Demand and supply of technical assistance and lessons for the health sector

Country perspective note – Tanzania

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Abstract

The Tanzanian public sector faces a sustained capacity gap, despite public service reforms. There is substantial external assistance through different modalities, organized in a complex formal dialogue structure. Most assistance that is proposed by donors is accepted and the government has insufficient capacity to strategically plan and manage technical assistance (TA). The effectiveness of TA is often impacted by a reluctance to draw on expatriate TA as well as the challenge of ensuring that there is a supportive enabling environment that includes individual counterparts and organizational systems and processes. This note draws on different experiences of TA and explores why they worked and what were some of the challenges that arose. A number of lessons relevant for the health sector are presented.

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List of Abbreviations

ALMA	African Leaders Malaria Alliance
BRN	Big Results Now
CCM	Chama Cha Mapinduzi party
CDC	Centre for Disease Control
DCF	Development Cooperation Framework
GDP	Gross domestic product
GoT	Government of Tanzania
HSSP	Health Sector Strategic Plan
JAST	Joint Assistance Strategy
ODI	Overseas Development Institute
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MoU	Memorandum of understanding
MoW	Ministry of Water
PO-PSM	President's Office – Public Sector Management
RMNCH	Reproductive maternal, neonatal and child health
TA	Technical assistance
TAS	Tanzania Assistance Strategy
TOR	Terms of Reference
TWG	Technical working group
URT	The United Republic of Tanzania (Government)
USAID	United States Agency for International Development
VFM	Value for money
WHO	World Health Organization

1 Introduction

Expenditure on technical assistance (TA) represents a large proportion of development expenditure in health. There are increasing concerns that this investment and its flow of costs in terms of staff time and opportunity cost is less effective than its potential.

This country note is part of a set of four papers covering Tanzania, Sierra Leone, Uganda and the Solomon Islands. They are guided by a framing paper that presents a demand and supply framework in an attempt to provide a common and focussed approach to analysing TA in country. The notes aim to review current practice drawing on examples of how the demand for TA is articulated and how the supply of TA is responding. This includes consideration of how requests for TA are coordinated among development agencies. The country explorations attempt to use these examples to illustrate particular cases and to consider the relevance of lessons for the health sector.

The research starts from the basis that each country environment is specific and presents particular challenges for the effectiveness of TA. At the same time, these country studies are expected to contribute an analysis of common themes around TA emerging from a range of countries.

This note presents a country overview, outlining the broad context in which TA operates. It then discusses the environment for TA itself, considering aspects such as attitudes towards TA and government coordination. The analysis of where TA has worked well explores some examples and analyses why they worked and what are some of the challenges that arose. Reflections are made upon particular features of demand and supply and how demand and supply interact. The final section draws out some lessons that are relevant for the health sector, within the demand and supply framework.

2 Country overview

2.1 The context for technical assistance in Tanzania

Tanzania has enjoyed strong macroeconomic performance with real gross domestic product (GDP) growing steadily since the late 1980s and being sustained at over 5 percent during the last 12 years. For several decades Tanzania has been one of Africa's largest recipients of foreign aid and around one third of the government's budget is financed by aid.[1] While general budget support is the preferred modality of government, project funding remains dominant and in recent years there has been a movement out of GBS into sector basket funds and projects. The health sector accounts for around 10 percent of the government's budget and around half of this is financed by donors (Danida, 2009). Allocations to the sector have tripled in real terms between 1999 and 2006 US$ 143.6 million to US$ 427.5 million (Joint External Health Sector Review 2007) although a substantial share is off budget, in 2006 20 percent was estimated as being off budget and this challenge persists despite efforts to bring projects on budget. Donors therefore remain important actors in Tanzania and their dialogue with government is well structured through the Joint Assistance Strategy (JAST, 2006).[2]

Despite this strong macro-fiscal performance, weaknesses in the use of government funds and inadequate quality of public services persist. While the government appears to be committed to improving both overall governance and service delivery, past inability to follow through on these goals has undermined public confidence.[3] Liberalization reforms generated economic dynamism while creating new governance challenges. However robust patronage networks between business and politics have remained untouched by governance reforms. These relationships pervade big business, where senior politicians and businesspeople appear to be linked in ways that involve conflicts of interest.

Given the ground lost by Chama Cha Mapinduzi (CCM) party in the 2010 elections the government appears to be focusing more on public perceptions of service delivery in the run-up to the 2015 elections.[4] Some argue that the adoption of the Big Results Now (BRN) agenda is a result of government concerns over the lack of progress made toward service delivery improvement goals.[5] The BRN 'labs' have highlighted the capacity gaps that are present and where TA may play a key role.[6]

[1] http://www.tzdpg.or.tz/external/aid-effectiveness/overview-of-aid-in-tanzania.html

[2] http://www.tzdpg.or.tz/dpg-website/national-development-framework/joint-assistance-strategies.html

[3] Raiamwema newspaper, May 22, 2013; Jamii forum blog (www.jamiiforums.com) postings on political leaders' promises, June 11, 2013.

