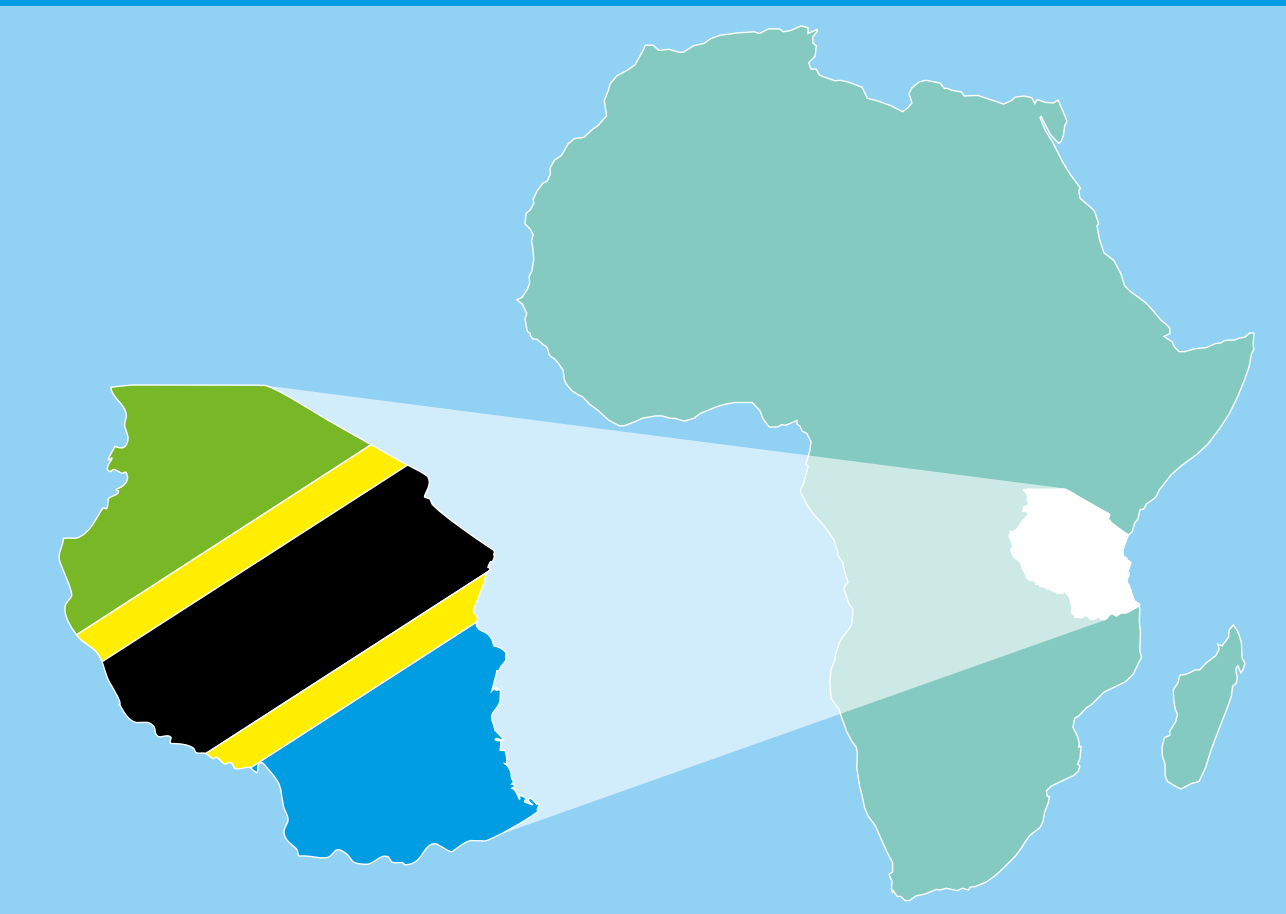
Ministry of Foreign Affairs

IOB Evaluation

Impact of Ending Aid

Tanzania country study



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List of acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AMP	Aid Management Platform
BoT	Bank of Tanzania (Central Bank)
BEST	Business Environment Strengthening Tanzania
BSG	Budget Support Group (of Development Partners)
CBF	Common Basket Fund
CBFSC	Common Basket Fund Steering Committee
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CCHP	Comprehensive Council Health Plan
CCM	Chama Cha Mapinduzi
CDC	Center for Disease Control and Prevention
CDG	Council Development Grant
CIDA	Canadian International Development Agency
CSO	Civil society organisation
Danida	Danish International Development Assistance
DFID	UK Department for International Development
DHS	Demographic & Health Survey
DHP	District Health Profile
DP	Development Partner
DPG	Development Partners Group
EKN	Embassy of the Kingdom of the Netherlands
ESRF	Economic and Social Research Foundation
EU	European Union
FCS	Foundation for Civil Society
FDI	Foreign direct investment
FMO	Dutch Entrepreneurial Development Bank
FP	Family planning
FY	Fiscal year
GBS	General budget support
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GGTTI	Global Go To Think Tank Index
GoT	Government of Tanzania
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
ITN	Insecticide-Treated Nets
IMF	International Monetary Fund
IPTL	Independent Power Tanzania Limited
IOB	Policy and Operations Evaluation Department
JAST	Joint Assistant Strategy for Tanzania
KfW	German Development Bank
LGA	Local government authority
LGDG	Local Government Development Grant

LG-DPG	Local Government Development Partners Group
LGRP	Local Government Reform Programme
MDG	Millennium Development Goal
MDRI	Multilateral Debt Relief Initiative
MESI	Monitoring and Evaluation Strengthening Initiative
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MKUZA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Zanzibar
MoF	Ministry of Finance
MoHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
ODA	Official Development Assistance
PAF	Performance Assessment Framework (for GBS)
PATA	Public Accountability Tanzania Initiative
PCCB	Prevention and Combatting Corruption Bureau
PEFA	Public Expenditure and Financial Accountability
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PER	Public Expenditure Review
PETS	Public Expenditure Tracking Survey
PFM	Public Finance Management
PHDR	Poverty and Human Development Report
PMO-RALG	Prime Minister's Office - Regional Administration and Local Government
PRBS	Poverty Reduction Budget support
PRSP	Poverty Reduction Strategy Paper
PSI	Private Sector Investment Programme (Dutch programme)
PSI	Population Services International
REPOA	Research on Poverty Alleviation
RMNCH	Reproductive, maternal, newborn and child health
RVO	Netherlands Enterprise Agency
SBS	Sector Budget Support
SDC	Swiss Development Cooperation
Sida	Swedish International Development Agency
SNV	Dutch not-for-profit development organisation
SRHR	Sexual and reproductive health and rights
TAS	Tanzania Assistance Strategy
TK	House of Representatives in the Netherlands
TZS	Tanzanian Shilling
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UK	United Kingdom
VNG	Association of Netherlands Municipalities
VVF	Vesicovaginal fistula
WHO	World Health Organization
WSDP	Water and Sanitation Development Programme

1

Introduction

In 2010, the government of the Netherlands decided to reduce the number of partner countries from 33 to 15. An argument was the conviction that decreasing fragmentation and specialisation would enhance the efficiency and effectiveness of Dutch bilateral aid. It would give the Netherlands a better position for gaining more in-depth knowledge of the political, economic, social and cultural structures in the (remaining) countries and would help to reduce the costs of operational management. The government also curtailed support to the social sectors (education and health), focusing more on the economic sectors, as it believed that the value added of the Netherlands in the latter would be higher. Both policy changes were also instrumental for realising budget cuts, as the government had decided to lower Dutch ODA from 0.8% to 0.7% of the GDP. Budget cuts also hit the Netherlands Ministry of Foreign Affairs, forcing it to cut down Dutch presence abroad. The embassies in five countries where the Netherlands had decided to phase out bilateral development cooperation were closed as well.

Tanzania is one of the countries where the Netherlands has ended its delegated bilateral aid relationship, after providing support for more than 50 years. One of the justifications for the choice was the presence of a large number of other donors in the country. The Netherlands intended to intensify trade and investment relationships with Tanzania, and the country remained eligible for the central programmes for private sector development. Nevertheless, for many observers the decision came as a surprise. Tanzania was not only one of the main recipients of Dutch aid, but the Netherlands was also a relatively large bilateral donor in the country.

The House of Representatives in the Netherlands has requested an evaluation of the impact of the budget cuts in bilateral aid on recipient countries. The Policy and Operations Evaluation Department (IOB) of the Netherlands Ministry of Foreign affairs has conducted this evaluation. IOB assessed the impact:

- at the macro level, focusing on the Dutch decision to phase out and the effect on total aid and the policy dialogue;
- at the micro level, concentrating on specific programmes and projects that were previously supported by the Netherlands.

IOB conducted six country case studies: Nicaragua, Guatemala, Bolivia, Zambia, Burkina Faso and Tanzania. The evaluation department selected these countries on the basis of income level and the relative importance of Dutch development assistance for the country. In each of the six country studies, the evaluation analyses the impact on key sectors that received Dutch support.

This report presents the results for the Tanzania case study, especially the impact of ending general budget support and exiting from the health and local government sectors. The report is based on the analysis of information obtained through interviews with various stakeholders, the review of documentation and existing evaluation reports, and the analysis of financial and other statistical information (part of which was provided by ministries and beneficiary organisations in Tanzania). Chapter 2 presents the country context. Chapter 3 discusses the phasing out process. Chapter 4 describes the macro-impact of the Dutch exit, including budget support. Chapters 5 and 6 discuss the impact on the local government and health sectors. Chapter 7 concludes.

2

Country context

2.1 Introduction

This chapter outlines Tanzania's recent political and socio-economic development in order to contextualise the Dutch decision. The chapter signals economic progress and the declining role of development cooperation. Nevertheless, the country still faces important challenges that justify prolonged donor support.

2.2 Political development

Tanzania is a politically stable country in a region that has faced many conflicts. Since its independence, the country has been governed by the same party, even after the introduction of a multiparty system in 1992. The ruling Chama Cha Mapinduzi (CCM) has won the presidential as well as the parliamentary elections with a vast majority. The first president, Julius Nyerere, followed a socio-economic programme based on self-reliance, state control of key industries, and financial and commercial institutions, and collectivisation of agriculture. These policies were economically ineffective, but Nyerere succeeded in creating political stability and preventing the rise of ethnic and tribal conflict that had been plaguing neighbouring countries (Collier, 2009; Mwase and Ndulu, 2010).

Since Nyerere's resignation in 1985, Tanzania has gradually followed a more liberal political and economic course. The government abolished price controls, made the Central Bank independent, removed foreign exchange controls and introduced a multiparty system in 1992 (Ngowi, 2009; Cooksey and Kelsall, 2011; Tripp, 2012; ADE et al., 2013; Gray, 2015). The power of the ruling CCM decreased as result of the process of democratisation and stronger opposition, but also because of disappointment in the government (Peter, 2014; Gray, 2015). In October 2015, CCM candidate John Magufuli succeeded Jakaya Kikwete, who had been president since 2005.

2.3 Socio-economic development

Aided by the growth of the world economy, donor support and a macro-economic policy, Tanzania has enjoyed prosperous economic development since the second half of the 1990s (Utz, 2008; Nord et al., 2009). In 2006 the World Bank identified Tanzania as one of the ten best reformers (Nord et al., 2009). The government improved the tax system, which increased domestic revenue from less than 9% in 2000 to 15% in 2008 (Nord et al., 2009). Public Finance Management (PFM) improved, making Tanzania one of the sub-Saharan countries with the highest Public Expenditure and Financial Accountability (PEFA) scores (Nord et al., 2009). Inflation fell from 27% in 1995 to 4% by 2004, and annual economic growth increased from 4% in the early 1990s to 7% from the end of the millennium onwards. Mining, construction, telecommunications, the services sector and government expenditure were the main drivers of economic growth. Foreign Direct Investment (FDI) increased to 4% of GDP in 2009 and Tanzania has become the main recipient of FDI in the region, with a total of USD 2.1 billion in 2014 (UNCTAD, 2015).

Table 2.1 Macro-economic indicators								
	2008	2009	2010	2011	2012	2013	2014	2015
GDP nominal (USD billion)	27.4	28.6	31.4	33.9	39.1	44.3	48.0	44.9
Real GDP growth (%)	5.6	5.4	6.4	7.9	5.1	7.3	7.0	7.0
Inflation (%)	10.3	12.1	6.2	12.7	16.0	7.9	6.1	5.6
Population (million)	42.8	44.2	45.6	47.1	48.6	50.2	51.8	53.5
GDP per capita (USD)	658	665	709	740	828	909	955	865
% of GDP:								
Exports	18.6	17.4	18.7	20.8	21.3	17.7	19.5	20.8
Imports	-30.8	-26.3	-29.1	-36.0	-33.1	-31.1	-29.9	-28.7
Trade balance	-12.1	-8.9	-10.4	-15.3	-11.8	-13.4	-10.4	-8.0
Current account balance	-9.4	-6.3	-7.0	-12.9	-9.6	-11.3	-10.4	-7.4
FDI	5.1	3.3	5.8	3.6	4.6	4.7	4.3	4.4

Source: IMF.

In the first decade of the new millennium, much of the economic growth was related to a rise in government expenditure, especially as a result of public service extensions in education, health care, water and sanitation and infrastructure (Utz, 2008; Mkenda et al., 2010; World Bank, 2010). Spending quadrupled in these sectors. Since 2010, the rate of expansion of government expenditure declined, due to disappointing revenue and declining aid flows (World Bank, 2015b). The government reduced investments in infrastructure and social services. In addition, the government borrowed to compensate for the shortfall in domestic revenue and aid, which helped to increase public debt (World Bank, 2015b).[1]

Since the growth of government expenditure slowed down, the private sector has become the main engine for economic growth, mainly through the growth of consumption, but also by increases in investment (World Bank, 2015b). The main growth sectors have become construction, communication, finance and transport. These sectors are benefiting from increased urbanisation and higher living standards (World Bank, 2015b).[2]

Despite the annual economic growth, income poverty hardly decreased initially. One of the reasons is that the majority of the working population is active in agriculture, a sector with lower annual growth rates (4%-5%). The effects of growth per capita were also limited due to high population growth. Investments in the social sectors, however, did help to reduce other kinds of deprivation and generate improvements in a number of the MDG targets. Recent data are also more encouraging, with a poverty rate of 28% in 2012. This is the first significant decline in 20 years. The depth and severity of poverty declined even more strongly, by respectively 35% and 48% (World Bank 2015c). Inequality decreased as well, and

[1] The debt service has increased from six percent in 2009 to 14 percent in 2014.

[2] Initially, the growth in exports was mainly due to an increase in gold exports. Between 2013 and 2014 the composition changed however, with a declining value of minerals (gold) and agricultural commodities and an increase in manufacturing and other exports (World Bank, 2015b).

is far below the sub-Saharan average (45%). Nevertheless, inequality is increasing between urban (especially Dar es Salaam) and rural areas because of expanding employment opportunities and increasing returns in the former (World Bank 2015c).[3] Poverty remains pervasive in rural areas. Moreover, a large part of the population has an income close to the poverty line. External shocks could cause large groups to regress.

