (CSSC) 3. Development of partogram, EmONC supportive supervision guidelines (WD) 4. Functional referral system (WD) 5. Banking policy, health centre regulation (APHFTA)

Incentive development and application: Staff payment, and retention strategies	10 (50%)	CUHAS, CSSC, BMAF, CHAI, WD, WRATZ, SIKIKA, APHFTA, MAT, TPHA	1. Human Resource Database System development (CSSC, BMAF) 2. Salary grants for retention of staff by LGAs and sponsorship of students with bonding (CSSC, BMAF) 3. Piloting recruitment, retention, productivity initiatives (BMAF) 4. National definition of underserved areas and their recommended incentives 5. National orientation package for new recruits in LGAs 6. Facilitate tripartite dialogue between community, providers and policy makers (WD) 7. Participate in HRH-TWG (BMAF, SIKIKA, APHFTA) 8. Working with MUHAS in CPD (MAT)
Partnership with other stakeholders: SWAP and networks	9 (45%)	IHI, NIMR, CSSC, BMAF, CHAI, UMATI, WD, WRATZ, APHFTA	1. Participate in SWAP and Joint Annual Health Sector Review meeting (All) 2. Commissioned for Poverty and Human Development Report IHI) 3. HRH-TWG member and seconding staff to work full time to facilitate operations of the HRH sect oral initiative (BMAF) 4. East African Initiative on Advocacy for Family Planning (UMATI)
Organization: Organizational reforms, including restructuring and decentralization	7	AMREF, NIMR, CSSC, BMAF, WD, APHFTA, TPHA	1. Building capacity for smaller CSOs 2. Participation in reform process (All) 3. Working with LGAs and ZHRCs in decentralizing some of the HRH functions 4. Creation of the PPP desk at the MoHSW (APHFTA)

Accountability: Consultancy or research to track funds with outputs or amount of work done	7 (35%)	IHI, NIMR, CSSC, CHAI, WD. WRATZ, TPHA	1. Budget analysis, PER, health financing, PE tracking system (IHI, CSSC, SIKIKA) 2. Support RHMT and CHMTs to track resources provided by CHAI and other partners (CHAI) 3. Budget analysis advocacy (WD, SIKIKA) 4. Track budgets from 2006 to date and funds allocated for implementation of CCHPs (WRATZ, SIKIKA) 5. Training of DMOs in budgeting (TPHA)
Monitoring and evaluation: Assessing the level of performance against programme objectives and planned targets	12 (60%)	MU, AMREF, IHI, NIMR, CSSC, CHAI, UMATI, WD, PSI, APHFTA, PRINMAT, TPHA	1. Impact assessment of health programmes/projects e.g. NETTS, EMPOWER (MU) 2. Conduct malaria surveillance and monitoring drug and insecticide sensitivity (IHI) 3. Participation in M&E TWG (IHI, NIMR, CSSC)
Coordination: Alignment of individuals and institutions to nationally agreed goals and processes	8 (40%)	AMREF, IHI, CSSC, CHAI, UMATI, WD, WRATZ, TPHA	1. Coordination of development partners in safe motherhood initiative (WRATZ) 2. Coordination of faith based institution in provision of health services and education (CSSC)

IV. Suggestions from HRPIs on how to best strengthen stewardship and governance

These are suggestions on how HRPIs could enhance governance and stewardship that came from different HRPIs.

Formalize Structure for Involvement of HRPIs

Some HRPIs have expressed concern that meaningful involvement mechanisms for them to participate in Ministry of Health policy development and programs are lacking. There is no formal structure through which they can be involved in health governance and stewardship. They find it difficult to identify a person or office through which they can contribute to health policy development.

The Ministry needs to design a structure for involvement of HRPIs and make it known to all stakeholders. They pointed out that, universities are very resourceful institutions but are underutilized because no clear mechanisms exist for working with the MoHSW on a continuous basis. Universities are only involved when there is a specific activity that needs to be done. Once that activity is accomplished, the collaboration ends until another issue crops up. Some HRPIs suggested having MoUs with the Ministry in undertaking some projects.

Provide opportunity for each CSO to participate

The government has been making the wrong assumption that NGOs can be represented by one umbrella body. The government sometimes even goes further to appoint an umbrella organization for NGOs, only to find out that it does not represent some NGOs at all. NGOs should be allowed to identify their own umbrella body, but the Ministry should also be prepared to work with individual CSOs as much as possible, as they have very heterogeneous missions and needs which are very specific to each one of them.

Government committed to PPP

While the Ministry of Health and Social Welfare has PPP as one of the strategy of HSSP III, there is little commitment to involve and support the private sector. The private sector is being seen as a competitor to the public sector and is not being given the opportunity to grow by creating a conducive environment for them to grow and deliver their service to the community. The PPP desk at the Ministry took very long to be established and is still not clear who is the focal person and where in the Ministry the PPP desk is anchored. The Ministry should complete the process of establishing the PPP and inform stakeholders accordingly.

Greater Involvement of HRPIs in Policy and Technical Matters

HRPIs have a wide knowledge base and experience in carrying out some key health projects. The Ministry should design a mechanism of involving them in policy and technical committees so that their knowledge and field experience, local and international, can effectively be utilized to facilitate health sector governance and stewardship.

Sharing of Information

Information should be freely shared between the Ministry and HRPIs so that both parties can be better informed to function more effectively. Universities and other HRPIs need to be involved in seminars and meetings organized by the Ministry so as to become better informed about health sector developments. The Government should also provide feedback to universities on performance of graduates so that they can improve their curricula and training to produce relevant and competent graduates. Other stakeholders specifically mentioned the reluctance of the Ministry to share information on budgets, allocations and expenditures.

