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Effective Technical Cooperation for Capacity Development

Tanzania Country Case Study

Joint Study on Effective TC for CD

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Capacity Development Country Case Study

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ABBREVIATIONS AND ACRONYMS

AfDB	African Development Bank
AMC	Arusha Municipal Council
ARVs	Anti-Retro-Viral Drugs
ASDP	Agriculture Sector Development Programme
ASDS	Agriculture Sector Development Strategy
ASLMs	Agriculture Sector Leading Ministries
CAS	Country Assistance Strategy
CCHP	Comprehensive Council Health Plans
CD	Capacity Development
CDC	Centre for Disease Control
CEDHA	Centre for Educational Development in Health, Arusha
CHMT	Council Health Management Team
CIDA	Canadian International Development Agency
CMR	Child Mortality Rate
CPs	Counterparts
CSO	Civil Society Organisation
CSSC	Christian Social Services Commission
DAC	Development Assistance Committee
Danida	Danish International Development Agency
DoL	Division of Labour
DPs	Development Partners
DPG	Development Partners' Group
ECA	Economic Commission for Africa
EPI	Expanded Programme on Immunisation
EU	European Union
FBOs	Faith Based Organisation
F/Y	Financial Year
GBS	General Budget Support
GDP	Gross Domestic Product
GoT	Government of Tanzania
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
HSBF	Health Sector Basket Fund
HSR	Health Sector Reforms

HSRP	Health Sector Reform Programme
HSRS	Health Sector Reform Secretariat
HSSP	Health Sector Support Programme
IDRC	International Development Research Centre
IFAD	International Food and Agricultural Development
IMG	Independent Monitoring Group
JAST	Joint Assistance Strategy for Tanzania
JICA	Japan International Cooperation Agency
JHCPO	JICA Health Cooperation Planning Office
JIR	Joint Implementation Review
JMG	Joint Management Group
JPD	Joint Programme Document
KATC	Kilimanjaro Agriculture Training Centre
LGA	Local Government Authorities
LGRP	Local Government Reform Programme
LSRP	Legal Sector Reform Programme
MAFC	Ministry of Agriculture, Food Security and Cooperatives
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MHP	Morogoro Health Project
MHS	Municipal Health Secretary
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania [National Strategy for Growth and Reduction of Poverty in Tanzania]
MMR	Maternal Mortality Rate
MO	Medical Officer
MOFEA	Ministry of Finance and Economic Affairs
MOFP	Ministry of Finance and Planning
MOHSW	Ministry of Health & Social Welfare
MOU	Memorandum of Understanding
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
MUCHS	Muhimbili College of Health Sciences
MUHAS	Muhimbili University of Health and Allied Sciences
NACSAP	National Anti-Corruption Strategy and Action Plan
NAO	National Audit Office

NETT	National Expansion of TEHIP Tools and Strategies
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
NORAD	Norwegian Agency for International Development
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
PADEP	Participatory Agriculture Development Empowerment Project
PEFAR	Public Expenditure and Financial Accountability Review
PER	Public Expenditure Review
PFMRP	Public Financial Management Reform Programme
PHC	Primary Health Care
PHDR	Poverty and Human Development Report
PHS	Principal Health Secretary
PIU	Project Implementation Unit
PMO-RALG	Prime Minister's Office - Regional Administration and Local Government
PO-PSM	President's Office – Public Service Management
PSRP	Public Service Reform Programme
RHMT	Regional Health Management Team
RHS	Regional Health Secretary
SBAS	Strategic Budget Allocation System
SBF	Sector Basket Fund
Sida	Swedish International Development Agency
SWAp	Sector Wide Approach
TA	Technical Assistance
TAS	Tanzania Assistance Strategy
TC	Technical Cooperation
TEHIP	Tanzania Essential Health Interventions Project
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollars
VAEO	Village Agriculture Extension Officers
WB	World Bank
WG	Working Group
WHO	World Health Organization

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1. BACKGROUND

1.1. REVIEW CONTEXT AND OBJECTIVES

This Review is part of a wider international **Joint Study on Effective Cooperation for Capacity Development**, covering five sub-Saharan African countries and six Asian countries. A local Joint Management Group (JMG), consisting of members drawn from GoT and DPs, was established to supervise the drafting of the Review by a team of local consultants. The JMG was assisted by a team of two international consultants who provided technical guidance and acted as peer reviewers to the team of local consultants. The Review has greatly benefited from comments and guidance of the JMG.