Table 2.2 Socio-economic indicators (percentages)

	2000-2001	2007	2011-2012	2014-2015
Poverty (headcount) national poverty line:				
Rural	39	39	33	
Urban (not including Dar es Salaam)	26	23	22	
Dar es Salaam	18	14	4	
Total	36	34	28	
Poverty (headcount) International poverty line (World Bank):				
Extreme poverty (USD 1.90)	84	53	47	
Moderate poverty (USD 3.10)	95	78	76	
Human Development Index (HDI)	0.37	0.44	0.51	0.52
Inequality (Gini coefficient)	37	40	38	
Employment (2006-2014):				
Employment to population ratio (15+)	84	86	79	
Employment in agriculture (% of total)	82	69	68	67
Informal employment (% of non-agricultural employment)		76		
Education:				
Literacy rates (WDI)	69		79	
Net enrolment primary education (WDI)	58	95	82	
Net enrolment lower secondary education	5	15	29	
*School attendance primary education:**				
Urban	71	85	88	
Rural	49	70	78	
Total	54	73	80	
*School attendance secondary education:**				
Urban		19	43	
Rural		3	19	
Total		7	25	

** Data for respectively 1999, 2004-2005 and 2010 (Source: DHS).*
Source: National Bureau of Statistics, WDI (WB), UNDP, and DHS.

[3] The depth of poverty (or poverty gap) is measured by the distance between the income of the poor and the poverty line; the severity of poverty is measured by the squared poverty gap.

2.4 The changing aid relationship

Historically, the government's relationship with development partners has had its ups and downs. In 2000, the Poverty Reduction Strategy Paper (PRSP) paved the way for debt relief under the HIPC and MDRI initiatives. The Tanzania Assistance Strategy (TAS) of 2002 provided the framework for further donor coordination, harmonisation and alignment. Two years later, donors established the Development Partners Group (DPG) in order to enhance coordination, harmonisation and alignment. Alignment became more effective in 2005 when most development partners adhered to the MKUKUTA, Tanzania's second PRSP. It was the basis for the GBS Partnership Framework Memorandum, signed by the government and 14 donors in 2006. That year, the Joint Assistance Strategy (JAST) was launched as a successor to the TAS.

From 2008 onwards, cracks began to emerge in the relationship with development partners. Several major corruption scandals, which were revealed in late 2007, played an important part in this.[4] The Netherlands, and other donors, suspended general budget support, but resumed payment in 2008 because the president had acted vigorously. Nevertheless, development partners became more critical of corruption, partly because of a changing political climate in their own countries, but also because they felt that the Kikwete administration was not doing enough to fight corruption. Fiduciary risk took on an increasingly important role in the policy dialogue. The sluggish pace of reform also caused several donors to question the government's commitment to poverty reduction. Increasingly, targets were being missed. In May 2010, donors announced cutbacks of USD 200 million in budget support for the years 2010-2011. In 2014 they suspended budget support because of a major corruption scandal in the energy sector. After the government took steps to resolve the crisis, which led to the resignation of two ministers and the attorney general, donors decided to resume budget support in March 2015.

As a result of the economic growth, ODA went down as a percentage of GDP from more than 10% in 2009 to 7.2% in 2014. In 2013 there was an increase in loans from the IMF, the World Bank and the African Development Bank (see Annex I), but in 2014 the ODA to GDP ratio fell to 5.6%, caused by a reduction of bilateral grants as well as multilateral loans. The value of aid relative to private capital inflows (FDI and public non-concessional borrowing) has also continued to decline (World Bank, 2015a). The discovery of gas reserves has increased foreign interest in the country and several donors, including the United States and the Netherlands, are shifting the focus of their relationship with Tanzania from aid to trade and investment.

[4] The first scandal involved fraud with an account for foreign funds at the Bank of Tanzania; the second case of corruption concerned a contract for an oil pipeline and the supply of emergency power plants (the Richmond affair).

Table 2.3 ODA as % of GDP							
	2008	2009	2010	2011	2012	2013	2014
Grants	6.5	5.9	6.4	5.8	5.2	5.5	3.6
Loans	1.9	4.2	2.9	1.5	2.0	2.7	2.1
Total	**8.4**	**10.1**	**9.4**	**7.3**	**7.2**	**8.2**	**5.6**

Source: Calculated from OECD/DAC (CRS) and World Bank (WDI) data.

In addition, the role and composition of aid is changing. First of all, the share of budget support and basket funds is going down in favour of projects. This development is in line with a more general tendency of donors to reduce programme aid and to return to project support. Second, the share of grants as a percentage of government expenditure is decreasing, with a high figure of 21% in fiscal year (FY) 2007-2008 and a low figure of 8% in 2014-2015. In combination with disappointing tax revenue, changes in the composition of aid have helped to increase the budget deficit and have forced the Tanzanian government to reduce expenditures, including poverty related expenditures.

Table 2.4 Government revenue and expenditure (FY 2007-2008 — 2014-2015)								
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
USD million:								
Budget support	805	713	841	564	615	548	628	502
Basket funds	248	280	311	348	301	283	246	165
Projects funds to government	731	529	655	613	570	325	441	436
Debt relief (HIPC and MDRI)	91	52	29	123	141	135	132	
Total	**1,876**	**1,574**	**1,835**	**1,648**	**1,626**	**1,292**	**1,448**	**1,103**
As % of government expenditure:								
Domestic revenue	69	64	57	61	67	66	73	75
Grants	21	17	17	17	17	11	13	8
Deficit after grants	10	19	26	22	16	23	14	17

Source: Ministry of Finance, BoT and IMF; authors' calculations

2.5 Challenges

A main challenge in the coming years and decades will be to find employment for Tanzania's fast-growing population. The country's population is young, with over 50% of the population under the age of 18. The high population growth may have a further negative impact on poverty reduction and undermine the effectiveness of pro-poor policies. Related to this is the question of how Tanzania can achieve inclusive growth, so that poor rural areas and vulnerable groups can benefit at least as much from economic progress as the urban upper and middle class. In spite of the high economic growth, the demand for labour is not able to keep pace with population growth. Indicators are the decreasing employment to (working) population ratio and the rapidly increasing informal employment. Employment in agriculture is also decreasing. National infrastructure is a key constraint for the further development of the private sector. Large investments are needed in roads, ports, electricity and telecommunications (ADE et al., 2013).

A main challenge for the government is to increase domestic revenue. The current level of tax revenue is one of the lowest in the world (World Bank, 2015b). One third of income tax revenue comes from less than 2% of Tanzania's workers, mainly in Dar es Salaam. The large majority of businesses evade paying taxes (World Bank, 2015b). Declining aid makes tax reforms more pressing. Lower than anticipated aid inflows and levels of revenue (around 90% of the anticipated revenue) as well as the accumulation of arrears with contractors and pension funds are challenging Tanzania's fiscal stability and may negatively impact infrastructure investment and social expenditure (World Bank, 2015b; IMF, 2016).

3

The process of phasing out

3.1 Introduction

This chapter describes the Dutch delegated bilateral aid relationship with Tanzania before the exit and analyses the process of phasing out. The chapter concludes that the quick exit was at odds with the long and intensive bilateral development relationship. Due to the short time interval, Dutch stakeholders paid insufficient attention to the interests of the former partner(s). The exit was not based on an assessment of its consequences and no measures were taken to prevent the loss of capital.

3.2 Background: The Dutch role before phasing out

Tanzania and the Netherlands have had a very long aid relationship. The former became one of the 13 'concentration countries' in the second half of the 1960s, when Dutch bilateral development cooperation was starting to evolve. By the end of the 1990s, when the sector-wide approach became an important instrument in the international aid architecture, the Netherlands supported health, decentralisation and local government, private sector development, and, until 2008, education. From 2000 onwards, the Netherlands belonged to the first donors that provided Poverty Reduction Budget Support (PRBS, see chapter 4). As one of the main advocators of the modality, the embassy used it to encourage donor harmonisation and alignment as well as to discuss governance issues, corruption and the business climate with the government. Between 2000 and 2008, the Netherlands granted USD 530 million as budget support and sector support. It became the third bilateral donor in the country after the United Kingdom and the United States with a total amount in 2007 of USD 128 million.[5]

Key elements of the *Multi-Annual Strategic Plan* for 2008-2012 of the Embassy of the Kingdom of the Netherlands (EKN) were improving service delivery, local government reform and promoting the business climate. In order to achieve objectives in these areas, the embassy provided *general budget support* and contributed to programmes for decentralisation and local government, health, and private sector development. The Netherlands supported the health sector through its contribution to the health basket fund, as well as sexual and reproductive health and rights (SRHR) and HIV and AIDS activities. The embassy was the largest contributor to the *Local Government Development Grants* (LGDGs) and a co-lead for the decentralisation process (until 2011). Dutch involvement in the water sector was through a long-term commitment (with a maximum of USD 70 million) to the Water and Sanitation Development Program (WSDP) through a silent partnership with KfW. Part of the Dutch support to the water sector was funded through the LGCDG system. In addition, the Netherlands supported several NGOs, such as the Foundation for Civil Society (FCS, see chapter 5 as well).

5 Not including USD 640 million debt relief by Japan in 2007.

The Netherlands' interest in private sector development was related to the relatively strong position of the Dutch business community and its role as one of the largest foreign investors in the country. The financial involvement of the embassy in private sector development was modest, but the Netherlands contributed to private sector development through the Dutch Entrepreneurial Development Bank FMO, the Netherlands Enterprise Agency (RVO) and the Private Sector Investment Programme (PSI), especially for energy and infrastructure projects.[6] The embassy participated with the government in the policy dialogue on the business and investment climate. The activities focused on access to financial services, representative and lobbying capacities among employers and trade organisations in general, and on the horticultural sector. The embassy supported the advocacy component of the Business Environment Strengthening Tanzania (BEST) programme. The Netherlands has ended bilateral development cooperation, but continues to provide aid through the Dutch Entrepreneurial Development Bank FMO and the Netherlands Enterprise Agency (RVO), especially for projects in health, energy and infrastructure. This support is not included in table 3.1.

Table 3.1 Dutch bilateral aid to Tanzania (2008-2014; USD million)

	2008	2009	2010	2011	2012	2013	2014
General budget support	43.7						
Health	27.5	25.2	27.0	32.3	21.1	7.3	0.5
Decentralisation and local government*	27.0	25.9	23.1	23.0	7.3	2.0	
Water and sanitation			7.9	10.4			
PSD and business climate	2.6	0.7	0.9	0.8	1.1	0.7	0.1
Other	2.5	0.7	0.4	0.3	0.2	0.2	
Total**	**102.8**	**52.6**	**59.2**	**66.8**	**29.8**	**10.1**	**0.6**

** Including REPOA.*
*** Figures may not sum to totals due to rounding.*
Source: Netherlands Ministry of Foreign Affairs.

3.3 The exit process

Around 2008, the aid relationship with Tanzania came under pressure because of Dutch worries about the business climate. The immediate cause was a conflict over the interests of a Dutch investor in Tanzania, whose legal rights had not been respected. In 2009, the Netherlands suspended general budget support disbursements. One year later, in December 2010, just as bilateral relations were about to normalise, the Netherlands decided to discontinue – or rather not renew – its contribution to general budget support. This decision was the result of a change in Dutch policy on the provision of the modality and

[6] This support is not included in table 3.1. Moreover, project support from Dutch NGOs, about USD EUR 60 million for the years 2011-2015, is not included in the table either.

was not related to developments in Tanzania (IOB, 2012). It was part of the new Dutch government's policy. The new cabinet drastically cut development cooperation, and budget support was immediately targeted as easy pickings (IOB, 2012). The fact that the Netherlands decided to act single-handedly again, at exactly the time when donors were about to make a joint decision on the continuation of budget support to Tanzania, was not understood by the GoT and other development partners (IOB, 2012).

Almost at the same time, the Netherlands also decided to discontinue bilateral development cooperation with 18 of its 33 partner countries, Tanzania being one of the exit countries. The selection was based on seven criteria:

- the prospects of achieving development objectives, also as a result of the perceived Dutch value added;
- income and poverty levels in the partner countries concerned;
- a 'quick scan', showing in which countries the Netherlands would have something to offer on the prioritised themes;
- Dutch interests;
- The financial scope of the existing aid programme and possibilities of reducing it;
- the quality of governance, including democratisation, respect for human rights and combating corruption in the partner countries concerned;
- the potential to help reduce the number of missions abroad.

The selection was not, and could not be, a mathematical exercise. Political arguments played a role and several criteria had the potential to conflict in practice. For instance, the Netherlands intended to continue providing support to fragile countries, but almost by definition the quality of governance is these countries is low. Tanzania was considered a donor darling because the country had a broad base for its own development. The ministry argued that it should be possible to find other donors who would be willing to take over the Dutch programmes.

In order to ensure a smooth and sound process of phasing out, the embassies in question were asked to develop an exit strategy, including a timetable and an assessment of the possibilities for ending or handing over Dutch funding of development cooperation programmes and projects to other partners. The exit strategy should adhere to the recommendations of the joint exit evaluation of 2008 (Slob and Jerve, 2008) and the Dutch reaction on this evaluation (TK, 2008-2009, 31 250, no. 56). Specifically, the recommendations demanded:

1. timely communication at a political level with the countries in question;
2. involvement of stakeholders in the process;
3. development of a realistic timetable with input from the countries in question;
4. flexibility in the allocation of budgets;
5. respecting existing obligations and political commitments;
6. to take into account the existing institutional capacity of recipient countries, in order to prevent the loss of capital and to ensure the sustainability of results.

The embassy incorporated the exit strategy in its *Multi-Annual Strategic Plan* for 2012-2015. While this seemed an efficient approach, it had a negative impact on the use of the document as an instrument in the discussion with the GoT and other development partners. There was a strong focus on the internal process. The document did not include a strategy for phasing out, for discussing the exit process with stakeholders, but only provided a financial timetable, a rough assessment of the impact with the conclusion that the challenges would be discussed with GoT and other donors. The embassy did not receive support from headquarters either.

Timely communication

Generally, the ministries and organisations in question were positive about the clarity and timeliness of communications regarding the Dutch decision to end bilateral cooperation. In March 2011 the Ambassador in Tanzania informed the Ministers of Foreign Affairs and of Finance and Economic Cooperation in personal meetings about the Dutch intention to end bilateral development cooperation with Tanzania. The arguments used to discontinue bilateral aid to Tanzania were the large number of bilateral and multilateral donors as well as the reduced importance of ODA for development expenditure in the country. When these two ministers were notified, the embassy started to inform other (sector) ministries, other development partners and other stakeholders. After the first round of communication there was a period of limited consultation, as the embassy waited for the parameters (such as financial and time limits) of the Dutch exit.

A *note verbale*, drafted by the ministry in March 2011, explained that the main aim of reducing the number of partner countries was to enhance the effectiveness of Dutch development cooperation. It added that the Netherlands would phase out its development partnership with the country carefully. The ministry would honour existing obligations and authorities would be fully involved in the phasing-out process.

Nevertheless, the decision came as a surprise for the Tanzanian government ('it was a shock'), as well as for other development partners. In the health sector, for instance, the Netherlands announced it exit when it was lead donor. It was felt that the Dutch decision to phase out was related to the 'Tembo' case, the discussion about the legal rights of a Dutch investor in Tanzania. Some observers felt that there was a pattern behind the Dutch discussion: the decision in 2009 to suspend budget support, the increased critique on decentralisation and the business climate in Tanzania, the decision to end budget support by the end of 2010, just before donors would assess progress by the government in several areas, and the decision to phase out in 2011. Moreover, not everybody understood how the Netherlands could end a long-standing relationship with an extremely poor country and yet continue to provide aid to countries with a higher income level (such as Kenya and Ghana). The GoT also feared a snowball effect.