Working with the Local Governments

Working with local governments and CSOs has been very rewarding as it provided the opportunity to support and facilitate stewardship and governance in the health sector at grass root level. One of the HRPIs remarked

"Health systems strengthening, in particular, HRH including leadership development in the health sector at community level provided us with strategic entry points through which we could facilitate infusion of principles and basics for health sector stewardship and governance at community level and building capacity for CSOs."

Health Systems research

The Ministry should put more emphasis on health systems research and building capacity for it so that research informs policy makers, health care providers and community at large on the desirable policies and practices that will produce better outcomes. Research should include human resources for health, governance and stewardship and health systems in general as well as monitoring and evaluation of programs.

Mechanisms should be developed for repackaging and communicating research findings, knowledge and data for policy makers, technical experts, planners, managers, practitioners and other health sector stakeholders.

Improve legal and policy environment to facilitate stakeholder participation in the budget process

The legal and policy environment is not conducive for budget related changes. There is lack of accountability, nobody takes action on findings and recommendations. Some HRPIs are just taken as noise makers. People should take HRPIs positively as they wish to make contribution towards improving governance and stewardship in the health sector.

Responsiveness

The MoHSW is not very friendly, is non responsive and bureaucratic with negative attitude towards NGOs. Ministry officials do not cooperate enough in responding to questionnaires on very important and relevant research. MoHSW is often not represented in meetings organized by NGOs when invited. MoUs take too long before they are approved.

MoHSW should adhere to their clients' service charter and work as business people.

Operationalization of Policies

No clear strategies are in place for operationalization of policies making translation of policy into action difficult. The Ministry should formulate guidelines for operationalization of policies at different levels.

Recognition and Accreditation of Continuous Professional Development

The Ministry of Health and Social Welfare should enforce continuous professional development (CPD) by recognition, certification, re-registration of health professionals, and remuneration according to achievement in CPD. Professional associations and professional regulatory bodies should be involved in this process and ensure standard professional practice. The Ministry should develop and maintain human resources for health databases to facilitate CPD, their promotion and remuneration.

Empower HRPIs to be oversight for the Ministry

A proposal came by that, the MoHSW should facilitate the formation of a group of ***Think Tank*** which will monitor, evaluate and provide oversight (independent eye) to the Ministry and provide feedback on a regular basis.

Support to NGO for HRH

Health provision health facilities and universities owned by church organizations face shortages of staff due to their inability to provide attractive pay packages. They request the government to assist them by giving subsidies to enable them pay salaries due to their contribution to service to the community and the training of human resources for health.

Participation of HRPIs in Ministry's Institutions Governance

Some respondents recommended that the Ministry appoints some individuals from HRPIs to sit in governance organs of some semi autonomous institutions under the Ministry of Health and Social Welfare such as the Government Chemical Laboratory Agency (GCLA), Tanzania Food and Drugs Authority (TFDA), the Medical Stores Department (MSD) etc. HRPIs have individuals who are very resourceful and can contribute to improved performance of the government agencies. Participation of HRPIs in governance of government agencies will also provide experience that will in turn build capacity for the HRPIs.

V. Discussion

The nature and character of HRPIs

Almost all HRPIs that were studied are well established legal and registered entities with strong leadership and governance structure. The HRPIs were established by the government, faith based organizations and individuals from within Tanzania and outside. Almost all of the studied HRPIs are based at Dar es Salaam and have well established premises and communication facilities; telephone, internet and have their own websites. Professional associations were difficult to locate as they do not have clear premises and their leaders were difficult to identify.

The HRPIs that have been studied have accumulated a wealth of experience due to their many years of operation and have stood a taste of time within a very dynamic environment. Most of them have reliable sources of funding. The human resources that they have, makes them indeed to qualify as HRPIs.

The combination of HRPIs being universities, research institutions, service provision, and professional association, governmental and nongovernmental, makes them to be really resourceful, providing a comprehensive mix of what one might need at any moment. The challenge has always been to identify them, characterize them, identify their potential, strengths and weaknesses and develop mechanisms for meaningful and effective engagement with them so as to achieve a coherent and harmonious partnership. This requires development of strong governance and stewardship which will motivate the HRPIs to contribute their best outputs for the development of the health sector and for their own survival. This study has addressed this challenge, but also opened the way for further studies that can result into better understanding of HRPIs and develop a meaningful engagement with them for the development of the health sector. More in depth study is needed to identify as many HRPIs as possible and characterize them. Professional Associations, international NGOs, private institutions and many more faith based institutions have not been identified and located. As noted earlier, the growth of NGOs working in the health sector is very rapid.

The growing number of NGOs operating in the health sector requires that the MoHSW develop mechanisms and capacity to coordinate them, guide them so that they can effectively contribute towards the achievement of the health policy vision and mission, the Primary Health Services Development Programme (PHSDP) 2007 – 2017) and the broader Government Development Vision 2025 and the Second Phase National Strategy for Growth and Reduction of Poverty (NSGRP)

2010/11 to 2014/15. To be able to harness all the potentials of the HRPIs through guidance and their motivation requires effective health stewardship and governance, the essence of this study.

The Legal Status of HRPIs

The general picture that emerged with regard to the legal status of the HRPIs is that Government HRPIs such as Mzumbe University and the National Institute for Medical Research are established by law while nongovernmental HRPIs are registered with the Ministry of Home Affairs. All universities, government or private are established by law under their specific university charters. One of the NGOs, WRATZ is neither established by law nor registered. WRATZ is an alliance formed by the MoHSW through its Reproductive and Child Health Unit, WHO, UNFPA. UNICEF, JHPIEGO, AMREF, EGPAF and WD. Others are Care International, Engenderhealth, Plan International and Save the Children Fund.