[4] CCM parliamentary representation and presidential majority in 2010 was 60.4 and 61.2 percent of the vote respectively. Voter turnout in 2010 was 42.9 percent, substantially below the average of 77.8 percent in the three preceding presidential elections.

[5] BRN identifies sectors that are strategically important for economic development and prioritises policy actions linked to resources. It is supported by a strong results monitoring system. It is a top-down approach, initiated and directed by the president.

[6] As part of the second round, a BRN health mini-lab was due to start at the time of writing and is expected to produce prioritized plans.

3 Technical assistance in Tanzania

3.1 Summary of technical assistance context

The Tanzanian public sector has a capacity gap that has been sustained for several decades, despite public service reforms. While the coordination of aid has increased during the last two decades, there remains limited government leadership and a lack of strategic coordination of external assistance, both within sectors and at a central level. There is a small pool of experienced senior technical and managerial staff from which to recruit, in the health sector and other sectors.[7] According to a 2007 workshop report produced by the President's Office – Public Sector Management (PO-PSM), government managers are motivated to use TA, as the uncompetitive terms and conditions of service in government make it difficult to attract high quality personnel.[8] This situation has however improved over time as the wage differential with the private sector has narrowed and allowances, training and job security offered by public sector employment are substantial perks such that strong candidates are attracted to vacancies.[9]

There has been a change in donor-government relations over time, moving from a position of high trust in the mid-2000s to low trust during the last five years. This has been influenced by a combination of factors including corruption scandals in Tanzania and changes in donor domestic politics that has increased the pressure to demonstrate short term results. Most assistance that is proposed by donors is accepted and the government has only limited capacity to take the lead. As Tanzania has many donors providing a lot of support through different modalities the context is highly complex and this presents difficultly in managing both donors and aid. TA sits within this broad external assistance context and is impacted by the same dynamics, such that there is not a strategic demand for TA by government.

In common with many governments, the Tanzanian government does not have a strategic view of TA. It is not implementing a strategy that outlines the role that TA should play in specific sector contexts and how it could benefit from gap filling, policy advice, support on particular technical issues or building capacity. Nor does the government seem to have expressed which kinds of TA are important for different purposes, for example, expatriate versus local, volunteer versus professional, or teams versus individuals. To ensure that the impact of TA is as high and as sustained as possible it is important to have considered these issues and to have incorporated them into a strategic approach that is being implemented.

There is often a reluctance to integrate external TA - contrasting with the open attitudes to TA in Sierra Leone and Uganda.[10] This resistance appears to be related to a perception amongst some that accepting TA may be an admission that government is unable to do the work for which it is mandated and the way in which TA has been used in the past by donors. Donor and government interviewees felt that this reluctance arose from a combination of factors including: i) some TA being

[7] In 2012 a human resource crisis in the health sector was acknowledged as doctors were on strike between January and June (Report of the Joint Annual Health Sector Review 2012). In response to this government health cadre salaries increased by two thirds in the 2013/14 budget (Health DPG 2013).
[8] Attempts to obtain data on the number and type of technical assistants working in government were unsuccessful.
[9] http://www.mof.go.tz/index.php?option=com_content&view=article&id=34&Itemid=49
[10] Two other countries taking part in this research with completed case studies.

provided to support agendas of donors; ii) some TA being unsuccessful due to a combination of limited capacity in government to effectively absorb the TA and also the approach or skills and experience of the TA not being well aligned to the working environment. There was also sometimes an overestimation of what the national staff within government ministries could achieve such that capacity gaps were not identified. The result is often ad hoc, fragmented and often frustrated TA, but there also are instances when this leads to a determined focus on developing national capacity. Prior to JAST there was the Tanzania Assistance Strategy (TAS) (2002-2005), which included 'reduce the adverse effects of…heavy dependence on technical assistance' as one of its aims (URT 2013).

As a result of limited coordination and a resistance to TA, it is often not in place where it could be beneficial. The GBS evaluation (ITAD 2013) notes that government is not demanding TA and is missing an opportunity to utilise outside support. As much TA is supplier led, it is not particularly well aligned with needs and is often not particularly well absorbed. Overall there is a mixed performance of TA and it is highly variable in quality.