The health sector plan was heavily underfunded and the Dutch exit would leave a financial gap as the Netherlands was one of the main bilateral contributors to the health basket. In addition, the withdrawal of Dutch expertise in the sector would be a great loss, as was recognised by the Ministry of Health and all donors active in the sector.

Realistic timetable

The timetable called for an exit by the summer of 2013, with another 18 months to wind down administrative issues. Delays soon made it clear that this timetable was not realistic. The ministry had envisaged a quick phasing out – within two years – and the embassy had to adapt the timetable, moving things forward from the summer 2013 to the summer 2014. The embassy received initial instructions to draw up an exit strategy in May 2011 and the financial details in July 2011. However, it took a long time before the ministry in The Hague approved the strategy (by late 2011). This made it more difficult to discuss the exit in a timely manner with the GoT and other stakeholders. The exit strategy also hardly mentioned (the results of) the consultations with stakeholders. A planned study on Dutch development cooperation in Tanzania over the past ten years was cancelled.

Flexibility

The Netherlands did not have a clear exit strategy, although the embassy showed some flexibility and tried to soften the blow for recipients. For the health sector, the exit strategy aimed to respect ongoing commitments until the summer of 2013. In addition, the Netherlands supported several one-year initiatives to (partly) compensate for the reduction in Dutch ODA funding to Tanzania due to the decision not to provide GBS. These initiatives included additional support to Population Services International (PSI) and a contribution to a Maternity & Child Hospital of Baobab Maternity Hospital in Dar es Salaam (managed by CCBRT). Nevertheless, the Ministry of Health asked the Netherlands to take more time for the exit, but the embassy and the ministry in The Hague did not want to extend the process. Supported NGOs did not have enough time to adapt (given the Dutch time frame). Overall, efforts to find new partners for the supported NGOs were not successful.

Involving stakeholders in the process

The exit strategy mentioned the risks of an untimely unilateral withdrawal of the Netherlands from the local government sector, which would endanger the achievements in the decentralisation process, but did not include a strategy to eliminate or reduce these risks. The embassy would only 'strive to ensure' that achieved results would be consolidated. In practice, the Netherlands ended its bilateral aid programme at a moment when other donors were also reducing their contributions. This contributed to the budget deficit of the GoT. The desire for a quick exit and the delays in communication meant that it was almost impossible to incorporate the Dutch exit into the GoT's medium-term planning. The government of Tanzania had just started preparations for the fiscal year 2012-2013 when the embassy wanted to discuss the Dutch process of phasing out. Therefore, in practice the exit process was extremely short.

The exit strategy aimed to ensure that the Dutch government's financial obligations were effectively transferred to the Tanzanian government and other donors. However, there was no strategy for handing over activities to other stakeholders. In practice, though, it was barely possible to interest other donors in the Dutch activities. Each donor had its own programme and priorities, though sometimes the Dutch exit coincided with another donor's budget increase. More often than not, however, the Dutch exit coincided with

another donor's exit or budget reduction. One of the donors (KfW) felt that the Netherlands should have informed it earlier.[7]

Respecting existing obligations

In principle, the exit strategy respected existing obligations. The early phasing out of silent partnerships in the water and gender sectors allowed the EKN to respect commitments in local governance and private sector development, while making a limited number of additional commitments in the health-care sector and for some NGOs. However, much less attention was devoted to the impact of the withdrawal of one of the larger bilateral donors that had been operating in the country for more than 50 years. While the exit strategy outlined the challenges that would arise in several sectors, there was no strategy for reducing the commensurate risks. Commitments to NGOs were not always respected.

Political impact

The exit also had important consequences for the embassy in its relations with the government and other development partners. Now, the embassy assists Dutch companies and continues to contribute to development in Tanzania through investments, business support and capacity building programs and centrally funded development programs. However, the exit isolated the embassy in the sense that it was no longer part of the policy dialogue on development cooperation. This reduced its possibilities to improve the business climate and strengthen the trade relationship by direct dialogue and cooperation with the government. Some felt that this also limited options for the embassy to promote Dutch business interests. The embassy continuously tried to convince the GoT and other development partners that the Netherlands still provided the country with substantial support, through FMO, RVO, Dutch NGOs and several Dutch funds, but the truth of the matter was that it had switched from being a highly engaged donor to a much less visible partner.

One influential policymaker questioned the logic of the Dutch exit, with an evaluation afterwards, suggesting that one would expect the decision to phase out, as well as the exit strategy, to be based on a thorough evaluation. Instead, the Netherlands opted for a quick exit and started to evaluate the process when the damage was already done. Also, some policymakers would have expected a more participatory approach on how the process of phasing out should be implemented while taking into account the interests of all involved partners. The time frame was too short to find alternatives, either in terms of interesting other donors or finding other resources within the government budget.

7 Due to the Dutch withdrawal, PSI Tanzania had to prioritise the use of Dutch funds, thereby forcing KfW to finds ways of postponing its contribution.

3.4 Conclusion

The joint exit evaluation of 2008 specified a number of recommendations for donors who intended to end their aid relationship in a specific country. Dutch policy wanted to observe these recommendations. However, the fact that the decision was taken before consultations had started, and the fact that a quick exit was desired, undermined the possibility of complying with the spirit of the recommendations. Although most existing obligations could be respected in letter and there was some budget flexibility, the strategy did not sufficiently take into account the interests and institutional capacity of the recipients (government and NGOs). The idea that other stakeholders would take over Dutch programmes was too optimistic, especially because the EKN could not provide anything in return. The EKN's position was weakened because it had to negotiate with other stakeholders when decisions had already been taken and the embassy had nothing to offer. The exit was not based on an assessment of its consequences. Therefore, there the prevention of the loss of capital was not assured.

4

Budget support and the macro-impact of phasing out

4.1 Introduction

Tanzania has been receiving general budget support (GBS) since 2000 from various development partners (DPs) to support the implementation of its economic growth and poverty reduction strategy. The Netherlands has been one of the main advocators of the instrument from the outset, as it was felt that GBS would contribute to more harmonised, aligned and efficient development cooperation, strengthen ownership and therefore enhance aid effectiveness. As it turned out, the Netherlands was not only a frontrunner in the provision of GBS, but also in ending the use of the modality. This chapter analyses the development of GBS in Tanzania, the Dutch contribution and the impact of Dutch withdrawal. The chapter concludes that while the macro-economic impact of the Dutch exit is limited, the impact on service delivery and access to public social services is significant.

4.2 GBS in Tanzania

Tanzania has been one of the major recipients of general budget support, not only in absolute but also in relative terms. The modality was good for almost USD 800 million in 2009-2010, which at that point accounted for about 42% of total bilateral aid. The instrument was introduced in the late 1990s and the beginning of the new millennium, when the development of a poverty reduction strategy paper (PRSP) was part of the conditions for debt relief under the HIPC and MDRI initiatives. In 2002 the Government of Tanzania (GoT) and the DPs (including the Netherlands) signed a GBS Framework Memorandum aimed at providing Poverty Reduction Budget Support (PRBS) and harmonising the budget support agreements and approaches of the various development partners and establishing a common approach regarding performance monitoring and disbursement schedules. The Framework Memorandum was renewed in 2006 (signed by 14 DPs) and in 2011 (signed by 12 DPs). The provision of budget support was embedded in an extensive policy dialogue that focuses on key issues, such as adherence to the underlying principles and a number of progress indicators.

Disbursements reached a peak in 2009-2010 with a total of USD 835 million, mainly due to a substantial contribution of USD 327 million (loans) by the World Bank. In the years thereafter (FY 2010-2011 and 2013-2014) they were dramatically lower than in preceding years, particularly because of the Dutch suspension in 2009, the Swiss exit in 2010 and reductions by DFID, the World Bank, Finland, Germany and Norway. Relations between the GoT and development partners had become tenser. The policy dialogue was not functioning effectively (ADE et al., 2013). In 2010 development partners decided to reduce the provision of GBS because of slow progress in improving (i) public finance management, (ii) the investment climate and (iii) the allocation of budgetary resources (IOB, 2012).

In mid-2014, the GoT and the GBS donors started a discussion about the 'future of budget support in Tanzania'. The initiative was instigated by the recommendations of the Joint Evaluation of GBS carried out in 2013 (ADE et al., 2013). However, in the second half of the year, discussions about that paper were subsequently severely hampered by accusations of fraud with an escrow account of Independent Power Tanzania Limited (IPTL), in which government officials were said to be involved. Most donors suspended their PRBS disbursements for FY 2014-2015 because they were concerned about how the GoT would handle the case. The issue was being investigated by the controller and auditor general and the Prevention and Combatting Corruption Bureau (PCCB). After the government took measures to resolve the issue, which led to the resignation of two ministers and the attorney general, donors decided to resume budget support in March 2015. By then, Norway had made its last GBS disbursement. In addition, the United Kingdom had announced that from FU 2015/2016 onwards, it would no longer provide GBS, but would support education and other sectors (Operational Plan 2011-2016, DFID Tanzania, Update December 2014). For the FY 2015/16 eight development partners pledged to provide GBS: AfDB, Canada, Denmark, EU, Finland, Ireland, Sweden and the World Bank. As a result of these developments, and the substantial increase of GoT's tax revenues, the relative importance of GBS for financing the GoT budget declined substantially from 18.5% of total government expenditures in 2007-2008 to 5.9% in 2013-2014 (see table 4.1).

Table 4.1 Disbursements of general budget support FY 2007-2008 — 2014-2015 (in USD million)

	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015*
Bilateral donors (incl. EU)	516	435	412	414	352	289	286	206
Multilateral (AFDB and WB)	284	233	383	118	138	128	201	178
Total GBS**	**801**	**668**	**795**	**532**	**490**	**417**	**487**	**383**
Total government expenditure	4,335	5,264	5,712	5,913	6,842	8,299	8,318	8,279
GBS as % of government expenditure	18.5%	12.7%	13.9%	8.4%	7.2%	5.0%	5.9%	4.6%

** Planned disbursements*

*** Figures may not sum to totals due to rounding.*

Sources of GBS data: Figures from FY 2008-2009 and FY 2011-2012 from Joint Evaluation of Budget Support to Tanzania, p.3 (2013). Figures from FY 2012-2013, FY 2013-2014, and FY 2014-2015 provided by the Ministry of Finance and Planning.

Source of total government expenditures: IMF reviews.

4.3 GBS provided by the Netherlands

The Netherlands was one of the first donors to provide Tanzania with *Poverty Reduction Budget Support* (PRBS). The embassy used it to stimulate donor harmonisation and alignment, and to discuss governance issues, corruption and the business climate with the government. Between 2000 and 2008, the Netherlands provided USD 246 million through this modality. The last Financing Agreement covered the Tanzanian FY 2006-2007 and 2009-2010. In the years 2006-2008 an amount of USD 40 million had been disbursed annually. One of the main advocates of the modality was the Dutch ambassador from 2005 to 2009. In his book, *Verloren in wanorde* (Lost in disorder, 2010), Van Kesteren argues that the key factor behind poverty and lagging economic development is the existence of a funding gap: '...budget support is there for additional spending flexibility...' (p. 145).

Nevertheless, several developments contributed first to the suspension of disbursements and later, by the end of 2010, to a complete ending of budget support. The disbursement of the final tranche of FY 2009-2010 was suspended because the Netherlands was dissatisfied about how the financial and legal case of a Dutch investor was handled and placed that in a broader context of a deteriorating business climate. A number of conditions were put forward, which were only partially met by mid-2010. Finally, the Netherlands cancelled the 2009-2010 tranche. The suspension created friction in diplomatic relations between the Netherlands and Tanzania (IOB, 2012). Other donors maintained that freezing budget support because of one incident was counterproductive and undermined harmonisation. It seems as if Dutch political considerations were more important than the signal this would send to the Tanzanian government. The Tanzanians, meanwhile, hard a hard time understanding why the Dutch were freezing budget support, and they interpreted it above all as a form of blackmail to protect the interests of a Dutch businessman. In the second half of 2010, the EKN considered a new GBS agreement starting in 2011. The Netherlands was planning to commit USD 150 million, with annual disbursements of USD 25 million. However, in December 2010 the newly formed Dutch government (after parliamentary elections) decided to phase out GBS. This was the formal end of Dutch GBS in Tanzania. The final withdrawal from budget support was independent of the later decision to completely phase out bilateral development cooperation. Nevertheless, the absence of PRBS commitments facilitated the exit. This may have influenced the exit decision.

4.4 The impact of ending budget support

In 2008-2009, the last year in which the Netherlands had disbursed GBS, its GBS represented 6.3% of the total amount of disbursed GBS and 0.7% of total government revenues in that fiscal year. In terms of disbursed GBS amount, the Netherlands ranked sixth among the 13 GBS donors in that particular FY (see Annex I). Two years later, in late 2010, the Netherlands considered a new GBS agreement starting in 2011 with a total commitment of USD 150 million and annual disbursements of USD 24 million, by then about 5% of total budget support. The decision by the end of 2010 to phase out budget support operations put a spanner in the works.

Table 4.2 Impact of continued GBS and bilateral ODA by the Netherlands								
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
NL GBS (USD million)	72	42	41	41	24	23	24	23
NL GBS as % of total GBS	9%	6%	5%	7%	5%	5%	5%	6%
NL GBS as % of deficit before grants	5%	2%						
NL GBS as % of deficit after grants			3%	3%	2%	1%	2%	2%
NL GBS as % of government revenue	1.3%	0.7%	0.6%	0.6%	0.3%	0.3%	0.2%	0.3%
NL GBS as % of GDP	0.29%	0.15%	0.14%	0.12%	0.07%	0.06%	0.05%	0.05%
NL total ODA (USD million)	110	78	56	63	62	61	62	59
NL ODA / Total bilateral ODA	6%	5%	3%	3%	3%	3%	3%	
NL / Total ODA	4%	3%	2%	2%	2%	2%	2%	
NL ODA as % of deficit before grants	8%	4%	2%	3%				
NL ODA as % of deficit after grants					6%	3%	5%	4%
NL ODA as % of government revenue	2%	1%	1%	1%	1%	1%	1%	1%
NL ODA as % of GDP	0.4%	0.3%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%

Note: Central PSD instruments and aid provided by NGOs are not include in the analysis. For GBS modelled estimates for 2009-2010 - 2014-2015 based on 2008-2009 data and intended disbursements from 2011 onwards; for total ODA modelled estimates for 2011-2012 - 2014-2015, based on 2010-2011 data.

The Dutch suspension and ultimate decision not to provide GBS again had a direct effect on total GBS grants. Other development partners were not prepared to take over (former) Dutch support. On the contrary, table 4.1 shows that the total support from bilateral donors (who provide grants) has decreased as well. The unforeseen suspension and later cancellation of Dutch GBS increased the financing deficit, which had either to be covered by additional government loans (short-term treasury bills and/or government bonds) or be eliminated by reducing expenditure during the FY. In the short run, the Dutch withdrawal contributed to the deficit (or alternatively: if the Netherlands had started to provide budget support again, the deficit would have been lower). Nevertheless, the impact must not be overstated. If the Netherlands had disbursed in FY 2011-2012, then the deficit could have been 2% lower (0.01% of GDP or 0.3% of the total revenues).