Governance of HRPIs

All the HRPIs are autonomous entities with well established governance structures. There are HRPIs that have a simple governance structure comprising of only one level of governing organ, being the Annual General Meeting, the Board of Trustees, Governing Council or the Board of Directors. There are also cases where the governance structure has two levels of different kinds of governing organs; the Board of Trustees and the Governing Council, the Annual General Meeting and the Governing Council, the Annual General Meeting and Board of Directors and the International Board of Directors and the Advisory Board. There were two HRPIs whose governance structure had three levels; Board of Trustee, Annual General Meeting and Board of Directors and Annual General Meeting, Board of Directors and Advisory Board. The general pattern is that, whenever there are multiple levels, the Board of Trustees is the supreme organ and the Annual General Meeting is the supreme organ where there is no Board of Trustees. The Governing Council and the Board of Directors occupy the same level, with the Advisory Board always below them.

Funding for the HRPIs

The main source of funding for HRPIs is donor funding. Membership contributions and revenue generated by HRPIs from fees and services and overhead accrued from implementation of projects, mostly donor funded, were the second most frequent source of funding. Unfortunately, most of the sources of information from the HRPIs could not give an estimation of the amount or proportion of funding from each source. Thus the frequency of source of funding is not equivalent to the proportion of funding. Some HRPIs seem to be very innovative in the manner they source for funds. The Association of Private Health Facilities in Tanzania (APHFTA) is such an example. They have an agreement with the CRDB Bank of sharing interest accruing from loans taken by their members, under the association's guarantee. Only one HRPI has utilized fundraising as a strategy.

The issue of sustainability is often raised when one depends on donors as a main source of funding. Some of the HRPIs are generating some revenue from services such as renting of their facilities for conferences or fees from the students. HRPIs have a challenge to develop project proposals that would attract funding from donors, or are innovative in identifying income generating activities.

Partner Institutions, Institutional Links and Networks

All HRPIs are linked with the government. Linkage with the government is needed for recognition, regulation, and guidance. The government is a source of information, policy, legal, guidelines and protocols documents. Link with the government is also needed for program implementation, technical advice and is also a source of human resources for health. They also need the government to advocate their policies and programs and influence change of government policies. Some HRPIs expressed bitterly, their frustration of not receiving adequate attention and support from the government. The government is a major source of funding for some HRPIs; however, seeking

for government funding was not a major reason for linkage with the government for most of the HRPIs.

Research institutions were the second most frequently linked institutions after government. The linkage with research institutions were seen to provide opportunity for conducting joint research. Research institutions are also a source of information and technical advice. However, linkage between the two local research institutions studied was not very apparent.

Institutions under the same ownership seem to be well linked, for example, CSSC is well linked with KCMUC as both of them are institutions of the protestant church. Some institutions are linked because they have similar mission. For example, Women's Dignity is linked with WRATZ, AGOTA and FIGO, all of them being concerned with reproductive health and safe motherhood. WD is linked with the International Fistula Surgeons because of its role in caring for women with fistula. WD is also linked with the International Society on Equity as well as Policy Forum and International Budget Partnership due to having similar missions. The WRATZ is affiliated to the Global White Ribbon Alliance as well as to professional associations that are concerned with safe motherhood such as TAMA, AGOTA, PAT and MEWATA. SIKIKA, a HRPI very strong in advocacy for proper budgeting, allocation and accountability for expenditure is linked with WD, WRATZ, and CSSC, which have the same mission.

Medical schools are linked with each other and jointly through such associations as the Forum for University Colleges of Health Sciences (FUCHS) and the Tanzania Private Universities Association (TAPU). In East Africa, universities area also linked by the Inter University Council of East Africa.

All HRPIs have links outside the country with affiliate institutions having similar missions, foundations, individuals, and bilateral and multilateral institutions. Some of the HRPIs are linked with foreign institutions due to common origin such as the GWRA, CHAI, and PSI while others by similarity of mission. Some foreign institutions, bilateral and multilateral organizations provide funding and technical assistance to the HRPIs studied.

HRPIs areas of focus and the ways they are involved in governance and stewardship

Demand for a formal structure for involvement of stakeholders

According to the representatives of the HRPIs interviewed, there is no formal structure for their involvement in governance and stewardship development of the health sector. The MoHSW currently has the Health Resource Secretariat (HRS) within the Department of Policy and Planning which is the focal point for all development partners and other stakeholders wishing to get information, policy documents, guidelines and different protocols as well as for them to introduce their contribution in terms of projects and possible funding to the health sector. The PPP desk which has for long been under the Department of Curative Services coordinates private and other non government health providers. The Ministry has also formed a number 13 TWGs within the SWAp through which different stakeholders participate in policy and strategy development, following up and monitoring implementation and outputs basing on milestones set. It is not certain that this current arrangement is known to all HRPIs. Apart from all this, the Ministry has the BFC, SWAP and the Health Sector PER and the Joint Annual Health Sector Review (JAHSR) which involve development partners in crucial policy issues, monitoring and evaluation.

Information Sharing

HRPIs mentioned the need to improve information sharing with the Ministry. The sharing of information should also be extended to sharing among them so that they can achieve synergy in what all of them are trying to achieve.

The Ministry produces various policies, plans, budgets, guidelines, protocols and all kinds of information that does not seem to reach other stakeholders. Such crucial information should be properly repackaged or otherwise distributed and shared through different means, such as distribution of hard copies of documents, organized meetings, the MoHSW through its different departments and the use of the MoHSW website, continuously being updated. .

VII. Recommendations

Basing on the findings of the study and suggestions given by representatives of the HRPIs studied, we are making the following recommendations.

1. Only 41 HRPIs were identified, 20 of which have been studied in detail. There are definitely more institutions that qualify as HRPIs. Thus, there is a need to conduct a thorough study to identify as many more HRPIs as possible, characterize them and identify their strengths and opportunities and build and maintain a database of HRPIs in Tanzania.