Box 1: The JAST on the role of technical assistance

Development Partners will provide technical assistance as a means to facilitate sustainable capacity development. Technical assistance (TA) to the Government will be demand-driven and respond to Government needs. It will be increasingly untied from the source of financial assistance and procured in a fair, non-discriminatory, competitive, transparent and accountable manner under the leadership of the Government, ensuring value for money (VFM) and the ability to meet identified capacity development requirements. This will be achieved among others through arrangements of pooling Development Partner finances for TA. For this purpose, possibilities to use the Performance Improvement Fund (PIF) for pooling funds for TA will be explored. Procurement of TA will use national rather than foreign expertise or supplies whenever these are able to meet VFM and capacity development requirements. The Government and Development Partners will undertake measures to strengthen national TA in these respects.

TA personnel will primarily be used for capacity development rather than for project or programme execution. Experts may however also be recruited as a temporary gap filling measure, particularly in highly specialised areas, whereas they will pay attention to skills sharing in the process. The recruitment, deployment, management, supervision and performance assessment of technical assistants will increasingly be led by the Government and integrated in the regular Government administrative system while Government structures and mechanisms to coordinate and manage TA resources will be strengthened in the process. The Government and Development Partners will also work towards providing a conducive incentive structure for TA personnel to effectively share their expertise and for counterparts to adapt and retain skills and knowledge from them. The Government will furthermore work closely with Development Partners and other stakeholders to formulate a national TA policy that outlines TA objectives, priorities and concrete guidelines for selecting, managing, monitoring and evaluating TA.

Source: JAST 2006: 11

While the JAST outlines an approach to TA, see Box 1, most of these principles do not accord with how TA is actually provided in Tanzania. Although a policy for TA, including capacity development as a measurable output was proposed (PO-PSM 2007, JAST APMF 2007) the drafting process stalled in 2009.[11] The draft policy included analysis on the current practice for TA provision and guidance on

[11] The JAST action plan and monitoring framework proposes the preparation and implementation of a national Technical Assistance Policy (JAST APMF 2007).
http://www.afrimap.org/english/images/documents/Tanzania-AGF7-CountryReport-English.pdf
The policy was drafted by MoF with support from UNDP, GTZ and JICA. As it was labelled a policy, the government was bound to follow standard procedures and subsequently develop a strategy and an action plan. There was also a desire to produce a strongly GoT owned

identifying TA needs, sourcing TA, managing TA, sharing skills and the monitoring and evaluation of TA. A Development Cooperation Framework (DCF) is currently being prepared by the Ministry of Finance (MoF), streamlining the early TA policy with the JAST. This is expected to contain guidance on TA although the implementation challenge in the context of limited capacity can be expected to persist.[12]

Given the absence of an overall government policy on TA, the approach to the identification and provision of TA is determined at a sector level, usually jointly between government and donors. This is not however guided by policies within the sectors, but rather it appears that norms that have evolved between government and donors are followed, based on previous practices. The donor-government interaction in the health sector is well organized. There are 13 technical working groups (TWGs) with the Ministry of Health and Social Welfare (MoHSW) representatives that meet frequently; work is organized within these groups.[13]

The greatest challenge currently facing the health system, as well as other areas of public service and the private sector, in Tanzania is the declining pool of young people coming out of the education system. The capacity gap in the health sector has been identified as being as high as 68 percent (MoHSW, 2007: 47). The World Health Organization (WHO) provides important technical support for the government as a result of its close relationship with the MoHSW. Through discussions with MoHSW WHO has facilitated thinking about skill and capacity needs across the entire health sector. Despite this, in the health sector there has however been very limited coordinated consideration of how TA specifically could bridge the capacity gap. The Human Resource for Health Strategic Plan finalised in 2008 was entirely focussed on national staff and permanent positions. The Primary Health Services Development Programme (MoHSW, 2007) refers to the need for TA most extensively: 'by using consultants in specialized fields' to fill the capacity gap (MoHSW, 2007: 47). More recently the Mid-term Analytical Review of Performance of the Health Sector Strategic Plan III (2013) identifies the need for TA support but neither considers any specific inputs nor presents guidance on its provision. There is greater scope to consider how TA can respond to the needs of the group or organization rather than focusing on the one-on-one counterpart relationship.

3.2 Where TA has worked well

This research carried out a brief scoping of the health sector in Tanzania. As extensive TA is provided to the health sector and the sector benefits from a substantial amount of donor support, efforts were made to understand how the sector operates and the nature of the TA that is provided. Discussions found there to be common characteristics and challenges faced in the operation of TA across several sectors with examples pointing to some general lessons for improving the effectiveness of TA.