In the longer run, a continuation (or rather a renewal) of budget support would have resulted in higher expenditures to the social sectors. The Joint Evaluation of Budget Support to Tanzania (ADE et al., 2013) concluded that budget support has been a key factor to help strength macro-economic management and increase the allocation of GoT budget resources to high-priority sectors, which has contributed to economic growth, improved results in the education sector and reduced non-income poverty. Budget support has enabled the government to spend in agriculture, education, health, roads, energy and water. The bulk of GBS resources was absorbed in the education sector, facilitating the continued growth of primary school enrolment, which doubled over the decade, and allowing transition rates from primary to secondary to grow from 20% in 2006 to 54% in 2012. In the roads sector, GBS contributed to a 14% expansion of the national roads network between 2008 and 2011. In other sectors, such as health, GBS contributed to steady improvements in outputs and outcomes (see chapter 6).

Other studies confirm this. In 2012, IOB concluded, based on an extensive literature review as well as econometric research, that in general governments have used budget support to increase budgets for the social sectors (see also De Kemp and Dijkstra, 2016). On average about 70%-80% of the provided budget support goes directly to the social sectors (with 1/3 going to the health sector and 2/3 to the education sector). Therefore, had the Netherlands provided GBS as intended (about USD 24 million annually), there would have been additional resources available for the health sector of about USD 6 million and for the education sector about USD 13 million. Chapter 6 discusses the impact on the health sector. For the education sector, it is comparable with the (government) costs of more than 100,000 pupils, 2,600 teachers or more than 800 classrooms in primary education.[8] In this way, ending Dutch-funded GBS has had a negative impact on the speed and level of achievement of the overall objectives of Mkukuta (the national strategy for promoting economic growth and poverty reduction). Cuts in the transfers to local governments had an impact on teacher recruitment and health service delivery.

Another direct effect of ending Dutch GBS was the termination of the Dutch contribution to the GBS policy dialogue focused on, among other things, macro-economic issues, PFM and governance. The departure of the EKN from the GBS policy dialogue did not have a major effect on the dialogue, as the embassy had already isolated itself in this dialogue when the Netherlands decided unilaterally to suspend its GBS disbursement as a result of a dispute about a financial and legal case involving a Dutch investor (see section 4.2). Moreover, by then the dialogue was no longer effective anymore, though the provision of GBS had created a forum for discussing corruption concerns with the government.

[8] Estimates based on UNESCO and ECDPM data. For more detail see the synthesis report (IOB, 2016).

4.5 Conclusions

Until 2009, the Netherlands was one of the medium-sized GBS donors within a group of 14 development partners. It was recognised as a donor with a constructive approach and a strong advocator of the Paris Declaration principles (including the promotion of harmonisation, alignment, ownership and partnership and using the budget support modality). The Netherlands contributed to the overall results of GBS, which were in particularly positive in terms of maintaining macro-economic stability, promoting economic growth, increasing the GoT funding of the six priority sectors of Mkukuta and reducing non-income poverty. However, in terms of reducing income poverty, the results, there were no clearly visible results, while the quality and results of the GBS policy dialogue were meagre and by times disappointing.

In 2009, the Netherlands took a unilateral decision to suspend its GBS, officially because the government had made insufficient progress improving the business climate. The immediate cause was a dispute about the legal and financial settlement of the interests of a Dutch investor. By doing so, the Netherlands deviated from the joint approach of the GBS donors, thereby placing itself outside the core group of GBS providers. By the end of 2010, the Netherlands decided it would no longer provide GBS to most of its partner countries, including Tanzania. The decision was taken before it was decided in 2011 to phase out bilateral development cooperation. Nevertheless, the fact that the Netherlands had no ongoing GBS obligations made the exit easier and therefore may have influenced the country choice. Had the Netherlands decided to continue both its bilateral aid programme and the provision of GBS to Tanzania, then it would have been involved in uncomfortable discussions about the IPTL corruption accusation. In the longer run, however, the Netherlands could have helped the country to achieve its development objectives more rapidly.

It may seem that favourable growth rates and increased domestic revenue have made aid unnecessary. The role of aid in the economy and the government budget has decreased, and the same is true for general budget support. Some donors feel that the instrument has become obsolete, precisely because of these positive developments. However, recent developments in Tanzania also show the fragility of the current phase in the country's development. Changes in the composition of aid and disappointing tax revenues have contributed to a high deficit, forcing the government to reduce investments in infrastructure and in the social sectors, which still face severe shortages. The Netherlands did not play a dominant role in this development, but the Dutch suspension and subsequent exit added to the challenges. The unforeseen suspension and later cancellation of Dutch GBS caused a small increase in the financing deficit. If the Netherlands would have disbursed in 2011, the deficit could have been 2% lower (less than 0.01% of GDP or 0.3% of government expenditure). In the longer run, it will a negative impact effect on service delivery.

5

Support to local government

5.1 Introduction

Before the decision to phase out, aid to local government and local accountability were key areas of the Dutch bilateral development cooperation programme in Tanzania. This support to decentralisation and local government in Tanzania has a long history and goes back to 1997-1998. In the late 1990s, the Netherlands started to contribute to the Local Government Reform Programme (LGRP) and later on the Local Government Development Grant (LGDG) system.

Additionally, the embassy provided financial resources to the Foundation for Civil Society (FCS) and developed the Public Accountability in Tanzania (PATA) Partnership, together with SNV Tanzania and VNG (Association of Netherlands Municipalities). This chapter assesses the Dutch exit in these areas. The chapter concludes that with the exception of FCS the impact of the exit was limited. The Dutch exit has also had a large impact on the institute Research on Poverty Alleviation, which the Netherlands supported for almost two decades. REPOA has become more dependent on commissioned research, which has had a negative impact on independent scientific socio-economic and poverty oriented research in the country.

5.2 Development

The Government of Tanzania (GoT) has shaped the process of decentralisation around two pillars: the Local Government Reform Programme and the Local Government Development Grant system. The *Local Government Reform Programme* (LGRP), developed in the late 1990s, aimed at furthering political, administrative and financial decentralisation through the strengthening of local authorities. It sought to create an improved, more enabling environment for the programming of the *Local Government Development Grant* (LGDG) system. The LGDG, created in 2004-2005, is a system that transfers funds to the Local Government Authorities (LGAs) so they can finance and implement development activities and investments for decentralised service delivery, socio-economic development and poverty reduction.[9] The overall objectives of the LGDG are:[10]

- to improve access of communities, especially the poor, to local services by expanding physical stock of new and rehabilitated infrastructure;
- to improve the sustainability of local development infrastructure by ensuring proper planning and adequate operations and maintenance;
- to enhance the delivery and management capabilities, productive efficiencies and financial sustainability of local governments; and
- to provide a national system for the delivery of development grants to LGAs.

[9] See: PMO-RALG, LGRP Implementation Report 1998-2008, p.73-74. Up to 2008 the LGDG was known as the Local Government Capital Development Grant.

[10] MDF, MTR of the LGDG system, October 2011, pp. 6-7, and LGDG Memorandum of Understanding, p.26.

Table 5.1 presents the funding for the LGRP and the LGDG system from FY 2009-2010 to 2012-2013. External funding of the LGDG dropped dramatically in 2011-2012 because Finland and the World Bank ended their support, while Germany, Ireland and Sweden reduced their contribution. Thanks to an increase of the GoT's contribution in 2012-2013, total funding was restored to the level of 2010-2011. The second phase of the LGRP had a budget of about USD 50 million for five years (2009-2010 and 2013-2014), of which about 11% was meant for financing technical assistance.[11] During FY 2009-2010 and FY 2011-2012 development partners disbursed about USD 21.7 million.

Table 5.1 Funding of the Local Government Development Grant system and the Local Government Reform Programme II (in USD million)

	2009-2010	2010-2011	2011-2012	2012-2013
Local Government Development Grants:				
Belgium	2.5	8.4	9.1	8.8
Finland	6.0	9.0		
Germany (KfW)		16.9	1.8	6.4
Ireland	1.4	4.3	2.7	
Japan (JICA)	0.9	1.1	1.2	
Netherlands	20.4	18.4	15.4	3.8
Sweden		3.4	1.2	
World Bank	14.8	8.8		
GoT	29.8	15.1	11.7	64.6
Total	**75.8**	**85.3**	**43.2**	**83.6**
Local Government Reform Programme II:				
Finland	1.5		4.6	
Germany		1.9	1.1	
Ireland	1.4	1.2		
Japan	0.6	0.5	0.5	
Netherlands			2.0	
Sweden	0.6	3.0	2.8	
Total	**4.0**	**6.7**	**11.0**	

Note: The data include financial contributions to the Council Development Grants and the Capacity Building Grants, and do not include contributions to the sector-specific grants. The contributions from the World Bank (up to 2010-2011) were not channelled via the Common Basket Fund. Nor was the World Bank a signatory of the Memorandum of Understanding regarding support to the LGDG system. GoT contributions are not channelled via the basket fund either, but transferred by the Ministry of Finance to the LGAs using the normal system for intergovernmental transfers.
Source: LGDG: Data from PMO/RALG collected by REPOA. Original data expressed in TZS; LGRP: Data provided by the Irish Embassy.

[11] PMO-RALG (December 2009), Local Government Reform Programme II, pp. 28, 105, 109 and 110.

Donors cancelled LGRP disbursements for FY 2012-2013. This was the result of a process that already began in 2011. By then, the partnership and policy dialogue between the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG) and development partners proceeded with difficulty, while PMO-RALG did not have sufficient capacity to manage the LGRP efficiently and effectively. The annual plan and budget for FY 2011-2012 had not been prepared in time and only 50% of the available budget had been used. Finalisation of the draft annual plan and budget for FY 2012-2013 was also much delayed until October 2012. DPs did not approve the plan and budget because the documents did not meet the minimum quality standards. They only approved the actual expenditures already incurred during the first four months of the fiscal year (July-October) and a budget of about USD 3 million for a limited set of activities selected from the proposed plan and budget.[12]

A mid-term review (MTR) of the LGRP-II (2012) concluded that the programme had not addressed the needs of the intended beneficiaries, the LGAs and lower level authorities.[13] Progress was not satisfactory, and in the absence of a functioning monitoring system it was impossible to establish what was achieved in terms of improving service delivery at the LGA level:[14]

- the administrative arrangements for LGRP were not functioning, there was little coordination, inadequate leadership and there were no proper channels of reporting;
- lack of funding for activities, due to delays with submission and approval of annual plans and budgets, hampered the implementation of the programme;
- regional secretariats and LGAs were understaffed and many of the available staff did not have the required skills and experience;
- LGAs were overwhelmed by orders from above to implement decisions not included in their plans and budgets.

In an internal performance assessment, the Technical Assistance (TA) Team (2012) came to comparable conclusions. The effectiveness of the TA was limited and the skills and experience of most TAs had not been well utilised.

In January 2013 a routine audit of the LGRP accounts of 2011-2012 carried out on behalf of the Swedish embassy concluded that financial management was virtually non-existent, that suppliers were often pre-selected and that there were clear indications of misprocurement if not fraud.[15] As a result of these findings, development partners immediately suspended their support to the LGRP, and requested an in-depth audit of the LGRP for the fiscal years 2009-2010 and 2011-2012. The final report of the in-depth audit (November 2013) noted that poor accounting practices had resulted in inaccurate financial reporting, poor value for money, and loss of donor funds. The audit concluded that the total of ineligible expenditures amounted to TZS 595 million (about USD 370,000 at that time), about 1.8% of total DP funding of LGRP-II.[16] Because of these findings, development partners first suspended and

[12] See minutes of the CBFSC meeting held on 31/10/2012.
[13] Liviga A. and M.D. Roell, *Mid-Term Review of the* LGRP, Final draft report (November 2012), pp.14 and 31.
[14] Liviga A and M.D. Roell, *Mid-Term Review of the LGRP*, Final draft report (November 2012), p.14.
[15] Charles Kendall Consulting, *Special procurement audit of LGRP-II*, FY 2011-2012 (January 2013), pp. 4-5.
[16] RSM Tenon, *In-depth Financial Audit of the LGRP-II*, Final issued November 2013, pp. 3 and 6.

later on cancelled funding of the LGRP.[17] They also discontinued funding of the LGDG in 2013-2014. GoT and development partners arranged for an in-depth audit to be carried out of the LGRP and LGDG accounts of FY 2012-2013 and the GoT accepted to reimburse TZS 459 million in FY 2014-2015 (about USD 260,000).

Due to the suspension of DP support to the LGRP, discussions about the annual plans and budgets of 2012-2013 and 2013-2014 came to a standstill. The Local Government Development Partners Group (LG-DPG) ceased to exist after Sweden stepped down as co-chair in December 2013 and Belgium in April 2014. The Memorandum of Understanding of the LGRP expired on 30 June 2014 and no initiative has been taken to extend and/or renew it. The same happened with the Memorandum of Understanding as regards the LGDG, which had already expired one year earlier on the 30 June 2013. The collaboration between the GoT and the DPs to strength local government had come to an end. The LP-DPG ceased to exist when the last co-chair (Belgium) stepped down in April 2014.

5.3 Dutch support to governance

For many years the EKN played a central role in coordinating and harmonising the DP support to Local Government Reform in Tanzania.[18] The EKN was an active member of the LG-DPG, co-chairing it for more than four years up to 2011. In that position, the embassy had frequent contact with the GoT on policy and strategy issues regarding local government reform in general and the implementation of the LGRP and the management of the LGDG in particular. The EKN continued playing an active role in the LP-DPG, the CBFSC and the LGDG Technical Committee until early 2013. The Netherlands was one of the donors that contributed to the LGDG since it was launched in 2004-2005 and renewed by the end of 2008 for the years 2008-2009 and 2012-2013.

Table 5.2 Dutch support to local governance (in USD million)

	2008	2009	2010	2011	2012	2013
LGDG	22.6	21.3	18.5	15.3	3.9	
LGRP*				2.3		
FCS	2.1	1.9	1.9	2.8	1.7	
PATA	0.0	0.0	0.4	0.5	0.8	1.3
REPOA	1.3	0.9	0.9	1.8	1.0	0.6
Other	0.9	1.8	1.3	0.4		
Total	**27.0**	**25.9**	**23.1**	**23.0**	**7.3**	**2.0**

** USD 2.0 million according to the financial statement of LGRP. The Netherlands disbursed EUR 1.64 million.*
Source: Netherlands Ministry of Foreign Affairs.

17 An amount of about USD 4.5 million was left in the LGRP basket fund at the end of June 2013. See page 25 of the LGRP annual report 2012-2013.

18 PMO-RALG, *LGRP Implementation Report 1998-2008*, p. 98.

In the exit strategy, the budget made available for LGRP-II and LGDG amounted to USD 12.8 million in 2012 and USD 2.3 million in 2013.[19] It was not specified how much would be made available for each of the two components, nor was it made clear whether or not the Netherlands was still considering signing the second Financing Agreement for the LGRP-II. In early 2013, when development partners were confronted again with a lack of progress on the implementation of LGRP-II, and in the absence of a constructive policy dialogue with PMO-RALG, development partners decided to suspend their support to LGRP II. For the Netherlands it implied that the contribution to the LGRP basket fund remained limited to the disbursement of USD 2.6 million in 2011. In addition, due to the lack of progress on the LGRP, the irregularities and the strained relations between development partners and PMO-RALG, the Netherlands could not entirely disburse the contribution to the LGDG in 2012.