2. The MoHSW may think that there are adequate mechanisms to involve development partners, HRPIs and other stakeholders. The mechanisms may not be effective and adequate and may not be known by all. Thus there is a need to review all the existing arrangements so as to come up with an improved mechanism and make it all known to all. There is a need to assess the adequacy of these structures and mechanisms, awareness of different stakeholders on these mechanisms and how they are currently being used. This review will enable the development of a structure that will effectively ensure the participation of all stakeholders in the development of the health sector. The structure should be supported by some policy and legal framework to ensure guidance and commitment of all players to use it.

3. The Ministry should ensure that policies, plans, budgets, guidelines, protocols and all kinds of information that is crucial is properly repackaged and shared through different means, such as distribution of hard copies of documents, organized meetings, through different departments of the MoHSW and the use of the MoHSW website, continuously being updated.

4. The MoHSW leadership should make deliberate efforts to change the negative attitude of all its staff working at the headquarters and the LGAs to change their negative attitudes towards DPs, NGOs and other stakeholders so that they cooperate with them and give them access to information that they need to make their contribution to health sector development more effective. The MoHSW should commit itself to fully implement the PPP Policy that is part of the main health policy and as presented in the HSSP III document. The Ministry should also implement its ***Clients Service Charter*** and be more responsive so that stakeholders get what the ministry has promised to deliver to its clients.

5. HRPIs mentioned that, clear strategies for operationalization and translation of policy into action are lacking. Non operationalization of agreed policies and plans demotivates and frustrates those who have participated in their development. The Ministry should formulate guidelines for operationalization of policies at different levels.

6. Identify HRPIs and form among them Think Tanks that would be relied upon to monitor health sector development and provide feedback to the MoHSW on an annual basis or as need arises.

7. For enhancing effective partnership between the MoHSW and HRPIs, there is a need for the MoHSW to assist in capacity building for HRPIs as well as for the MoHSW itself. Capacity building can be in terms of provision of staff grants for employing people with the required skills, secondment of staff, and provision of working tools, such as ICT and networking.

Training in health systems and operations research and monitoring and evaluation is essential to enable HRPIs and MoHSW generate evidences for effective development of policies, strategies and plans and ensure their implementation.

VIII Conclusions

HRPIs play a crucial role in governance and stewardship of the health sector. Identifying them, recognizing their work, supporting them and building mechanisms for collaboration and networks for information sharing are crucial if the government is to effectively utilize the great potential that HRPIs possess.

8. Missions/ or publications

HRPIs have been publishing documents related to their programs of operation, documents arising from their research work and policy advocacy documents. Universities and research institutions have many publications which can be accessed through their websites. Other HRPIs have published the following documents.

CSSC

1. Financial and Materials Management
2. Human Resources Manual
3. Procurement Manual
4. ICT Manual

TEC

1. TEC Health Policy

UMATI

1. National Population Policy 1992
2. Assessment of Tanzania National Status on Youth Friendly Services in Tanzania
3. National Strategy for Adolescent Health
4. Partnering with Young Men for Sexual Reproductive Health and Promotion and HIV/AIDS Prevention

WD

1. Best Practice in Reduction of Maternal Deaths in Nkasi District, Rukwa Region. December 2010.
2. Leaflets, calendars

WRATZ

1. Journal of African Midwives
2. Advocacy Packages, Posters, Leaflets,
3. Bill boards, Media,

Look at WRA website for more

SIKIKA

1. Unnecessary expenditures: a brief on the Government's initiative to refocus expenditures. Vol 2, July 2010
2. Post Election Political Advertising: A case of 2010 Tanzania General Election
3. Medicines and medical supplies availability report, using absorbent gauze availability survey as an entry point: a case of 71 districts and 30 health facilities across Mainland Tanzania, 10 – 20th May 2011
4. Do Audit Reports Eeffect Financial Discipline, Integrity and Accountability? The case of Audit Reports for the Tanzania Ministry of Health and Social Welfare Fiscal Years 1999 – 2010
5. Petty Corruption in Health Services in Dar es Salaam and Coast Regions. Sikika 2010 Published by E & D Readership and Development Agency for Sikika
6. Medicines and Supplies Availability Survey May to August 2011. Brief No. 1, 2011
7. The Ineffectiveness of Complaints Mechanisms in the Tanzanian Health Sector. Brief No. 2, 2011
8. Health Governance and Financing: Failure to attain Abuja Declaration, Equity and Allowances in the Ministry of Health. Brief No. 4, 2011

MAT

1. Tanzania Medical Journal (Quarterly)
2. Ethic Publication

http://www.amref.org/info-centre/online-resource-centre
www.ihi.or.tz
www.nimr.or.tz

9. Annexes

Annex I: Full List of HRPIs

Annex II: Powerpoint Presentation

Annex 1: List of HRPIs Studied (*HRPI Studied in detail)

S/N	Health Resource Partner Institute (HRPI)	Year Established	Address	Founders	Headquarters	Branch Location
UNIVERSITIES						
1.	Muhimbili University of Health and Allied Sciences (MUHAS)	1991	P.O. Box 65001 Dar es Salaam. Tel : +255 22 2150302/6, 2151596 Fax : +255 22 2150465 E-mail : vc@muhas.ac.tz	Government	Dar es Salaam	NIL
2.	Hubert Kairuki Memorial University (HKMU)	1997	Plot No. 322 Regent Estate, Mikocheni P.O. Box 65300 Dar es Salaam Tel : +255 22 2700021/4 Fax : +255 22 2775591 E-mail : info@hkmu.ac.tz www.hkmu.ac.tz	Late Prof. Hubert Kairuki	Dae es Salaam	NIL
3.	Kilimanjaro Christian Medical University College (KCMUC)	1997	Longuo Street Kibosho P.O. Box 2240 Moshi Tel: +255 27 2753616 Fax: *** E-mail: psec@kcmcollege.ac.tz www.kcmcollege.ac.tz	Evangelical Lutheran Church of Tanzania Presiding Bishop and Trustees	Moshi	NIL
4.	International Medical and Technological University (IMTU)	1995	****	Vignan Educational Foundation, Vignan Educational Foundation (Tanzania)	Dar es Sallaam	NIL