3.3 Danida's TA to the health sector

Danida has been providing support to the health sector in Tanzania since the 1980s with the support through the Health Sector Strategic Plan (HSSP) commencing in 1996. Danida provides up to six

document and a TA databank, which itself required a policy. Donors also had little appetite to invest the substantial resources need to jointly formulate a national policy.
http://www.afrimap.org/english/images/documents/Tanzania-AGF7-CountryReport-English.pdf

[12] It was not possible to obtain these documents at the time of writing as they were in draft formats.

[13] http://www.tzdpg.or.tz/index.php?id=1289

international advisers as direct staff to the ministry.[14] Danida pays the salaries of the TA but they report to the Ministry of Health and Social Welfare (MoHSW).[15]

Over time trust with government has been built, however it requires discipline on the part of Danida to maintain distance from the TA and to delink from an influencing agenda. At the start of the programme in 2009 this trust had to be developed. Embedding the TA in MoHSW is key to enabling the TA to have a degree of responsibility and to be well integrated. Danida is able to do this as they are able to report on long term contribution rather than having to make direct attribution in their performance reporting.[16] This provides the TA the flexibility to respond to the needs of MoHSW and urgent and ad hoc tasks arising – important for establishing trust.

The terms of reference (ToR) list 'Participate on a regular basis in briefings with the Royal Danish Embassy' as an area of work, indicating that some regular contact was intended (Danida 2009: 69). In practice the advisers have very little contact with the Embassy and are fully embedded. Taking the specific example of the health policy adviser, there is contact with donors in practice through participation in TWG meetings. While this participation is highly appreciated some donors were disappointed that the government counterpart did not usually attend the SWAp Task Force and the Joint Annual Health Sector Review meetings himself.

Although Danida maintains distance from the TA, commitment from government is considered to be important and Danida tries to ensure that this is a pre-requisite. An example of where this has caused a change in implementation is the case of the hospital reform adviser whose position was terminated in December 2012 due to a lack of evidence of strong commitment from government. There has sometimes been a sense of frustration as TA found themselves to be underused. Some considered this to stem from both a lack of organization in the MoHSW and demand not being independently expressed. Consequently available counterparts were not forthcoming and a strong working relationship was not formed. It can also sometimes be the case that frustration arises as the capacity building expectations of international TA are higher than the context allows for.[17] Although the TA primarily have a capacity building role specified in their ToR, the areas specified are likely to result in gap filling activities (e.g. assist in preparation of annual work plans and mechanisms for coordination and collaboration). Indeed, through interviews it was clear that there is an understanding that some gap filling takes place.[18]

In contrast to this Danida model of TA provision where the donor maintains distance from the TA, United States Agency for International Development (USAID) implementers have a closer relationship to their TA.[19] An example of this is the CDC, an implementing partner of USAID. CDC

14 The positions are hospital reform, pharmaceutical services, public private partnerships, health policy, planning and management, and public financial management. Additionally an Organizational Development adviser is provided for TACAIDS and there is a provision for 120 months of short term TA over six years (Danida and GoT 2009). The hospital reform position was closed in 2012 due to a lack of evidence of strong commitment from Government.

[15] As this support has been long term it does not accord with the definition of TA used in the framing paper. However as it was considered an important model for the health sector it has been included here as an example.

[16] It is however expected that stricter and more constraining M&E demands from headquarters may start to have an impact in the future.

[17] An example of where this was the case with the Local Government Reform Programme (LGRP) II that was supported by a large TA team and which experienced difficulties building capacity due to high expectations and overlapping roles of building the capacity of the secretariat and helping to implement the programme.

[18] This analysis takes a narrow definition of capacity building, targeted at individuals and systems working in the organization through training, coaching and mentoring (e.g.AusAID 2005) (Welham, Krause, Hedger 2013).

[19] USAID is a substantial donor in the health sector, whose support is outside the basket fund, and therefore is not disbursed through the national budget. They have an estimated 70 projects that are led by prime implementing partners, for whom USAID approves their

provides TA to support GoT but also acknowledges how the TA is used to move the agenda forwards by the CDC adviser heavily investing in working closely with the TA and the government staff counterparts, largely to determine what government needs and to help the TA to carry out their roles.

This model is also appreciated amongst government and donors and the two types were considered to be complementary by some interviewees. Donors welcomed the CDC model as it presented the possibility to lever policy influence via the TA in discussions with government as well as being able to get tasks done more quickly. In contrast Danida's model was particularly important in being able to embed the TA, to establish trust with government and to ensure that there are government representatives at donor meetings.