5.4 Impact of the Dutch exit

In a strict sense, the decision to end the bilateral cooperation programme (including the Dutch support to LGRP-II) did not have a direct effect on the LGRP II, because it was a temporary programme that would have been phased out anyway. The decision not to disburse more than the first USD 2.3 million was not related to the Dutch exit, but rather to the lack of progress, the financial mismanagement and irregularities, and the lack of trust between development partners and PMO-RALG. The programme was not functioning well and results were disappointing. Nevertheless, PMO-RALG abruptly lost donor funding for the management, reporting and review system of the LGDG.

The LGDG system worked quite well. The LGDG funds were actually transferred to the LGA level, which allowed them to expand the physical stock of infrastructure for social and economic services. However, there are no research and evaluation results available showing to what extent that has led to improved social and economic indicators at the local level (mid-term review of the LGDG, 2011). The direct effect on the LGDG of phasing out the Dutch bilateral cooperation programme in Tanzania has been limited nevertheless, because donor support to the LGDG would have ended anyway after mid-2013. It had been agreed that the GoT would gradually take over funding of the LGDG.

5.5 Impact on supported NGOs

Apart from contributing to the LGRP and the LGDG basket, the Netherlands supported several NGOs as part of the governance and accountability thematic support programme. In 2004, the EKN started providing financial support to the Foundation for Civil Society (FCS). Since 2009-2010, the embassy contributed to the Public Accountability in Tanzania (PATA) Partnership, together with SNV Tanzania and VNG (Association of Netherlands Municipalities). In addition, the Netherlands supported the institute Research on Poverty alleviation (REPOA).

[19] No breakdown per component. See *Multi-Annual Strategic Plan 2012-2015*, including exit strategy, p. 9.

FCS

The Foundation for Civil Society (FCS), a Tanzanian non-profit organisation, provides grants, advice, networking facilities and training to civil society organisations all over Tanzania. The overall goal of this support is to strengthen CSOs to become key catalysts of ongoing change and development processes.[20] The foundation focuses on three thematic areas: (i) policy engagement: influencing and monitoring policy processes to improve service delivery; (ii) governance and accountability: strengthening the demand for good governance and accountability in the management of public resources; and (iii) strengthening the capacity of CSOs. FCS's main instrument is providing grants to CSOs for implementing activities (projects), based on clear project proposals, work plans and budgets. Since its start, FCS has funded almost 4,000 projects, reaching millions of people. FCS has about 33 staff members. A mid-term evaluation of the implementation of FCS' 2009-2013 Strategic Plan showed that FCS managed to strengthen the capacities of the CSOs engaged in policy dialogues and put pressure on the government – in particular local governments – to improve governance and accountability.[21]

Since its establishment in 2002, the CSO received financial support from more than 12 different donors, including the EKN (since 2004). During the implementation of the 2009-2013 Strategic Plan the Netherlands was the second donor (until 2012), with DFID as the main contributor (see table 5.1). In 2013, Canada and the Netherlands ended their support. In 2014 Norway also ended its support and only two donors provided core funding (DFID and Denmark).

During the period 2008-2012, the Netherlands disbursed an amount of USD 10.4 million, on average USD 2.1 million per year. The EKN had intended to offer FCS a new four-year commitment starting in 2011 and meant to support the last three years of FCS's 2009-2013 Strategic Plan and the first year of a new strategic plan. However, the exit decision made it impossible to live up to that intention. Instead the EKN offered a phasing-out financing plan consisting of USD 2.6 million in 2011 and USD 1.9 million in 2012.

Phasing out Dutch support to FCS had the direct effect of reducing the number of CSOs benefitting from funds for their activities in the field of (i) policy engagement, (ii) advocacy for improving governance and accountability, and (iii) strengthening their own capacity and organisation. An average Dutch contribution of about USD 2 million per year would have supported about 100 to 150 additional CSOs. But now, in 2014, only 54 new projects had been approved. Norway stopped funding after 2013. So within two years, FCS had lost three major donors (the Netherlands, Norway and Canada).

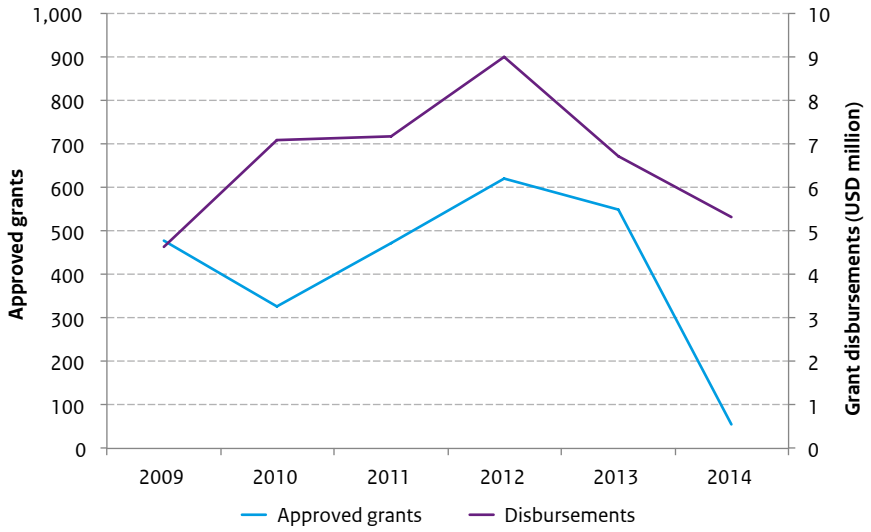
[20] *FSC Annual Report 2013*, p.5.

[21] ECOM Research Group, *Mid-term Impact Assessment of the FSC*, draft report, February 2012.

Table 5.3	Funding of the Foundation for Civil Society 2009-2014 (in USD million)					
	2009	2010	2011	2012	2013	2014
DFID	2.7	1.0	3.0	4.9	3.4	6.5
Netherlands	2.0	2.0	2.6	1.9		
DANIDA			1.8	1.7	1.7	1.8
Norway	0.4	0.4		2.6	2.4	
SDC	0.7	0.9	0.9	1.5	0.7	
SIDA		4.3				
CIDA	0.8	1.0	0.5	0.4		
Irish Aid	1.0	0.7				
Comic Relief			0.9	0.9	0.8	
Anonymous		0.2	0.2	0.4	0.4	0.4
Trade Mark					0.2	0.2
ILO					0.1	0.2
IRC					0.1	0.1
Total	**7.6**	**10.6**	**10.0**	**14.3**	**9.8**	**9.1**

Source: FCS 2014 Annual Report.

Figure 5.1 *Development of approved grants and disbursements (2009-2014)*



Source: FCS annual reports.

Public accountability in Tanzania

The Public Accountability in Tanzania (PATA) Partnership supported accountability initiatives and projects undertaken by local capacity builders (LCBs).[22] A main component of the Public Accountability in Tanzania (PATA) Partnership was the PATA Innovation Fund, financed by the embassy. With these resources, SNV helped LCBs to design, formulate and implement accountability initiatives and projects. SNV also took care of monitoring the implementation. PATA supported projects in water, sanitation and hygiene (68% of the expenditure), agriculture (27%), health (2%), tourism (2%) and renewable energy (1%). The projects and programmes covered a total of 41 districts.[23] In total 105 contracts were signed with 28 different LCBs.[24]

The embassy made an amount of USD 10.6 million available for funding the PATA programme during the years 2010-2014. Actual expenditures during the years 2010-2013 only amounted to USD 3.0 million, due to the time needed to identify, design and formulate suitable accountability activities and projects and to train LCBs to become acquainted with the procedures.

PATA was originally supposed to last until the end of 2014, but as a result of the exit decision, no new proposals were developed after mid-2012. The potential direct (negative) effect of phasing out the EKN support to the PATA programme was limited because SNV was able to secure other timely sources of funding. The PATA approach attracted the interest of other donors, who were interested in financing similar initiatives and programmes albeit under a different name. These alternative funding sources have gradually taken over the funding of LCB's accountability activities, which would otherwise have been funded by the PATA Innovation Fund. The new donors include DFID, Irish Aid, UNICEF, RVO and Endev. By the end of 2014, commitments totalled USD 14.2 million (of which USD 6.3 tentative). SNV and the LCBs implementing the accountability activities probably would not have had the capacity to identify, formulate and implement a much higher number of activities and projects.

Research on Poverty Alleviation

In order to promote economic growth and poverty reduction, the Netherlands has had a long relationship with research institutes in Tanzania, initially focusing on agricultural research. From the mid-1990s onwards, it supported the then new institute Research on Poverty Alleviation (REPOA). The Ministry of Foreign Affairs provided core funding, in order to enable the institute to develop its own research programme on the causes of poverty and instruments to alleviate poverty. Over time, REPOA became less dependent on Dutch funding, especially with the rise of commissioned research. The Dutch share in total income decreased from 100% in 1998 to 35% in 2003.[25]

[22] LCBs are civil society, public sector or private sector organisations providing capacity development services (SNV, 2014, p. 8).

[23] In total, there are 133 districts in Tanzania.

[24] See SNV, *PATA partnership initiative*, final report, July 2014, p.29.

[25] From 2005 to 2010, the Netherlands provided core funding together with the United Kingdom, Sweden, Norway and Finland. In 2010, Finland ended its contribution.

In 2007, an IOB evaluation concluded that REPOA is highly relevant and successful with an important role in Tanzanian socio-economic and development-related research and a strong international network. Over the years, the organisation has developed a successful multiannual multidisciplinary research programme. The organisation helped to strengthen the national research capacity, while showing strong ownership. The evaluation also concluded that core funding is necessary to ensure independence in its relationship with the government. Since 2007, the organisation has invested a great deal in the quality of its research and has extended its international network, working with organisations such as the World Bank, the Center for Global Development, and UNU-Wider. In 2014, REPOA was ranked as the top think tank in Tanzania and number 18 of the 65 leading think tanks in sub-Saharan Africa in the Global Go To Think Tank Index (GGTTI).

The announcement in 2011 that the Dutch were intending to exit was untimely and came unexpectedly. One year earlier, the EKN and donors had discussed a joint funding arrangement for the 2011-2014 Strategic Plan. By then, the embassy had stated its willingness to contribute USD 6.3 million as core funding. In the summer of 2011, the embassy announced that it would need to change the contract, and in the end the Netherlands only disbursed USD 3.4 million, leaving a gap in the funding of the strategic plan. The embassy told the management of REPOA that it would help to mobilise other development partners, but the influence of the embassy in this regard proved to be insignificant.

Table 5.4 REPOA budget 2008-2014 (USD 1,000)

	2008	2009	2010	2011	2012	2013	2014
Government of Tanzania	35		71				
Netherlands	1,376	889	944	1,764	1,028	636	
Sweden	333	248	519	443	450	306	287
United Kingdom	643	141	460	468	234	465	486
Norway	659	629			665	1,008	1,247
Finland	139	129	103				
Interest							23
Total core funding	**3,185**	**2,036**	**2,096**	**2,675**	**2,377**	**2,415**	**2,043**
Other sources	1,591	1,705	2,461	892	1,485	1,022	2,226
Total	**4,775**	**3,742**	**4,558**	**3,568**	**3,862**	**3,437**	**4,269**
Netherlands as % of core funding	43%	44%	45%	66%	43%	26%	
Core funding as % of total	67%	54%	46%	75%	62%	70%	48%

Source: REPOA; Netherlands Ministry of Foreign Affairs.

Between 2010 and 2013 the Netherlands provided about 45% of REPOA's core funding, which was more than 60% of the institute's total income. The funding requirement for the 2015-2019 Strategic Plan was estimated at USD 29 million, USD 21 million of which was core funding from development partners. As a result of the Dutch exit, the budget still has a deficit, though the institute receives some support from the Think Tank Initiative. In 2014, the total budget remained fairly stable, thanks to contract research, but core funding dropped to 48% of the total.

The mid-term review of the 2010-2014 Strategic Plan concluded that there was a need to increase number of basket funders and reduce reliance on one or two donors. However, core funding was increasingly becoming a challenge as donors were changing their priorities to projects that would immediately generate tangible results. Now, REPOA has become more dependent on commissioned research, which has had a negative impact on the institute's scientific independence. The possibility of recruiting senior researchers is limited. This is having a negative impact on the quality of independent scientific socio-economic and poverty oriented research in the country, resulting in a reduction of policy relevant information on the causes and development of poverty in Tanzania.

5.6 Conclusions

For more than 10 years, the Netherlands has been one of the key donors supporting local government reform in Tanzania. The Dutch embassy played an important role in setting up the LGDG system in 2005, and it was the largest foreign donor of the LGDG system in the periods 2008-2009 and 2011-2012. The Netherlands also contributed to the design, funding and implementation of both LGRP-I and LGRP-II. Furthermore, the EKN was co-chair of the LG-DPG for more than four years up to March 2011. In view of this track record, phasing out Dutch support to local government reform could be considered a great loss for the sector.

However, at the time the Netherlands decided to phase out its bilateral cooperation programme in Tanzania and thus also its support to local government reform, the LGRP faced serious implementation problems, and the collaboration between PMO-RALG and the development partners was confronted with great difficulties. Due to repeated, long delays in submitting annual plans and budgets, disagreements about the content and quality of the annual plan and budget for FY 2012-2013 and the alarming conclusions of an audit report, the development partners decided to suspend further funding in February 2013. In view of this course of events, the Dutch decision in 2011 to phase out its bilateral cooperation programme in Tanzania did not make much difference. In the counterfactual case of a continuation of the bilateral cooperation programme, Dutch support to local government reform would still have been phased out (as would support from other DPs). Therefore, impact of phasing out the Dutch bilateral cooperation programme on local government reform in Tanzania has been minimal.

The phasing out of the Dutch support to FCS has had major consequences for FCS's budget and scope of activities. Initially, in 2012 and 2013, Norway was ready to fill the gap caused by the Dutch exit, but Norway stopped funding after 2013. So FCS lost three major donors in two years (the Netherlands, Norway and Canada), causing a reduction of FCS's budget and consequently its activities.

The PATA programme, which initially had a budget of USD 10.6 million for the years 2010-2014, helped to improve accountability at the local level, in particular water, sanitation and hygiene (WASH), and cattle dip functionality, and it strengthened the oversight capacities of local councillors. As a result, these councillors were increasingly demanding better service delivery. The impact of the Dutch exit was limited, as other donors have funded comparable projects.

The Dutch exit has a large impact on the institute Research on Poverty Alleviation. For almost two decades the Netherlands provided core funding and contributed to a large portion of REPOA's resources. The exit decision was taken at a moment when the embassy, other donors and the REPOA's management had reached an agreement about the funding of the 2011-2014 Strategic Plan. The Dutch exit contributed to a large budget deficit and the embassy was unable to find other partners for REPOA. As result, REPOA has become more dependent on commissioned research, which has had a negative impact on independent scientific socio-economic and poverty oriented research in the country.

6

Health and SRHR sector

6.1 Introduction

The Netherlands has been a major donor to the health basket fund, to SRHR programmes and to programmes to fight HIV/AIDS and malaria. Through this support, the Netherlands helped to improve service delivery and reduce infant and child mortality. This chapter provides an assessment of the impact of the Dutch exit. It concludes that it is a great loss. The sector is in crisis and faces serious (budgetary) challenges and severe shortages, also because more donors phased out. The Netherlands played an important role in the sector dialogue and the highly qualified expertise of the sector specialist was valued highly by all partners involved. Continuation of Dutch support would have saved lives and helped to improve the health of vulnerable groups, especially women and children, through better availability of essential drugs at the local level and better functioning health posts.