5.	Catholic University of Health and Allied Sciences (CUHAS)	2003	Bugando Hill P.O. Box 1464, Mwanza Tel: +255 28 2599881 Fax: +255 28 2592678 E-mail: vc@bugando.ac.tz	TEC Bishops	Mwanza	NIL
6.	University of Dodoma (UDOM)	March 2007	P.O. Box 259, Dodoma Tel: +255 26 2310000 Fax: +255 26 2310011 E-mail: vc@udom.ac.tz	Government	Dodoma	NIL
7.	Mzumbe University	MU	P.O. Box 1 Mzumbe. Tanzania. Tel.255 023 260 4380-4 Fax 255 023 260 4382 E-mail: info@mzumbe.ac.tz Website: www.mzumbe.ac.tz Top of Form Bottom of Form	Government	2006	Dar es Salaam Mbeya
RESEARCH INSTITUTIONS						
8.	National Institute for Medical Researc	1980	2448, Ocean Road, P.O.BOX 9653 Dar es salaam, Tanzania Tel: +255-22-2121400 Fax: +255-22-2121360 *Email*: *hq@nimr.or.tz or* info@nimr.or.tz	Government	Dar es Salaam	Amani, Mwanza, Tabora, Muhimbili Tanga, Tukuyu

9.	Ifakara Health Institute (IHI)	1956	Plot 463, Kiko Ave, Mikocheni P.O. Box 78373, Dar es Salaam Tel: +255 22 2774756 Fax: +255 22 2771714 -mail: ifakara@ihi.or.tz	Dr. Rudolf Geigy	Ifakara	Dar es Salaam, Bagamoyo,
10.	Traditional Medicine Unit	1974	Under MUHAS	Government	Dar es Salaam	NIL
11.	Economic and Social Research Foundation (ESRF)	1994	51 Uporoto Street, Ursino Estates P.O Box 31226, Dar es Salaam. ******	Individuals	Dar es Salaam	NIL
FAITH BASED ORGANIZATIONS						
12.	Tanzania Episcopal Conference (TEC)	1957	Kurasini P.O. Box 2133 Dar es Salaam Tel : +255 22 2851075 Fax : +255 22 2851133 E-mail : info@tec.co.tz	Roman Catholic Bishops Under	Dar es Salaam	33 dioceses in Tanzania

13.	Christian Social Services Commission (CSSC)	1992	Ali Hassn Mwinyi Road P.O. Box 9433, Dar es Salaam. Tel: +255 22 2112918 Fax: +255 22 2118552	Christian Council of Tanzania (CCT) and Evangelical Lutheran Church of Tanzania (ELCT)	Dar es Salaam	NIL
NON GOVERNMENTAL ORGANIZATIONS						
14.	Benjamin WIliam Mkapa HIV/ AIDS Foundation	2006	Plot No. 372, Chole Road, Masaki P.O. Box 76274 Dar es Salaam. Tel: +255 22 2600540/2, 2600590, 2600531 E-mail: info@ mkapahivfoundation. org www. mkapahivfoundation. org	President Benjamin William Mkapa and President William Jafferson Clinton	Dar es Salaam	Mwanza, Iringa, Mtwara, Arusha and Coast Region
15.	Clinton Foundation (CHAI)	2004	Ohio Street/Sokoine Drive P.O. Box 77277, Dar es Salaam Tel: +255 22 2124885 E-mail: kmccrystal@ clintonhealthaccess.org	President William Jefferson Clinton	Global HQ: Washington DC Tanzania HQ: Dar es Salaam	NIL
16.	Family Planning Association of Tanzania (UMATI)	1959	Maliki St. Upanga Plot. No. 439 P.O. Box *** Dar es Salaam. Tel : +255 22 2150156/2152479 E-mail : infor@umati. or.tz	Mrs. M.C. Lloyd Mrs. V.M. Varma Mrs. B. Knight	Dar es Salaam	NIL

17.	Association of Private Health Facilities in Tanzania (APHFTA)	1994	44/644 Lumumba Street P.O. Box 13234, Dar es Salaam Tel: +255 22 2184667 Fax: +255 22 2154508 E-mail: info@aphfta.org www.aphfta.org	Prof. Hubert Kairuki Dr. Kaushik Ramaiya Dr. Kanabar Dr. TMJ Hospital Aga Khan Hospital	Dar es Salaam	Dar es Salaam Zone, Lake Zone, Southern Highlands Zone, Northern Zone
18.	Private Nurses and Midwives of Tanzania (PRINMAT)	1999	Msisiri B, Mwananyamala P.O. Box 60442, Dar es Salaam Tel: +255 22 2761518 E-mail: info@prinmat.org www.prinmat.org	Kezia M. Kapesa Atuswilage Konga Late Jane Munthali Rita Kulwa Clara Lweganwa	Dar es Sallaa	NIL
19.	SIKIKA (SIKIKA)	2000	Off Tunisia Road, Kinondoni P.O. Box 12183, Dar es Salaam Tel: +255 22 2666355-7 Fax: +255 22 2668015 E-mail: info@sikiks.or.tz www.sikiks.or.tz	Irenei KIria	Dar es Salaam	NIL
20.	Women's Dignity (WD)	2002	P.O. Box 79402, DSM Tel 022-2152577/8 Fax: 022-2152986 e-mail: info@womensdignity.org web: www.womensdignity.org	Ms. Maggie Bangser	Dar es Salaam	NIL