3.4 Demand led maternal, neonatal and child health score cards

While, in general, TA in Tanzania is not demand led, there are examples from within the health sector where there has been strong leadership which in turn has resulted in positive uptake of the outputs. An example of where TA has been clearly led by GoT and supported by a regional network is the development of the reproductive maternal, neonatal and child health (RMNCH) score cards. International and local TA, under a specific short term contract, worked over four weeks to review the indicators from the health management system alongside data availability to develop the scorecard.[20] The development of the scorecards was supported by the Futures Group and USAID who provided three international TA at very short notice in response to the demand complete the work to enable the Sharpened One Plan to be launched.[21]

The African Leaders Malaria Alliance (ALMA) served as a facilitator in developing the scorecard, having the role of keeping the conversation and decisions focused and moving forward.[22] The TA worked with the MoHSW to select the top 15-20 indicators that have the greatest impact on RMNCH in Tanzania and ALMA helped them to translate this into a scorecard that can be updated by MoHSW. The TA supported the "pressure testing" of the indicators to ensure they change frequently enough to show a difference in quarterly or twice-yearly scorecard updates and ensuring that there is enough accurate data. ALMA also trained MoHSW staff to use a web platform to create the scorecard and to upload information. ALMA is able to return to countries to support the updating of the scorecards or to support additional TA around the web platform.

In Tanzania and internationally, this initiative arose following a concern that progress had been slow and the recommendations were made to improve mechanisms for reporting on progress. President Kikwete of Tanzania, as the founding chair of the ALMA, launched the plan and instructed regional commissioners to use the scorecard to monitor the performance of districts.[23]

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workplans. Each prime implementing partner has sub partners, with whom they contract. 75-80% of USAIDs support is for HIV/AIDS, and is mainly off-budget. Although most of their support is off-budget, USAID sets its target with GoT and reports thrgou34h GoT systems.

[20] The scorecards collate data on the delivery of public services and are linked to follow up actions. They are intended to be a management tool for MoHSW to aid accountability through tracking and reporting on intervention implementation and by identifying bottlenecks.

[21] One interviewee commented that the due to the time pressure the duration of the TA was too short.

[22] ALMA is an alliance of 46 African Governments working to combat malaria. It issues quarterly scorecards to track progress on a few MNCH indicators and offers support to cover funding gaps and address bottlenecks.

[23] http://www.afro.who.int/pt/tanzania/press-materials/item/6565-the-united-republic-of-tanzania-launches-the-sharpened-one-plan-and-the-rmnch-score-card-to-prevent-maternal-newborn-and-child-mortality.html
http://www.alma2015.org/media/2012/01/alma-thanks-president-jakaya-mrisho-kikwete-his-service-founding-chair-african-leaders

This is an example of strong and clear government leadership where the TA is responding to a well identified problem within a clear timeframe. Important elements appear to have been the coming together of international agencies within a regional network supported by the pan-African network, ALMA, with a Presidential directive in Tanzania. The Presidential leadership provided a window of opportunity which was successfully supported by leaning on the networks providing technical expertise. The role of ALMA as a facilitator and in providing follow up has been important to the successful implementation and can be expected to ensure that the scorecard continues to be updated and used in the future. Essential to the work was the ability of donors to respond to this demand by providing the necessary TA on time. This was recognised as crucial by those involved.

3.5 Capacity building in MoF

A positive example of where a strong capacity building impact has been achieved is in the Aid Coordination Department of MoF. Due to the availability of two competent and committed government counterparts, a supportive line management relationship and two effective Overseas Development Institute (ODI) Fellows, a close working relationship was fostered that has sustainably enhanced the capacity of the department.[24] The embeddedness of ODI Fellows is an advantage as they have a contract with and directly report to their Tanzanian ministry. The day to day location of the Fellows within the ministry and the technical role of the Fellows enabled responsiveness to Tanzanian authority which was important for being accepted as a member of a team and for developing trust and relationships.

During the final year of the first Fellow's posting the Deputy Commissioner for External Finance responsible for aid coordination established the Aid Coordination Department. She assigned specific roles for staff and ensured an emphasis on developing the capacity of local staff. It was at this point that a national counterpart was identified for the ODI Fellow. During the tenure of the second ODI Fellow the number of staff in the department increased substantially and there were two full time national counterparts with whom the Fellow worked closely and who have remained in their positions. The assignment of specific roles and stability of staffing encouraged enhanced skill transfer and continued professional development. This directly translated into a more effective capacity of the department. This effect has persisted, even four years after the departure of the second ODI Fellow.

3.6 Reflections on the demand and supply of TA

The most common way in which demand and supply interacted was that donors found an area of interest in their strategy which was in line with that of the government. They then approached government with an offer of support. If the government agreed and made some suggestions for how this would be useful the donor drafted the ToR which it then sent to government for comment. Sometimes comments were received, other times there was no response and procurement of the TA was initiated with government sign off. While this involves some interaction of demand and supply, this approach reflects very limited government ownership and limited leadership.