6.2 Development of the sector

During the 1990s, the health sector in Tanzania faced a period of stagnation. The structural adjustment programmes of the IMF and the World Bank contributed to macroeconomic stability, but they had a negative impact on the development of public sector spending. In the health sector it played a part in reducing available resources, leading to severely underfunded health services and deteriorating health care (COWI, 2007). There was also little coordination between the Ministry of Health and Social Welfare (MoHSW) and development partners. This changed by the end of the 1990s. In 1999 the Ministry of Health and Social Welfare (MoHSW) and six development partners, including the Netherlands, agreed to a joint funding mechanism for the sector, the *health basket fund* (HBF), providing the ministry with un-earmarked resources. In 2008 GoT and ten other development partners signed a new MOU for the health basket fund. Seven years later, in 2015, GoT and five development partners renewed the MoU for 2015-2020 for a total of USD 250 million. Roughly half of the health basket is disbursed to the districts for basic health services. Regional authorities receive a small portion for planning and supervision. The balance is spent at the central level based on agreed priorities, including essential drugs, training, referral hospitals and system-strengthening activities.[26]

Overall, about 35% of the sector expenditure (not including private expenditure) is foreign funded (see table 6.1). However, development partners channel the majority of their support through projects, particularly for HIV/AIDS and malaria (the Global Fund and funds such as the United States President's Emergency Plan for AIDS Relief (PEPFAR, about USD 360 million in fiscal year 2013-2014) and the fund to combat malaria (PMI, USD 46 million for 2013-2014).[27]

[26] In FY 2011-2012 it was agreed to allocate about 51% to the councils (for basic health care), 3% to the regional secretariats and 46% to support the MTEF of the MoHSW. This amount included a sum of TZS 20 billion (20% of the total) for the provision of medicines at the district level.

[27] The data in table 6.1 do not include all health expenditures. First of all, it does not include all (off-budget) donor expenditures. In particular, support to specific health projects is not included in the data. Overall about 60% of the overall health expenditure is foreign funded (not including the private sector; Dutta, 2015). Second, the data do not include private expenditures. The national health accounts for 2009-2010, the most recent year for these data, give an estimate of TZS 2,323 billion (USD 1.7 billon), 26% of which is government funded, 40% donor funded and 34% private (households and business).

As a result of the investments in the sector, the health status of the population is slowly improving and life expectancy is increasing, while child and infant mortality rates are decreasing. Disease control programmes in HIV/AIDS, malaria and tuberculosis are quite successful in early detection and treatment (MoHSW 2015, HSSP IV). The health basket enabled the government to mobilise new resources for the delivery of basic services at the district level. It contributed to the introduction of an *essential health package* at the decentralised level that helped to increase and improve service delivery, particularly at the primary health-care level (COWI, 2007). This also helped to reduce child mortality (in addition, it resulted in high immunisation coverage, malaria control, improved breastfeeding, improved nutrition and higher vitamin A coverage) (EKN, 2007).

Table 6.1 Government health expenditure FY 2007-2008 — 2014-2015 (USD million)

	Expenditure / realisation							Budget
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
Government	311	367	424	389	454	485	500	622
Health basket	67	68	94	86	97	89	84	66
Foreign non-basket*	92	123	147	144	121	107	221	153
Total**	**470**	**557**	**665**	**619**	**672**	**681**	**805**	**841**
Share in total budget:								
Government	66%	66%	64%	63%	68%	71%	62%	74%
Health basket	14%	12%	14%	14%	14%	13%	10%	8%
Foreign non-basket	20%	22%	22%	23%	18%	16%	72%	18%
Government expenditure on health per capita	8.0	9.2	10.4	9.2	10.4	10.8	11.0	13.4
GOT allocation to health	11.3%	11.1%	11.6%	12.3%	10.4%	10.2%	8.9%	9.1%

** Includes on-budget Global Fund expenditures.*
*** Figures may not sum to totals due to rounding.*
Source: Data MoHSW and Dutta (2015).

In spite of all the progress, the health sector faces many challenges. The sector is severely underfunded. Real expenditure per capita is well below levels targeted by international organisations (COWI, 2007; MoHSW, 2013a). The government has not met the target of 15% to which heads of state of African Union countries committed themselves in Abuja in 2001, and the share of health in the government budget has had a tendency to decline. Donor support is decreasing, especially for the health sector basket (going down to USD 50 million for FY 2015-2016). This affects access, equity and quality of services. There is a chronic shortage of qualified health personnel. The health force is slowly increasing, but shortages continue to exist. There are 5.4 doctors, nurses and midwives per 10,000 inhabitants (MoHSW, 2013b). Councils report a skilled health-care workers deficit of 55% (MoHSW, 2015).

Considerable disparities continue to exist between socio-economic strata and regions. Poor socio-economic regions score worse on service delivery and outcome indicators. Almost 50% of the population does not live within five kilometres of health facilities. Overall service use is not near the required level yet (MoHSW 2015, HSSP IV). Maternal and child health care are underperforming, and neonatal mortality and maternal mortality are still too high, despite having gone down. Since 2014, health-care indicators have been included in the government's *Big Results Now* approach, in order to enhance the implementation of the Five Years Development Plan in 2011-2012 and 2015-2016.

Table 6.2 Health indicators

	2000	2005	2010	2013/ 2014
Health expenditure per capita (current USD)	10	15	37	49
Births attended by skilled health staff (% of total)		43	49	
Births in health facilities	44%	46%	51%	
Immunisation, DPT (% of children)	79	90	91	97
Prevalence of HIV, total (% of population ages 15-49)	7.9	7.0	6.1	5.3
Incidence of tuberculosis (per 100,000 people)	238	215	174	164
Life expectancy at birth	50	54	59	61
Lifetime risk of maternal death (%)	4.2	3.4	2.6	2.3
Maternal mortality ratio (per 100,000 live births)	770	578	450	410
Under 5 mortality rate	143	106	81	
Mortality rate, infant (per 1,000 live births)	78	59	42	36

Source: WDI / DHS.

6.3 The role of the Netherlands in the sector

Until its withdrawal, the Netherlands was the largest bilateral donor to the health basket (as well as lead donor and chair of the Troika) and active in the sector's technical working group. The health specialist at the embassy in Dar es Salaam was highly experienced, active and well-respected by all stakeholders and was able to take the sector dialogue to a higher level and push for progress on themes that had come to a standstill. An example is the *Monitoring and Evaluation Strengthening Initiative* (MESI 2009-2015), which the Netherlands founded and actively promoted. Based on the original plan and many discussions facilitated by the EKN and the Norwegian embassy, other funding and technical partners such as GFATM and CDC have been attracted as well. The EKN contributed USD 2.7 million a year to MESI. From 2012 onwards, MESI started to contribute to health sector accountability and monitoring and evaluation.

In the sector dialogue, the embassy in Dar es Salaam pushed for more emphasis on sexual and reproductive health and rights (SRHR) at the service delivery level. In addition, the embassy supported a programme for malaria control and NGOs such as Comprehensive Community Based Rehabilitation in Tanzania (CCBRT), AMREF and Population Services International (PSI). The EKN had a long-term cooperation relationship with AMREF and supported the fistula repair programme, implemented through NGOs and GoT hospitals. The PSI programme for the social marketing of family planning (FP) and HIV products added an innovative and promising component of private sector engagement (franchising) in 2012. Table 6.3 provides an overview of Dutch health expenditure between 2008 and 2014 (USD million).

Table 6.3 Netherlands health expenditure in Tanzania 2008-2014 (USD million)

	2008	2009	2010	2011	2012	2013	2014
Health basket	20.9	20.9	21.1	23.6	16.1	1.9	
HIV/AIDS	4.0	2.9	3.1	3.6	1.7	4.9	0.5
Malaria control	2.1	0.9	2.2	0.4			
SRHR	0.5	0.5	0.5	4.7	3.2	0.4	
Total	**27.5**	**25.2**	**27.0**	**32.3**	**21.1**	**7.3**	**0.5**

Source: Netherlands Ministry of Foreign Affairs.

6.4 The impact of the Dutch withdrawal

The health basket

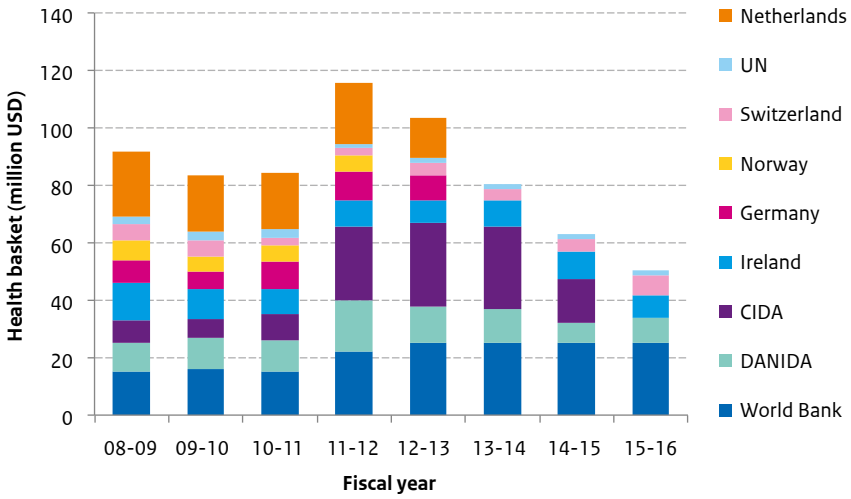
Until fiscal year 2011-2012 donors provided USD 83-92 million through the health basket. As a result of increases that year by the World Bank, Denmark and especially Canada, the contributions peaked at USD 116 million. Since then, donor support has decreased rapidly to USD 63 million in FY 2014-2015 (see figure 6.1). In two years' time, Norway, the Netherlands and Germany pulled out, leading to an annual loss for the HBH of about USD 35 million. Like the Netherlands, Norway and Germany also ended their support because of changes in domestic policies and not because of a negative assessment of the health sector's performance. Canada (CIDA) and Denmark (DANIDA) have reduced their contribution. The new MoU envisages a total of TZS 531 billion (about USD 250 million) for 2015-2020, about USD 50 million annually.

Non-basket support has grown until recently, but a risk with these earmarked funds is that fewer resources will be available for general health service delivery. The non-basket funds focus on specific (MDG-related) results, but less on strengthening health systems and procedures. They reflect donor preferences rather than recipient priorities. This may also pose challenges to the country's ownership and reduce flexibility. The non-earmarked funds, on the other hand, have helped to build up and strengthen the health system and are important to help achieve the objectives of the earmarked funds. They are necessary to cover general operational costs, which are in turn required to implement programmes with

earmarked funds. Finally, earmarked support proves to be more volatile and the Global Fund and other development partners are also reducing their (non-basket) support.
A positive development is the increase in the GoT's contribution to the health budget and a significant increase in government funding towards LGAs and the medicine budget, especially in the area of essential medicine (RBA, 2014). Nevertheless, budget increases by the GoT are constrained by macro-economic limiting conditions (see chapter 2) and the share of health in the overall GoT budget continues to decline. Moreover, GOT's own resources are primarily allocated for staffing, with inadequate funding for medical supplies (Dutta, 2015; MoHSW, 2013a). About 60%-68% of government spending for health are recurrent expenditures, and the majority of spending (about 60%) is at the central level (Dutta, 2015). It includes salaries and the majority of drugs and commodities (about 20%-28%).

As a result of these developments, the health sector faces a major deficit. Despite the increase in resources from the government, the budget for drugs and medical supplies faces serious shortages. Public health facilities continue to experience a severe lack of medicine and medical supplies. There is a dramatic drop in the non-salary budget. Performance is going down, leading to significant risks. Equal access to health services is still a problem (DSW, 2015; Dutta, 2015). The new Health Sector Strategic Plan (HSSP IV) for 2015-2020 aims to improve the quality of health-care services and ensure equitable access by focusing on geographic areas with higher disease burdens and vulnerable groups in the population at higher risk. To address the social determinants of health, the plan aims to collaborate with other sectors. The plan already envisages a funding gap of about USD 250-1,250 million, depending on a number of income assumptions.

Figure 6.1 *Development of contributions to the health basket (FY 2008-2009 - FY 2015-2016)*



Source: MoHWS.

The direct impact of the discontinuation of Dutch support to the health basket is a reduction in the available resources of about USD 20 million a year. This includes a reduction of resources available to the councils for basic health care of USD 10 million, for medicine supply at the local level of about USD 4 million and about USD 5 million for the Ministry for Health for health-care funding (especially development expenditure). As a result, the Dutch decision has contributed to the underfunding of the sector and has created a number of challenges. The reduction of the HBF has had a particularly strong impact on the health councils through the Comprehensive Council Health Plans (CCHP) and especially on development funds. It has forced the councils to scale down planned services, as LGAs now have little room for raising their own revenue. Basic health facilities lack the means for adequate service delivery and there is no money for essential drugs.[28] A large part of the council budget goes to maternal, newborn and child health (58%).

Development partners agree that the Dutch exit was a big loss, not only for the health basket, but also for the sector dialogue and cross-cutting themes such as SRHR and gender. The Dutch technical expertise was highly valued. It had authority and was capable of bridging different positions and moving difficult dossiers forward. Part of the expertise has now been lost, which has had a negative impact on the DPG health group's ability to function, on the dialogue and on progress in the health sector. As an important development partner in the health sector, the Netherlands helped to improve district health planning and management, technical progress in disease control, and the quality of health services.

Support to MESI

During the implementation of the Health Sector Strategic plan II (2003-2008), the monitoring and evaluation system was not prioritised and it was underfunded. As a result, the ministry had not been able to modernise its HMIS system. The system was not reliable and reports were incomplete. For the HSSP III (2009-2015) the ministry tried to mobilise resources to strengthen the health information system, in order to enhance the availability of information for decision making. The Dutch embassy supported the *Monitoring and Evaluation Strengthening Initiative* (MESI) actively from its inception. The implementation of MESI started in 2010 thanks to funding from the Dutch embassy. Later on, other contributors followed as well. Between 2010 and 2013 the Netherlands paid USD 5 million of MESI's costs, 26% of the total until then.[29] Dutch funds supported ICT services in the health sector, training and countrywide HMIS supervision. By the end of 2014, MESI was implemented in almost 7,000 health facilities and 163 councils. By then over 85% of all health facilities reported on a monthly basis. Now reliable and complete data are available and districts produce annual district health profiles (DHP).

[28] In FY 2013-2014, the health basket contributed 11% to the councils' health budgets. The main contribution (47%) was from the government and another 6% in kind through the Medical Stores Department (MSD). The Global Fund also contributed 11%.

[29] The Global Fund contributed USD 9.3 million and CDC another USD 5 million.

The MESI project faces serious challenges. There is a financial gap of 40% in the budget for medical registers, rollouts of ICT connectivity to the remaining councils are delayed, there is not enough money for training and data analysis to strengthen the recording of morbidity statistics using International Classification of Diseases (ICD-10), there are not enough funds to train tutors at training institutions, roll out training of DHPs or purchase computers for health centres to support DHIS2 data collection. In addition, there is an urgent need to invest in data quality checks and audits at both the facility and district levels in order to master massive data collection, analysis and use at the district, regional and national levels and documentation of the entire MESI. As a result, the MESI's sustainability is under threat.