21.	White Ribbon Alliance for Safe Motherhood in Tanzania (WRATZ)	1999	JHPIEGO, Plot 481 Ring Street, Msasani. P.O. Box 9170, Dar es Salaam. Tel : +255 22 2771346/8 Fax : +255 22 2771341 Mobile +255 754 316369	Ms. Rose Mlay with JHPIEGO, UNICEF, UNFPA, WHO, RCH Unit of the MoHSW, AMREF, EGPAF, WD, EngenderHealth, Save the Children, Care International, Plan International	GWRA is headquartered at Washington DC, U.S.A. WRATZ is based at Dar es Salaam	GWRA operates in 15 countries worldwide. No branches in Tanzania.
22.	National Council of People Living With HIV & AIDS (NACOPHA)		National Council of People Living With HIV & AIDS (NACOPHA) P.O. Box 55881, Kijitonyama Uganda Street, House No. 309/44 Dar es Salaam Tel: +255 22 2701210 Fax: +255 22 2701209 E-mail: nacopha@ nacopha.or.tz			
23	Policy Forum (PF)	2002	P.O. Box 38486, Dar es Salaam. Tel : +255 22 2772611 Fax : +255 22 2701433 E-mail : info@ policyforum.or.tzTel : +255 22 2772611 Fax : +255 22 2701433 E-mail : info@ policyforum.or.tz			
24.	Family Health International (FHI)					
25.	Plan International (PI)					

	HEALTH INSURANCE COMPANIES					
26.	NHIF	1999	Kurasini Bendera Tatu P.O. Box 11360, Dar es Salaam. Tel : +255 22 2133958 Fax : +255 22 2133972 E-mail : info@nhif.or.tz		Dar es Salaam	Dar es Salaam, Mwanza, Mbeya, Mtwara, Iringa, Moshi
27.	AAR	1984	Plot 1, Ali Hassan Mwinyi Rd/Chato Street P.O. Box 9600, Dar es Salaam. Tel : +255 22 2701121 Fax : +255 22 270 1120 E-mail : info@aar.co.tz		Nairobi Kenya	Has branches in Kenya Uganda and Tanzania
	PROFESSIONAL ASSOCIATIONS					
28.	Medical Association of Tanzania (MAT)	1965	Muhimbili University College of Health Sciences P.O. Box 701 Dar es Salaam. Tel : +255 22 754047857 E-mail : info@mat-tz.org www.mat-tz.org		Dar es Salaam	Lake Zone, Northern Zone
29.	Dental Association of Tanzania (DAT)					
30.	Tanzania Public Health Association (TPHA)					
31.	Tanzania Pharmacy Association (TPA)					
321.	Tanzania Nurse Association (TANA)					

33.	Medical Laboratory Association of Tanzania (MeLSAT)					
34.	Medical Women Association of Tanzania (MEWATA)					
35.	Association of Gynecologists and Obstetricians in Tanzania (AGOTA)					
PROFESSIONAL REGULATORY BODIES						
36.	MCT					
37.	TNCM					
38.	MLC					
39.	PH C					
40.	OC					
41.	TMC					

Annext Ii: Powerpoint Presentation Of Report

1

ACHEST STUDY: Tanzania Report

Mapping of Health Resource Partner Institutions (HRPIs):

Modeling a sustained approach for strengthening health governance and stewardship in low-income countries

Presented at Kampala Meeting on 21st March, 2012 by Dr. Gilbert R. Mliga

2

IDENTIFICATION of HRPIs

Possible HRPIs identified by

- The principal researcher basing on his knowledge
- Consultation with heads of department and the Health Resource Secretariat at the MoHSW
- Coordinators of the 13 TC SWAp Technical Working Groups of the MoHSW
- HRPIs websites

3

DATA COLLECTION

- Data was collected during the second week of November 2011 through the second week of January 2012.
- The questionnaire was sent by e-mail to some HRPIs
- Face to face interview of 12 top executives were conducted by the researcher
- Group Interview of 2 HRPIs

4

DATA ANALYSIS

The information was coded and data analyzed using Microsoft Office Excel 2007

5

LOCATION OF HRPIs

- 16 out of the 20 HRPIs are located in Dar
- 4 are located outside Dar es Salaam
  - IHI – Dar es Salaam and Ifakara, Morogoro
  - KCMUC – Moshi
  - CUHAS – Mwanza
  - UDOM - Dodoma

6

ESTABLISHMENT OF HRPIs

PERIOD	HRPIs ESTABLISHED
Before Independence in 1961	IHI, AMREF, TEC, UMATI
1965 - 1963	MAT, NIMR, TPHA, MeLSAT, CSSC, PSI
1994 - 2006	APHFTA, KCMUC, PRINMAT, SIKIKA, WD,CUHAS, CHAI, WRATZ, BMAF, MU

7

LEGAL STATUS OF HRPIs

- Registered NGOs
  - CSSC, TEC, BMAF, CHAI, APHFTA, PRINMAT
  - AMREF, IHI
  - MAT, MeLSAT, TPHA
  - UMATI, WD, SIKIKA, PSI
- Govt Institutions established by Law
  - MU, NIMR
- NGOs established by Law
  - CUHAS, KCMUC
- HRPIs without Legal Status
  - WRATZ

8

GOVERNANCE OF HRPIs

NO. OF LEVELS	GOV. STRUCTURE	NO. OF HRPIS	%
ONE LEVEL	AGM	5	25
	BOT	2	10
	Gov. Counc	1	5
	BOD	3	15
TWO LEVELS	BOT+ Gov. Counc	4	20
	AGM + Gov. Counc	1	5
	AGM + BOD	1	5
	Int. BOD + Local Adv. Board	1	5
THREE LEVELS	BOT+AGM+BOD	1	5
	AGM+BOD+Adv. Board	1	5