Supporting increasing leadership. An example of where this dialogue did support increased government leadership was found in the water sector. Where there was openness to external

[24] The first Fellow was there from 2000-2003 and the second from 2004-2007.

support, a dialogue about TA resulted in a lengthy process of determining capacity needs. In 2013 delivery pressure associated with the BRN goals led the Ministry of Water (MoW) to request external support from donors for the implementation of the rural water component. An adviser was recruited to help the ministry's leadership to determine where TA would be most effective and it was concluded that the TA could both help with getting the work done and also leave capacity behind. Subsequently the initial recommendation of the TA was for the ministry to fill the vacant posts at the leadership level after which a reassessment was carried out to determine specific areas where technical assistance was required and could add value: whether the TA should be local, international or both; at which level it should be placed i.e. working with the PS, the director or both; and the length of service etc. The ministry then approved the recruitment of local TA for a period of two years, which will be assisted by an intermittent international TA.[25]

This is a positive example of dialogue around TA needs feeding into a capacity development initiative that has clarified roles and responsibilities and increased understanding of management gaps within the department. At the same time linkages have been made with the BRN's Presidential Delivery Unit to ensure consistent support at both national and local levels. This process has however taken place over the period of a year and it has been important that sufficient time for this dialogue has been allowed.

3.7 Reflections on the demand for TA

- The demand for TA is uncoordinated and ad hoc. Although there is agreement amongst donors and government that the government should lead and coordinate TA, this is rarely implemented. In reality donors fill the gap, often directly determining where TA is to be provided or suggesting TA inputs to government. As a result there is a perception amongst donors that all support is accepted, rather than being strategically guided by government, and sometimes not well used. Equally the MoHSW commented that it benefitted from a lot of support despite sometimes being overwhelmed by TA. This created pressure for senior staff as along with managing the TA itself, the TA generated additional tasks. A more selective uptake of offers of support linked to instances where there is both the management capacity and supporting systems is likely to increase the effectiveness of the TA.

- The importance of identifying individual counterparts who are available in order to build capacity and who are supported by enabling systems.[26] The challenge of carrying out sufficient capacity building exists for all TA that is supplied. Often a capacity building role is specified in the ToR whereas in reality due to the firefighting environment within government, the role becomes *de facto* gap filling. Where the TA does not have counterparts with appropriate levels of education and experience with whom s/he can work who are in turn supported by their managers to carry out such a role; or if the role is predominantly gap filling, the impact is limited sustainability. Despite individual counterparts being critical to the success of the TA, they are not always clearly identified. The two counterparts in the MoF example were clearly identified and they had the same role so all three were working to the same objectives. Supporting systems were also in place such as IT

[25] Recruitment of the national TA is currently ongoing under the leadership of the ministry. Recruitment of the international TA will be supported by DFID.

[26] Counterparts here refer to individuals whose role is related in function to that of the TA. Counterparts may also be understood in a broader sense to refer to supporting systems and enabling conditions with the focus being on making the organization function more effectively.

systems, recruitment of additional staff and supportive management. It is more challenging where the TA reports to two counterparts who have different positions and where one is more senior to the other. In order for a capacity building role to be effectively undertaken, there is clarity needed as to who are the primary counterparts.[27]

- Attitudes to TA can change in the face of positive experience. In the context of a general resistance to TA, positive experiences reinforce the view that external inputs can be beneficial, and vice versa for negative experiences. One positive example was cited in the MoW where within an initial contract of 10 days the TA, was able to produce a PowerPoint presentation with accessible and clear content. As this output directly responded to the needs of government, the Permanent Secretary turned it into a memorandum of understanding (MoU). A donor representative also noted that TA has been well received where it has been provided in line with needs, such that senior people who are experts in their field have provided support (e.g. Paul Collier in his support to the BRN energy lab). Indeed, since 2013 with the roll out of the BRN programme there appears to have been an increased interest in TA by some parts of GoT. As well as being encouraged by positive experiences, this may be due to capacity gaps being more clearly evident and delivery pressures increasing, in an overall context of frustration that things are not working as had been hoped.

3.8 Reflections on the supply of TA

- TA is usually supply led. In most cases TA is not clearly demand driven and as a result may not be well used. Some donors formulate their support through a review of GoT strategies and then propose support that, although it is then aligned with the sector plan, has not been demanded by government. The Sino-African agreement from China that includes TA in the package is such an example. Many donors appreciate how some TA allows them increased access to information and in some cases can provide policy leverage or can fulfil a monitoring function.