Support to NGOs in the health sector

As has been mentioned before, the Netherlands not only supported the sector through the health basket, but also funded several NGOs and NGO projects, especially in the areas of HIV/AIDS, SRHR and malaria. Four examples (the largest projects) provide more information on the Dutch role and the impact of the Dutch exit. These examples include support to PSI Tanzania for the social marketing of family planning and HIV products, a project for bed nets, together with USAID, an SRHR project by AMREF flying doctors and the construction of a maternity hospital by CCBRT.

Table 6.4	Netherlands support to NGOs in the health sector 2008-2014 (USD million)								
	2008	2009	2010	2011	2012	2013	2014	Total	Dutch contribution
PSI			1.0	5.3	2.6	5.1	0.5	14.4	35%
USAID/PSI*	2.1	0.9	2.2	0.4				7.2	50%
AMREF	0.4	0.3	0.3	0.4	0.4	0.2	0.0	2.0	100%
CCBRT				2.6	1.9	0.1		4.7	20%
Total	**2.5**	**1.2**	**3.5**	**8.7**	**5.0**	**5.4**	**0.5**	**28.3**	**41%**

** Total includes expenditures in 2007.*
Source: Netherlands Ministry of Foreign Affairs.

HIV/AIDS and Family planning

Since 2001, the Netherlands embassy has supported Population Services International (PSI) Tanzania financially for the social marketing of HIV prevention activities and for malaria prevention activities. The organisation delivers affordable and accessible health products and services to poor and vulnerable people through a network of private and public sector partners. Main intervention areas include the fight against malaria, HIV/AIDS, tuberculosis, and diarrheal diseases and the promotion of reproductive health and family planning.

As a follow-up to earlier support, the Netherlands embassy funded a project for the social marketing of FP and HIV products with a commitment of USD 16 million for the years 2010-2015. The objective was to improve sexual and reproductive health and rights in Tanzania through the social marketing of integrated HIV and FP products and services. In Tanzania, the use of contraceptives for family planning is low (about 20% at the start of

the project). PSI expected to generate about 465,000 couple-years of protection (CYP) at a cost of USD 28.50 per CYP. A specific characteristic of the project was the distribution of products for family planning by the social sector through social franchising. The franchising system involved medical doctors, nurses, pharmacists and community health workers. After four years, PSI Tanzania supported more than 300 private providers. These providers have been trained in short-term and long-term reversible FP methods, HIV and STI screening and counselling. Communication workers, trained by PSI, reached almost 400,000 women a year, and more than 25% were referred for modern family planning methods. Available evidence points to a successful model, while there is a need to focus on programme development in order to achieve significant health impacts (Beyeler et al., 2013).

PSI Tanzania did not directly depend on Dutch support, as the organisation also managed programmes from the government, multilateral funds, bilateral donors and private foundations. However, no organisation was willing to take over Dutch funding, especially not the contribution to social franchising, and the Dutch exit has had a direct impact on this programme, as other donors are not willing to fund it.[30] The use of contraceptives has improved, but is still very low. A result is a high fertility rate of 5.2 children per woman (WDI). Many women give birth in high-risk conditions: the women are too young or too old, the time span between births is too short, or the number of children is already too high. Because of these conditions, maternal mortality and morbidity rates are high, and many children are born prematurely, too small and do not survive their first week of life.

Malaria

Malaria is one of the leading causes of childhood illness and death in the country, especially among children. Around 2006, over 16 million cases per year, resulting in over 100,000 deaths annually, approximately 80,000 of which were children under the age of five. From 2007-2011 the embassy contributed USD 7.2 million to a project for the manufacturing and distribution of long-lasting insecticide-treated nets (LLINs) as a silent partner of lead donor USAID/PMI (President's Malaria Initiative). The objective was to provide insecticide treatment kits (ITKs) and insecticide retreatment kits (IRKs) to Tanzanian net manufacturers. The programme was implemented through PSI Tanzania for the distribution of net retreatment kits to local manufacturers and MEDA Tanzania for infant vouchers and JSI (insecticides and diagnostic tests). The project was ended in 2012 (with the last Dutch contribution in 2011).

Improved malaria prevention and treatment have played a significant role in the reduction of malaria deaths in Tanzania by 70% since 2003 (Lorenz et al., 2014). Mosquito nets treated with insecticide belong to the most cost-effective instruments in fighting malaria with significant effects on child survival. Its regular use is estimated to reduce clinical episodes of malaria by 50% and severe malaria by 45% (Lengeler, 2004). It can reduce overall child mortality by 20% (MEDA, 2011). Aided by the project, the use of insecticide-treated bed nets

[30] KfW contributed USD 6.3 million to PSI between 2011 and 2013, but not as a result of the Dutch withdrawal, nor has KfW taken over Dutch funding of the social franchising system. An effect of the Dutch withdrawal was that PSI Tanzania had to prioritise the use of Dutch funds, thereby forcing KfW to finds ways of postponing its contribution.

has increased from 26% of the under-5 population in 2008 to 72% in 2012. Together with immunisation programmes and HIV interventions it contributed to the rapid reduction of under-5 mortality, from 130 deaths per 1,000 livebirths in 2000 to less than 50 in 2015 (WB, WDI; Afnan-Holmes et al., 2015).

Because of the exit, the Netherlands embassy in Dar es Salaam could not contribute to a new project. Donors such as GFATM, PMI and DFID are still funding projects, but this was not because of the Dutch exit. As a result of reduced external support, the distribution of bed-nets and other life-saving control tools may slow down with the risk of a reversal of the achievements (Lorenz et al., 2014).

Fistula repair

As part of the support to SRHR in Tanzania, the Netherlands contributed to the National Fistula Programme, from 2008 onwards mainly through the African Medical and Research Foundation (AMREF). AMREF is a leading African health development organisation, founded in 1957 as the Flying Doctors of East Africa. AMREF Tanzania works with different partners and government structures to reduce HIV/AIDS and tuberculosis and to improve maternal, newborn and child health. The organisation has set up surgical camps in hospitals and health facilities throughout the country and provides consultations and operations for women living with vesicovaginal fistula (VVF).[31] Without AMREF, many women in Tanzania cannot afford the costs of fistula repair. They are stigmatised, become socially isolated and live in poverty (WHO, 2006).

The project aimed to reduce maternal morbidity and mortality due to obstetric fistula. Aided by Dutch support, AMREF was able to perform 3,300 fistula repairs in 40 hospitals in three years. The Dutch contributions for 2012 and 2013 aimed to extend the programme and train doctors, nurses and trainers, as well as set up preventive services. A single fistula repair operation in Tanzania costs around USD 200-300 (AMREF). AMREF subsidises fistula repair by refunding the hospitals. In addition, the organisation trains doctors, nurses and clinical officers how to surgically repair VVF and provide obstetric care, antenatal care and family planning. In spite of the progress, there are few doctors who can perform the complicated surgery to repair obstetric fistula. AMREF is now supported by USAID, but USAID's contribution is far too low to even cover the costs. As a result, the number of surgeries has been massively reduced. Overall, AMREF Tanzania's budget has decreased from USD 15 million to USD 10 million, as other donors have followed the Dutch example. Staff has left as well.

Baobab Maternity Hospital

In late 2010, when the Netherlands decided it would no longer provide general budget support, Tanzania's bilateral budget was about to be hit disproportionally, as it would also suffer a general reduction cutback of 11%. As compensation, the embassy was allowed to fund additional activities for a total of USD 17 million. One of them was for the construction

[31] Obstetric fistula is a hole in the birth canal caused by obstructed labour and is one of the major causes of maternal mortality. Women who experience the disorder suffer constant urinary incontinence, leading to skin infections and kidney disorders. If left untreated, it may cause death. See also WHO website: http://www.who.int/features/factfiles/obstetric_fistula/en/.

of a maternity hospital to strengthen maternity and reproductive health services in Tanzania, together with other donors. The new hospital, the Baobab Maternity Hospital, has a national function for referral and training on reproductive health. Its capacity is 15,000 deliveries per year. The hospital also provides outpatient services, increased antenatal and postnatal care, immunisation clinics for infants, prevention of mother-to-child transmission services and family planning sessions. Overall, the whole project is expected to improve health-care services to 140,000 women and newborns. The Netherlands has contributed USD 4.6 million (at the time, about 28% of the total) for the construction of the hospital delivering the core services, specific gynaecological and paediatric services and departments.

A locally registered NGO, Comprehensive Community-Based Rehabilitation in Tanzania (CCBRT) runs the hospital. The organisation also manages a pro-poor disability hospital in Dar es Salaam, as well as an extensive community-based rehabilitation programme. CCBRT serves more than 120,000 people with disabilities a year, many of them vulnerable people who cannot otherwise access quality services. Apart from donor grants, the NGO is able to do its work by charging higher fees for services to those who can afford at a more comfortable level (7% of the patients).

The importance of the hospital cannot be overestimated. It aims to prevent 50% of the facility-based maternal deaths and 2,000 newborn deaths every year in the fast growing Dar es Salaam region. Tanzania is one of the countries with the highest maternal and neonatal death rates. Almost two million deliveries take place in the country every year. About 8,000 women die due to complications from pregnancy and childbirth, and 39,000 babies do not survive their first month of life (WHO et al., 2014). Most maternal deaths are caused by obstetric conditions (WHO et al., 2014). The causes are closely linked to the quality of care and lack of emergency services (CCBRT, 2013). Key problems include overcrowding of existing facilities, lack of human resources, inadequate skills, and inadequate infrastructure. Skilled attendance at birth and emergency obstetric care belong to the most effective ways of reducing maternal and neonatal mortality (Afnan-Holmes, 2015).

The Dutch exit has no direct impact on the hospital, as funding has been secured by other donors (KfW). However, the operational start of the hospital has been delayed due to significant delays in construction and increased costs. Moreover, donors are reluctant to provide core finance for running costs as they prefer project specific funding and the government has not shown to be a predictable funding partner. The revenues of the private wing of the hospital will be used to finance part of the (regular) hospital expenditures, but that will not be a major part. In addition, the existing CCBRT disability hospital faces significant financial challenges, due to decreasing donor contributions, the difficulty to raise patient's contributions and low contributions from the government. Continuation of Dutch support in this area would have enabled higher investments in maternal and child health thereby contributing to a further reduction of maternal and infant mortality.

Assessment

Overall it is difficult to give a precise estimate of the impact of the Dutch exit. There is evidence that the Netherlands has supported highly relevant projects, implemented by specialised agencies, and used proven approaches. The IOB policy review on SRHR (2013) concluded that Dutch support to the health sector and SRHR in Tanzania, mostly through sector budget support and basket funding, has helped to decrease child and maternal mortality. Progress on MDG indicators was related to improved health resources in combination with a decentralised health system (Masanja et al., 2008). Through the HBF, support to NGOs such as CCBRT, PSI and AMREF and technical support by the health specialist of the embassy, Dutch assistance had an important impact on the health sector in the country, especially at the local level. The Dutch exit had a direct impact on AMREF, PSI, while continued support from the Netherlands would have helped CCBRT to extend its activities.

In spite of all efforts, the country is unlikely to reach the 2030 target of 140 maternal deaths per 100,000 livebirths (Afnan-Holmnes et al., 2015). Funding by GoT has increased, but the sector still faces serious challenges. With 5.5 doctors, nurses and midwives per 10,000 people the human workforce density is 50% too low. Remote areas are the most affected. Coverage remains low for family planning methods. The programmes have not received enough attention and have not been scaled up (Afnan-Holmes et al., 2015).

In an impressive paper, published in 2013, the Lancet Commission estimated the costs and benefits of achieving dramatic health gains by 2035 (Jamison et al., 2013). These estimates are based on an extensive review of rigorous empirical research and include estimates for individual low-income countries. For Tanzania, the authors calculated at the time that it would cost an additional USD 1.4 billion to avert 170,000 deaths in 2015, or USD 8,310 per averted death (or USD 27 per capita in Tanzania). In these calculations, most of the (incremental) costs are health systems costs, with main components for skilled health workers and infrastructure. According to the authors, these investments are important for ensuring a well-functioning health system platform for service delivery that not only tackles infections and reproductive, maternal, newborn and child health (RMNCH) disorders, but also other long-term challenges. In addition, the authors concluded that the returns on investing in health are very high: reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries.

The results could be used to assess the impact of Dutch withdrawal in the health sector, as Dutch support (to the health basket and SRHR) focused on the areas of intervention addressed by the commission. Much of the Dutch contribution was used for basic health services, especially maternal, newborn and child health, through the health basket. Basic health facilities are now facing severe shortages and there is no money for essential drugs. In addition, the Dutch health expert played an important role in the dialogue and often boosted new initiatives. The Dutch exit left the development partner group weakened, which had a negative impact on the sector dialogue. The contribution to the CCBRT referral Maternity & Newborn Hospital helped CCBRT to lobby for funds from other development partners and the private sector, which therefore gave the hospital more long-term

sustainability. Fistula repair helps to reduce maternal morbidity and mortality. Indeed, the PSI project helped to reduce maternal and neonatal mortality and morbidity. Sustained malaria control is effective in reducing child mortality, but it is also costly, and depends on continued political and donor support. Therefore, as an overall estimate, one could say that the continuation of Dutch support to the health sector, on average about USD 34 million, could have saved about 4,000 lives (annually), in addition to the improved health of a much larger group of people as a result of improved access to essential drugs at the local level and better functioning health posts. These are especially vulnerable groups: women and children.[32]

6.5 Conclusions

One of the challenges for the health sector in Tanzania is the government's meagre contribution to the sector (about 10% of the budget and far below the Abuja target of 15%), even though resource allocation to health has increased over time. In addition, the trend at the moment is one of decreasing external resources, especially resources that are not earmarked, even though earmarked (project) support is highly volatile. The budget has increased significantly but most of it went into personal emoluments.

As a major donor to the health basket, to SRHR programmes and programmes to fight HIV/AIDS and malaria, the Netherlands has helped to improve service delivery (e.g. increase health facility attendance, attended births, vaccination coverage and malaria, tuberculosis and HIV/AIDS prevention and treatment) and reduce infant and child mortality. Moreover, the Netherlands played an important role in the sector dialogue. The Dutch exit was problematic because of the existence of severe shortages, the loss of highly qualified sector expertise and the withdrawal of other development partners. The Netherlands did focus on its financial obligations, but much less on the consequences of the exit. An overall estimate suggests that the continuation of Dutch support to the health sector, including general budget support on average about USD 34 million, could have saved about 4,000 lives (annually), in addition to improving the health of a much larger group of people by providing better access to essential drugs at the local level and better functioning health posts.

[32] This total includes USD 28 million support to the health sector and USD 6 million general budget support (see chapter 4). Using data for 2010, the synthesis report for tis evaluation gives an estimate of 3,600 saved lives.