9

HRPIs PARTICIPATION IN HEALTH GOVERNANCE AND STEWARDSHIP: Health Policy Development, 13/20 (85%)

- Undertake research and publication (MU, IHI, WD, WRATZ, SIKIKA, APHFTA, MeLSAT, TPHA)
- Policy development and review (All)
- Advocate for policy (UMATI, WD, WRATZ, SIKIKA, APHFTA, TPHA)
- Policy dissemination (All)
- Act as policy expert adviser (IHI, TPHA)
- Participate in SWAp/Network policy meetings (NIMR, SIKIKA, IHI, CSSC)

10

FUNDING OF HRPIs

Source of Funding	Frequency of HRPIs	% Frequency
Government	5	12
Members' Contributions	8	19
Revenue from Project s/Fees	8	19
Donors	17	40
Research Grants	1	2.5
Consultancy	1	2.5
Banks	1	2.5
Fund Raising	1	2.5

11

INSTITUTIONAL LINKS

LINKED INSTITUTION	NO. OF HRPIs	NATURE OF LINKS
University	11 (55%)	Under same ownership, Consultancy, information, joint research
Other Academic Institutions	6 (30%)	Training Opport., information, joint research
Research Institutions	15 (75%)	Joint research, information, techn. Advice
Nat. Government	20 (100%)	Recognition, prog. Implementation, funding, regulation,information, techn. Advice, source of HRH, policy advocacy
Foreign Gov.	9 (45%)	Funding
Multi. Org	8 (40%)	Funding, guidelines
Affiliate Inst.	12 (60%)	Shared mission

12

HRPIs PARTICIPATION IN HEALTH GIOVERNANCE AND STEWARDSHIP: Oversight through legislation process and development, 9/20 (45%)

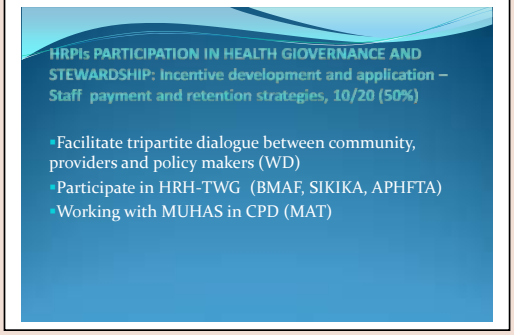
- Participate in health sector legal reviews (All)
- Collaboration with Parliamentary Group (WRATZ, WD, SIKIKA)

13

14

15

16



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20

HRPIs PARTICIPATION IN HEALTH GOVERNANCE AND STEWARDSHIP: Accountability – Consultancy or research to track funds with outputs or amount of work done, 7/20 (35%)

- Budget analysis, PER, health financing, PE tracking system (IHI, CSSC, SIKIKA)
- Support RHMTs and CHMTs to track resources provided by CHAI and other partners (CHAI)
- Budget analysis and advocacy (WD, SIKIKA)
- Track budget from 2006 to date and funds allocated for implementation of CCHPs (WRATZ, SIKIKA)
- Training of DMOs in budgeting (TPHA)

21

HRPIs PARTICIPATION IN HEALTH GOVERNANCE AND STEWARDSHIP: Monitoring and evaluation – Assessing the level of performance against program objectives and planned targets, 8/20 (40%)

- Impact assessment of health programs/projects e.g. NETTS, EMPOWER (MU)
- Conduct malaria surveillance and monitoring drug and insecticide sensitivity (IHI)
- Participation in M & E SWAp TWG (IHI, NIMR, CSSC)

22

HRPIs PARTICIPATION IN HEALTH GOVERNANCE AND STEWARDSHIP: Coordination – Alignment of individuals and institutions to nationally agreed goals and processes, 8/20 (40%)

- Coordination of development partners in safe motherhood initiative (WRATZ)
- Coordination of faith based institutions in provision of health services and education (CSSC)

23

SUGGESTIONS FROM HRPIs ON HOW STEWRDSHIP AND GOVERNANCE CAN BE STRENGTHENED

- Formalize structure for involvement of HRPIs
- Provide opportunity for each CSO to participate. No entity can fully represent all CSOs
- Government should be more committed to the development of PPP
- Government should utilize the various expertise of HRPIs through its different technical committees
- Information should freely be shared. Some information such as budgets, allocation and expenditures is not fully shared

24

SUGGESTIONS FROM HRPIs ON HOW STEWRDSHIP AND GOVERNANCE CAN BE STRENGTHENED

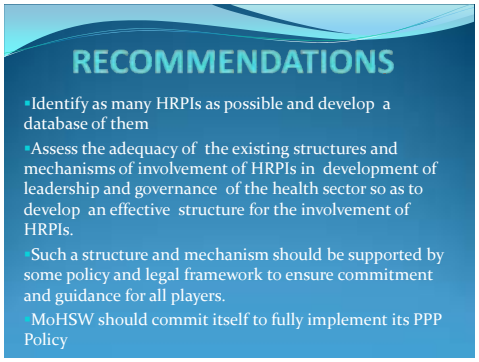
- MoHSW should put more emphasis on health systems research and building capacity for it so that research informs policy makers, health care providers and community
- Improve legal and policy environment to facilitate stakeholder participation in the budget process
- MoHSW should be more respionsive
- MoHSW should formulate guidelines for operationalization of policies at different levels
- MoHSW should establish mechanisms for recognition and accreditation of CPD

25

CONCLUSION

- HRPIs play a crucial role in governance and stewardship of the health sector.
- Identifying them, recognizing their work, supporting them and building mechanisms for collaboration and networks for information sharing are crucial if the government is to effectively utilize the great potential that HRPIs possess.