- Donor procurement substitutes for using national systems. Although the JAST specifies that national procurement systems should be used, government is requesting donors to carry out the procurement, despite financing being available in basket funds. Government appears resistant to using its own systems to procure TA and the explanation for this varied from the Ministry of Water saying that they could not find the right person if government systems are used, to the complex procedures and lengthy time needed from identification to recruitment. It is easier for government, with its limited capacity to rely on donors to procure TA. It is however also likely that donors are needed to purchase expensive TA as GoT could not sign a large contract with high wage rates. The specifics of the procurement challenges were not however well understood by donors, although this had been discussed in the Development Partner Group. There was an agreement made recently in the health sector that donors would plan in advance and use government procurement systems for TA as an experiment to highlight some of the challenges. It is not expected that this will result in any sustained changed practices but it is likely to serve the purpose of highlighting the specific challenges that are involved in using the government's system.

- Early outputs and the style of the TA are important. It was noted by many interviewees that the approach of the individual TA is crucial to their acceptance within government. Providing distinct

[27] An example of the availability of counterparts having a direct impact on engagement with TA is when the MoHSW Permanent Secretary changed. This temporarily reduced the government engagement with Danida's PFM adviser.

input that adds clear value in a humble and collaborative manner are crucial attributes in an environment where external input is often resisted. Where a directive approach is taken by the TA resistance amongst technical staff is common. Some government interviewees felt that the selection process of some TA was not sufficiently in-depth and correspondingly poor quality sometimes results.

4 Lessons learnt for the health sector

The provision and use of TA in Tanzania reflects the wider aid context and the challenges faced mirror those arising more broadly in the donor-government relationship. The analysis above has highlighted instances where TA has worked well and has considered features associated with the way in which it is provided or the supporting environment that are considered important facilitating elements. It also illustrated several shortcomings of external TA that are recognised by donors and government alike, including that it is supply-led, it faces procurement challenges, and that it has uneven results in ensuring sustained increases in capacity. The examples presented here from the MoHSW, MoF and MoW share some common lessons for how TA could be made more effective within the health sector.

4.1 Demand

- Improving government leadership of TA. Many of the features of the way in which TA is provided depend on effective leadership from government. Enhancing senior management capacity to enable stronger directives from senior leadership can have positive effects on increasing the effectiveness of TA. In MoHSW most senior staff have been acting since 2013 which has had an impact on leadership capacity. In terms of performance management, it was recognised by donors that the health sector has a complex structure and subsequently it is hard to clearly see what problems are being presented to be solved. To overcome this, efforts to enhance leadership are needed which in turn could move TA from being supply led to demand led. This could include mentoring or coaching and support from the Uongozi leadership training institute.[28] It also requires an alignment of incentives so it may be that this will develop over the longer term.

- Establishing and enforcing guidelines and sector protocols for strategic TA. This would help TA to be provided in a way that directly supports the development of long term capacity in the health sector, such that it improves the coordination of TA and ensures that TA is provided in a way that is of most use for the MoHSW. The development of the DCF presents an opportunity to formulate government wide guidelines for TA. The challenge remains to ensure that these are implemented and interpreted in line with priorities in the health sector and in order to achieve this there must be parallel reinforcement of leadership capacity. This was a lesson and also a challenge recognised in Uganda and Sierra Leone.

4.2 Supply

- Increase donor coordination of TA in working group discussions. Although there is a highly structured system of working groups and dialogue fora in Tanzania, donor coordination of TA is not strong. The context in Tanzania is one where there is the potential for an oversupply of TA and

[28] http://www.uongozi.or.tz/

occasionally duplication of support and even competition to provide TA has arisen.[29] A change in the approach to supplying TA such that it responds to demand can change the nature of the TA provided, as in the case of MoW. Despite the well structured dialogue framework in the health sector and the TWGs meeting regularly, there is little discussion around the coordination of TA, although this is an ideal forum for information sharing. Usually TA is discussed when a new initiative is started, whereas a more concerted effort to have a stock-take on support has the potential to improve the coordination of TA.

- Establish the comparative advantages of using government or donor procurement systems. The advantage of donors procuring TA is that it can be done more quickly than via government systems where there is an urgent need to produce an output or to fill a specific short term gap. While donor procurement can be quicker, this takes the emphasis off the need to improve the government's planning systems and to streamline national procurement systems such that they are able to function effectively. To ensure that government systems continue to be developed it is generally accepted that efforts should be made to use GoT procurement methods where possible and feasible. The future test of government systems is expected to provide interesting lessons and also to clarify what the incentives for using donors' procurement systems are in specific instances (e.g. is it a government planning constraint or would government be unable to sign off high cost TA).

- Follow a rigorous recruitment process to employ appropriate TA. The approach of the TA determines their effectiveness and their style is an important determinant of how well integrated and accepted, and therefore effective they are able to be. Often TA are recruited on the basis of a CV, however a known candidate or a thorough recruitment process can often yield more effective TA. Government requested that the interview process was thorough to provide an appropriate candidate. This is particularly important in the health sector where it is a challenge to finding good people in the context of a resource shortage.