7

Summary and conclusions

The joint exit evaluation of 2008 specified a number of recommendations for donors who intended to end their aid relationship in a specific country. The Netherlands wanted to observe these recommendations when it decided in 2011 to phase out the delegated bilateral aid relationship with Tanzania. However, the desire to exit quickly, and the limited and late character of consultations undermined the possibility to comply with the spirit of the recommendations. There was not much consultation with the GoT to discuss an exit strategy or how to phase out the exit, nor with other development partners on how to take over Dutch programmes. Although most obligations have been respected officially, and there was some budget flexibility, the strategy did not sufficiently take into account the interests and institutional capacity of the recipients (government and NGOs). The idea that other stakeholders would take over Dutch programmes was too optimistic. The position of the embassy was weakened, because it had to negotiate with other stakeholders even though the decisions were already final and the embassy therefore had nothing to offer. The exit was not based on an assessment of its consequences. Therefore, the prevention of the loss of capital was not assured.

In spite of considerable economic growth in the country, the Dutch exit has a significant impact. Tanzania will face a serious challenge in coming years to find employment for its fast-growing population. This may have an adverse effect on efforts to reduce poverty and may undermine the effectiveness of pro-poor policies. Major investments are needed. The Tanzanian government has been forced to curtail its budget, including poverty related expenditures, due to a combination of disappointing tax revenues and changes in the composition of aid.[33] Cuts in transfers to local governments have impacted teacher recruitment and the delivery of social services. If the Netherlands had decided to provide general budget support again in 2011, then this would initially have slightly reduced the deficit. In the long run, it would have enabled GoT to increase expenditure, especially in the social sectors. The decision not to provide GBS again has had an impact particularly on the education and health sectors. Rigorous impact evaluations show that this has an impact on enrolment and learning achievements.

One way that the Netherlands has tried to improve service delivery is through its support to the decentralisation programme. For more than 10 years, it has been a key donor supporting local government reform in Tanzania. It played an important role setting up the Local Government Development Grant (LGDG) system in 2005, and in the following years it was the largest donor. The Netherlands also helped to design, fund and implement the Local Government Reform Programme (LGRP), and for many years was co-chair of the Development Partners Group for Local Government. Nevertheless, the Dutch contribution to local government does not mean that the exit had a large impact. When the Netherlands decided to phase out its bilateral cooperation programme, the LGRP faced serious implementation problems and was all but dysfunctional. The collaboration between PMO-RALG and the development partners was difficult. Moreover, it was already agreed upon much earlier that the government would take over the funding of the LGDG.

[33] Donor support for the government and in particular budget support and local government support was partly reduced because of huge challenges in governance including widespread corruption by government actors. Estimates of tax revenues were far too optimistic, but actual revenues are also low because of (illegal) high tax exemptions.

The Dutch exit in the health sector was a major loss, on the other hand, as a result of the severe shortages in the sector, the central Dutch role in the policy dialogue and the withdrawal of other development partners. As a major donor to the health basket, to SRHR programmes and programmes to fight HIV/AIDS and malaria, the Netherlands had made a substantial contribution to improved service delivery (increase in health facility attendance, attended births, vaccination coverage and malaria, tuberculosis and HIV/AIDS prevention and treatment) and the reduction of infant and child mortality. The Netherlands largely observed its financial commitments, but did not devote much attention to the consequences of its country's exit, despite repeated warnings by the Dutch health sector specialist at the embassy in Dar es Salaam. The Dutch withdrawal has had a negative impact on service delivery and the further improvement of the sector. As a result of the Dutch, Norwegian and German exits, as well as reduced contributions by Canada and Denmark, the health basket has gone down from USD 90 million to USD 50 million. Earmarked support, such as from the Global Fund, is decreasing as well. In spite of significant increases in government funding, the health sector faces a major deficit. The new Health Sector Strategic Plan (HSSP IV) for 2015-2020 envisages a funding gap of about USD 250-1,250 million. Public health facilities continue to experience a severe lack of medicine and medical supplies. There is a dramatic drop in the non-salary budget. Performance is going down, leading to significant risks. Local facilities in particular are feeling the impact of a reduction of the HBF. This is having a particularly harsh impact on maternal, newborn and child health care. NGOs, previously supported by the Netherlands, were not able to attract other donors and had to scale down their activities on HIV/AIDS, malaria and SRHR. Therefore, an overall estimate would suggest that the continuation of Dutch support to the health sector, on average about USD 34 million (including USD 6 million GBS), could have saved about 4,000 lives (annually), in addition to improving the health of a much larger group of people via better access to essential drugs at the local level and better functioning health posts.

The Dutch exit also had a strong negative impact on several other supported NGOs, mainly because other development partners were not willing to take over Dutch core funding. These organisations include the institute Research on Poverty Alleviation (REPOA) and the Foundation for Civil Society (FCS). REPOA has not been able to find other donors to replace the Netherlands, and as a result it has a major deficit in its research budget and is now depending more on commissioned research. The latter is having a negative impact on the quality of independent scientific socio-economic and poverty oriented research in the country. FCS has lost three major donors (the Netherlands, Norway and Canada) within two years. This is having important consequences for FCS's budget and scope of activities.

The Netherlands has closed its embassies in other partner countries, such as Zambia, Burkina Faso, Bolivia, Nicaragua and Guatemala. This was not the case in Tanzania. Therefore, in Tanzania it would have been much easier to achieve a more gradual shift from aid to trade by means of a more strategic phasing-out process. A mechanical focus on a maximum of 15 partner countries, rather than on budgetary constraints and the impact of the exit decision, rendered this option impossible.

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Annexes

Annex I Macro-economic indicators

Table I.1 Macro-economic indicators								
	2008	2009	2010	2011	2012	2013	2014	2015
GDP nominal (USD billion)	27.4	28.6	31.4	33.9	39.1	44.3	48.0	44.9
Real GDP growth (%)	5.6	5.4	6.4	7.9	5.1	7.3	7.0	7.0
Inflation (%)	10.3	12.1	6.2	12.7	16.0	7.9	6.1	5.6
Population (million)	42.8	44.2	45.6	47.1	48.6	50.2	51.8	53.5
GDP per capita (USD)	658	665	709	740	828	909	955	865
USD million:								
Exports	5,104	4,964	5,888	7,032	8,320	7,825	9,357	9,331
Imports	8,426	7,509	9,149	12,209	12,943	13,774	14,357	12,903
Trade balance	-3,322	-2,545	-3,261	-5,177	-4,623	-5,949	-5,000	-3,572
Remittances	37	40	344	410	390	382	389	389
Current account balance	-2,577	-1,810	-2,211	-4,381	-3,764	-4,988	-5,017	-3,312
Foreign Direct Investment	1,383	953	1,813	1,229	1,800	2,087	2,045	1,961
%of GDP:								
Exports	18.6	17.4	18.7	20.8	21.3	17.7	19.5	20.8
Imports	-30.8	-26.3	-29.1	-36.0	-33.1	-31.1	-29.9	-28.7
Trade balance	-12.1	-8.9	-10.4	-15.3	-11.8	-13.4	-10.4	-8.0
Current account balance	-9.4	-6.3	-7.0	-12.9	-9.6	-11.3	-10.4	-7.4
FDI	5.1	3.3	5.8	3.6	4.6	4.7	4.3	4.4

** Figures may not sum to totals due to rounding.*
Source: World Bank (WDI).

Table I.2 ODA as % of GDP							
	2008	2009	2010	2011	2012	2013	2014
Bilateral and EU:							
Grants	5.5	5.3	5.7	5.2	4.7	4.8	2.9
Loans	0.1	0.2	0.2	0.3	0.2	0.3	0.4
Total bilateral	5.6	5.4	5.9	5.5	4.9	5.1	3.3
Multilateral:							
Grants	1.0	0.7	0.7	0.6	0.6	0.7	0.7
Loans	1.8	4.0	2.8	1.3	1.8	2.4	1.7
Total multilateral	2.8	4.7	3.5	1.8	2.3	3.1	2.4
Total ODA:							
Grants	6.5	5.9	6.4	5.8	5.2	5.5	3.6
Loans	1.9	4.2	2.9	1.5	2.0	2.7	2.1
Total	8.4	10.1	9.4	7.3	7.2	8.2	5.6

** Figures may not sum tot total due to rounding.*
Source: Calculated from OECD/DAC and World Bank data (WDI, GDP).

Table I.3 External support to the government budget								
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
USD million:								
Budget support	805	713	841	564	615	548	628	502
Basket funds	248	280	311	348	301	283	246	165
Projects funds to government	731	529	655	613	570	325	441	436
Debt relief	91	52	29	123	141	135	132	
Total	**1,876**	**1,574**	**1,835**	**1,648**	**1,626**	**1,292**	**1,448**	**1,103**
Grants	1,314	1,021	921	880	1,034	1,137	946	898
Loans	546	844	1,277	966	700	824	772	885
As % of government expenditure:								
Domestic revenue	69	64	57	61	67	66	73	75
Grants	21	17	17	17	17	11	13	8
Deficit after grants	10	19	26	22	16	23	14	17
As % of GDP:								
Government expenditure	17.7	18.9	19.9	19.4	18.9	20.6	18.5	17.1
Domestic revenue	11.5	11.7	11.5	11.8	12.7	12.9	13.5	12.8
Grants	5.0	3.9	3.5	3.5	3.3	2.6	2.1	1.2
Budget balance (after grants)	-1.2	-3.5	-4.8	-5.0	-3.6	-5.0	-3.3	-3.3

Source: Ministry of Finance; BoT; IMF; author's calculations.

Table I.4	Disbursements of general budget support 2007-2008 – 2014-2015 (in USD million)							
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015*
AfDB	80	89	55	0	39	53	117	78
Canada			14	25	10	13	5	5
Denmark	14	18	16	16	17	20	22	20
DFID (UK)	225	166	152	163	78	80	70	58
EU	35	46	76	74	81	58	60	56
Finland	12	19	18	19	20	13	14	14
Germany (via WB)	21	11	12	14	14	8	8	6
Ireland	17	18	15	14	13	11	10	
Japan (via WB)	22	20	19		18		14	15
Netherlands	72	42						
Norway	42	37	38	43	45	26	24	
Sweden	53	53	46	46	55	61	59	32
Switzerland	5	5	6					
World Bank	204	144	327	118	100	75	84	100
Total GBS	**801**	**668**	**795**	**532**	**490**	**417**	**487**	**383**
Total government expenditure	4,335	5,264	5,712	5,913	6,842	8,299	8,318	8,279
GBS as % of government expenditure	18.5%	12.7%	13.9%	8.4%	7.2%	5.0%	5.9%	4.6%

** Planned disbursements*

Sources of GBS data: Figures from FY 2008-2009 and FY 2011-2012 from Joint Evaluation of Budget Support to Tanzania, p.3 (2013). Figures from FY 2012-2013, FY 2013-2014, and FY 2014-2015 provided by the Ministry of Finance and Planning.

Source of total government expenditures: IMF reviews.

Annex II List of interviewees

Prof. Adolf F. Mkende	Deputy Permanent Secretary, Ministry of Finance
Mr. Emmanuel M. Tutuba	Assistant Commissioner for Budget, Ministry of Finance
Mrs. Mameltha K. Mutagwaba	Assistant-Commissioner Bilateral Aid, Ministry of Finance
Mr. Peniel Lyimo	Deputy Chief Executive Officer, President's Office
Mr. Joseph E. Sokoine	Ambassador, Director for the Department of Europe and Americas, Ministry of Foreign Affairs and International Cooperation
Mr. Josibert Rubona	Director Policy and Planning, Ministry of Health and Social Welfare
Mr. Andy O-Connell	PPP Advisor, Ministry of Health and Social Welfare
Mr. Claude John	Ministry of Health and Social Welfare
Mr. Jaap Frederiks	Ambassador, Royal Netherlands Embassy Dar es Salaam
Mr. Paul Gosselink	Former Senior Advisor, Office for International Cooperation
Mrs. Teddy Mcha	Senior Advisor Economic Department, Royal Netherlands Embassy Dar es Salaam
Mrs. Hinke Nauta	Deputy Head of Mission, Royal Netherlands Embassy Dar es Salaam
Dr. Rik Peeperkorn	Former Health Specialist, Royal Netherlands Embassy Dar es Salaam
Mrs. Renet van der Waals	Former Head of Development Cooperation, Royal Netherlands Embassy Dar es Salaam
Mrs. Isabelle Wittoek	Head of cooperation, Embassy of the Kingdom of Belgium
Mr. Cranmer Chiduo	Senior Programme Officer, BTC Tanzania, Belgian Development Agency
Mrs. Joanne Pindera	Senior Programme Analyst, High Commission of Canada
Mrs. Michelle Roland, MD	Country Director, CDC Tanzania
Mr. Sriyanjit Perera	HIS Advisor CTS Global Inc., Assigned to: Center for Disease Control Prevention, Tanzania
Mrs. Mette Melson	Counsellor Economics and Public Financial Management, Embassy of Denmark
Mrs. Liz Taylor	MDG Team Leader, DFID Tanzania
Mr. Eric Beaume	Head of Operations, EU Delegation in Tanzania
Mrs. Kati Manner	Head of Cooperation, Embassy of Finland
Mrs. Claudia Imwolde-Kraemer	Head of Cooperation, Embassy of the Federal Republic of Germany
Mr. Pascal Kanyinyi	Senior Project Officer Health, KFW
Mrs. Aran Corrigan	Senior Governance Advisor, Irish Aid
Mrs. Anne Kristin Hermansen	Deputy Head of Mission, Royal Norwegian Embassy

Mrs. Maria van Berlekom	Head of Development Cooperation, Embassy of Sweden
Dr. Sudha Sharma	Chief Health and Nutrition, UNICEF
Mrs. Susna De, M.SC,MPH	Health Systems Team Lead, USAID
Dr. Rufaro R.Chatora	WHO Representative for Africa
Dr. Festus Ilako	Country Director AMREF, Tanzania
Mr. Erwin Telemans	Chief Executive Officer CCBRT
Mr. John Ulanga	The Foundation for Civil society
Mrs. Melissa Higbie	Director of Programs, PSI Tanzania
Prof. Samuel Wangwe	Executive director REPOA
Dr. Donald Mmari	Director of Research on Growth and Development / Executive Director REPOA
Mr. Alison Muembei	Director of Finance and Administration, REPOA
Mr. Niko Pater	Country Director, SNV Tanzania
Mrs. Julie Adkins	Senior Advisor Local Governance, SNV Tanzania

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Photo chapter 1: Young Maasai girls during the Alternative Rite of Passage ceremony in Kilindi. Photo: AMREF Tanzania.
Photo chapter 2: Women discussing family planning methods. Photo: PSI Tanzania.
Photo chapter 3: Dr. Donald Mmari, Executive director of REPOA at a conference of IOB (the Netherlands), the German Institute for Development Evaluation, and the Evaluation Department of the Belgian Ministry of Foreign Affairs, Foreign Trade and Development Cooperation in Berlin in 2015. Photo: André Wagenzik.
Photo chapter 4: Professor Benno Ndulu, Governor of the Bank of Tanzania at a conference on budget support in The Hague in 2012. Organised by IOB and the Amsterdam Institute for International Development (AIID).
Photo chapter 5: Child labour in Tanzania. Photo FCS Tanzania.
Photo chapter 6: Father and son at the CCBRT hospital in Dar es Salaam. Photo: Sala Lewis (CCBRT).
Photo chapter 7: A Tanzanian woman walks past a billboard for the ruling party's presidential candidate John Magufuli, in Dar es Salaam, Tanzania, October 2015. Magufuli won the elections and is the country's fifth president. Photo: Khalfan Said (Associated Press).

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