26


RECOMMENDATIONS
▪Identify as many HRPIs as possible and develop a database of them
▪Assess the adequacy of the existing structures and mechanisms of involvement of HRPIs in development of leadership and governance of the health sector so as to develop an effective structure for the involvement of HRPIs.
▪Such a structure and mechanism should be supported by some policy and legal framework to ensure commitment and guidance for all players.
▪MoHSW should commit itself to fully implement its PPP Policy

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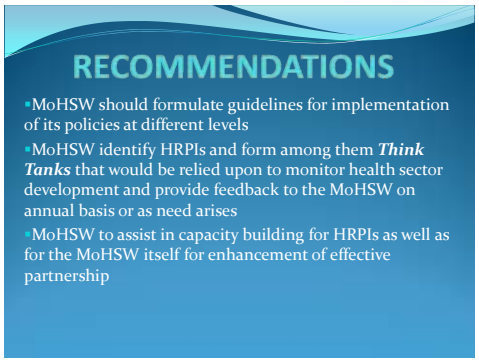
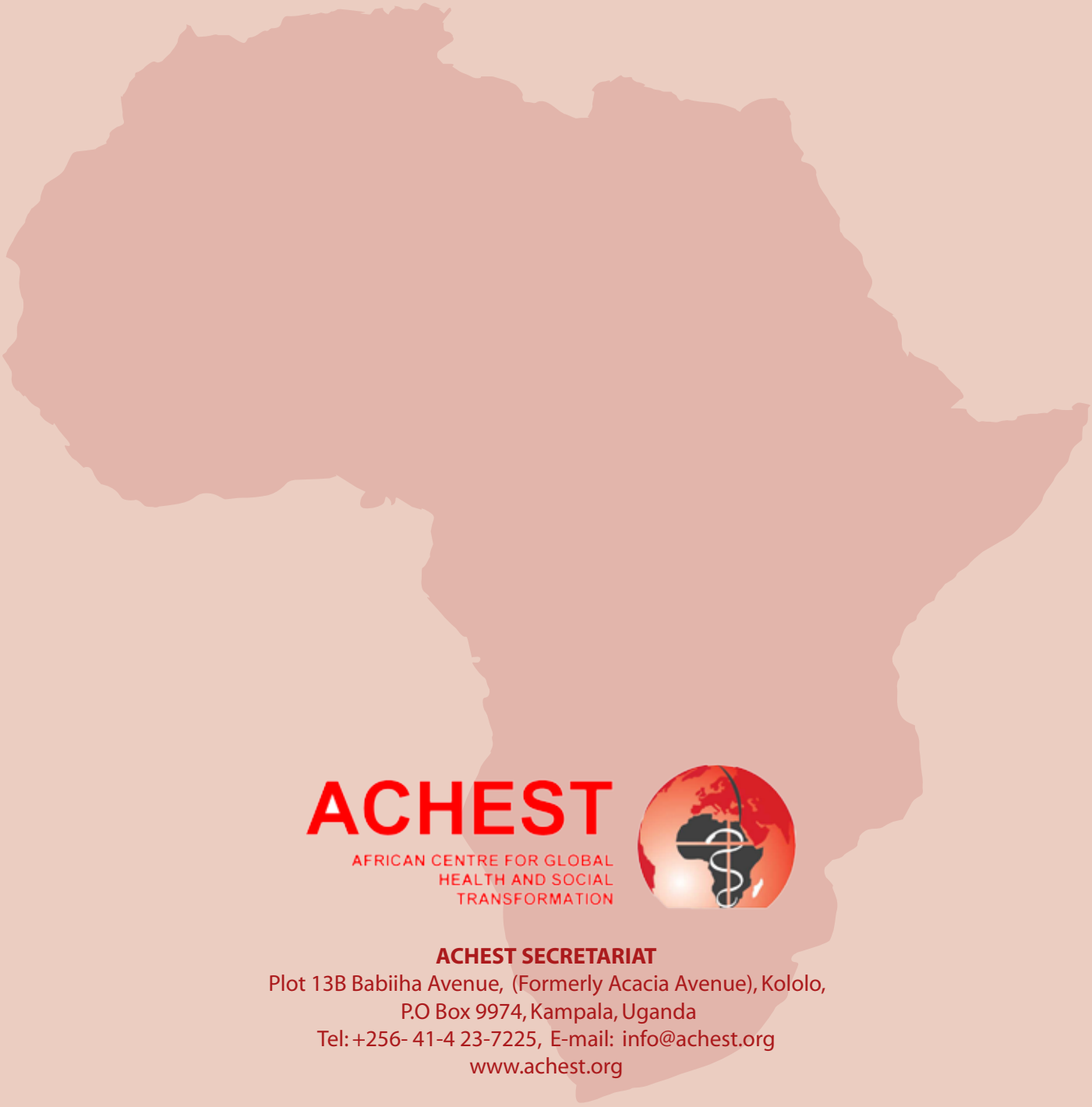
RECOMMENDATIONS
▪MoHSW should ensure that policies, plans, budgets, guidelines, protocols and all kinds of information are repackaged and shared
▪The MoHSW leadership make deliberate efforts to develop a positive attitude towards DPs, HRPIs and other NGOs and CSOs
▪MoHSW should implement its Clients Service Charter
▪Such a structure and mechanism should be supported by some policy and legal framework to ensure commitment and guidance for all players.

28


RECOMMENDATIONS
▪MoHSW should formulate guidelines for implementation of its policies at different levels
▪MoHSW identify HRPIs and form among them ***Think Tanks*** that would be relied upon to monitor health sector development and provide feedback to the MoHSW on annual basis or as need arises
▪MoHSW to assist in capacity building for HRPIs as well as for the MoHSW itself for enhancement of effective partnership



ACHEST

AFRICAN CENTRE FOR GLOBAL
HEALTH AND SOCIAL
TRANSFORMATION

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www.achest.org