4.3 The interaction between demand and supply

- Fostering a close relationship between donors and government can help to determine demand. Where there is a clear overlap in interests between donors and government TA is well identified and provided. A close relationship between donors and government can facilitate dialogue around whether there is a gap and the nature of the support needed. This can also allow alertness to any emerging windows of opportunity. The example of the MoW showed how the dialogue actually resulted in the government recruiting for permanent positions as they realised that they needed more staff rather than TA support. The limited capacity in the MoHSW impacts upon both its policy making capacity and directly limits the ability that it has to be able to effectively pinpoint where TA may be needed and the specific role that it should be carrying out. The Danida TA is a good example of how a close relationship has been established and trust built up over time. However, as the TA partnership is long term, a sustainable exit strategy for these positions is less clear and there is a common expectation that these positions will continue. This is a risk that needs to be balanced in a close relationship where trust has been developed.

[29] Many donors have offered TA support to the oil and gas sector and in the health sector there was some competition around the Sharpened Plan where 'UNICEF and WHO are also willing to provide TA and financial support for the costing of the Sharpened Plan.. (consensus required amongst the agencies)' (MNCH TWG 2014).

- Building trust between donors and government allows a dialogue on quality. This was present in the health sector in the mid-2000s and arose from a close working relationship between government and donors. If quality was not good then it was identified and could be addressed. This requires clarity around what are the measures of success.

- Facilitating the development of capacity at the individual level by rigorous recruitment processes for TA, ensuring that individual counterparts are available and that there is a supporting working environment.[30] The *de facto* gap filling function that is carried out by most TA often directly substitutes for staff positions and effectively fulfils a staff position and provides a free (donor funded) substitute for national staff. This may present an opportunity cost in terms of potential capacity enhancement. This limited capacity building role can arise from the TA not having the skills to carry out coaching and mentoring and it may also arise from the absence of absorptive capacity in the recipient organization such that the TA does not have counterparts with whom s/he can work. Often the ToR may include mention of capacity building without there being an understanding of what this means. Subsequently the constraints of the daily working environment persist. Providing counterparts who are able and available to work with TA who have the appropriate style and approach, is one element that contributes to increased skill transfer. The MoF example showed how there was a sustainable impact. In the health sector it was recently agreed that there would be an enhanced focus on capacity building in an attempt to increase national capacity to reduce the routine provision of TA by development partners.[31] This is a welcome initiative however it should be accompanied by recognition of the contextual factors that are required in support (the selection process should routinely involve an interview rather than making the selection based only on Curriculum Vitaes, accepting that it may take longer to get the job done, etc.).

  As was observed in the Uganda and Sierra Leone studies, TA in the health sector in Tanzania sits within the wider donor-government relationship and is impacted by the challenge of increasing the capacity of the public service. The health sector in particular faces a shortage of qualified managerial and technical staff, making recruitment of national capacity challenging. In addition to the lessons identified above, it is suggested that this context is factored into a coordinated donor approach to supporting the government to build this capacity. This may involve reducing expectations of how swiftly the government can respond to donor requests or put in place policy actions, but over the longer term it is hoped that this adjusted approach to TA may facilitate enhanced capacity. Furthermore, formulating a strategic approach to target specific capacity shortfalls would enable the government to increase the sustained impact of TA.

[30] Such as functioning IT systems, a wider team of colleagues who effectively work together, etc.

[31] This was agreed through an exchange of letters between MoHSW and the health DPG. It was not possible to get a copy of the letters.

5 Annexes

5.1 Annexe 1 List of documents consulted

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5.2 Annex 2 List of interviewees

D. Mtasiwa	President's Office – Regional Administration and Local Government
P. Sangawe	President's Office – Planning Commission
N. Magonya	Ministry of Finance
N. Mkwizu	Ministry of Finance
M. Kamuzora	Ministry of Finance
A. Mpangala	Ministry of Finance
D. Kizenga	Ministry of Finance
Kakule	Ministry of Finance
A. Kwakisu	Ministry of Finance
J. Rubona	Ministry of Health
S. Lake	Ministry of Health
R. Chatora	WHO
N. Knudsen	UNDP
S. Sharma	UNICEF
C. Hannon	Embassy of Ireland
G. Kihunrwa	DFID
C. Sokile	DFID
N. Leader	DFID
L. Tayler	DFID
I. Dhillon	Danida
S. Perera	Centers for Disease Control Prevention
O. Praz	Swiss Embassy
S. De	USAID
M. Komba	USAID
J. McLaughlin	World Bank
H. Gray	London School of Economics