The overall objective of the Review is to synthesise and update existing information about technical cooperation for capacity development in Tanzania. The Review also documents specific cases of good practice for TC for CD and lessons learned in the agricultural and health sectors.

The Review will particularly provide a valuable input into the planned OECD/DAC Accra High Level Forum. It is also intended to provide valuable input into the ongoing preparation of a **Tanzania Technical Assistance Policy Framework**.

1.2. REVIEW RATIONALE

Capacity development (CD) is not easy to define. Contrary to conventional wisdom, CD is not a sheer technical process, involving simple transfer of knowledge and skills or organisational models from developed to developing countries. According to the OECD/DAC (2006), CD is "the process whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time" to manage their affairs successfully. This definition is, however, silent about capacity utilisation as a dimension of CD. Taking this dimension into account, CD is a process of change and capacity utilisation at three levels: individuals, organisations/institutions, and society. This review deliberately emphasises the importance of capacity utilisation because it is often neglected. Therefore CD comprises: (i) enhancing the knowledge and skills of individuals, (ii) improving the quality of organisations in which individuals work, (iii) developing the enabling

environment – the structures of power and influence and the institutions – in which they are embedded, and (iv) improving incentives and governance for optimal capacity utilisation. As articulated in the 2005 Paris Declaration, CD is essentially an endogenous process, strongly led from within the country, with DPs playing a supporting role.

Technical Cooperation (TC) for CD includes international assistance for consultants, experts, scholarships, training, and institutional twinning and networking. This review focuses on technical cooperation support for CD in the Tanzanian public sector. This sector receives the bulk of TC for CD in the country.

The Review attempts to assess the overall impact of TC on CD efforts in Tanzania in recent years. The Review is about the experience in recent years of developing management capacities through TC in Tanzania's public sector in general and in agriculture and health in particular.

There is general recognition that CD is a fundamental component of development and, hence, a key element in achieving the MDGs and Vision 2025 goals (as operationalised in MKUKUTA and sector policies and programmes) in Tanzania. Meeting the MDGs and MKUKUTA objectives is dependent on adequate CD, without which even increased financial support to programmes associated with these initiatives will not succeed. CD is about how new resources are used and managed, the commitment of leaders, the ability of the organisational structures to deliver benefits, and the broader policy and institutional environment of facilitation and empowerment. This is now recognised by both GoT and DPs.

1.3. REVIEW METHODOLOGY AND APPROACH

To ensure consistence between the Tanzania Review and other Country Reviews under the Joint Study, the major approaches and the specific analytical guidelines suggested in the Reference Guide for Review Work were adapted.

The Review used the criteria specified in Box 1 to gauge TC effectiveness. In particular, the cases of good practice were premised on meeting these conditions to a large extent. This does not mean that all cases fully satisfied all these necessary conditions.

Availability and quality of data from both GoT and DP sources were a daunting challenge. In both cases, it was almost impossible to ascertain the amount of TC resources. Lack of transparency for TC expenditures still persists among the DPs. This made it almost impossible to estimate the volumes and patterns of TC for CD in Tanzania. Since doing nothing about this shortcoming was not a viable option, estimates of TC were derived from ODA data contained in public documents. Thus the estimated volumes and patterns of TC included in this review are, at best, crude indicators. With this constraint, it was not possible to compute reliable types, patterns and trends in TC. This shortcoming affected the situation analysis at sector level and the case studies as well. Relying on ODA data to derive TC

estimates does not mean or imply equating ODA or development assistance to TC. The former usually embeds TC and, hence, determines its delivery mechanisms to a large extent.

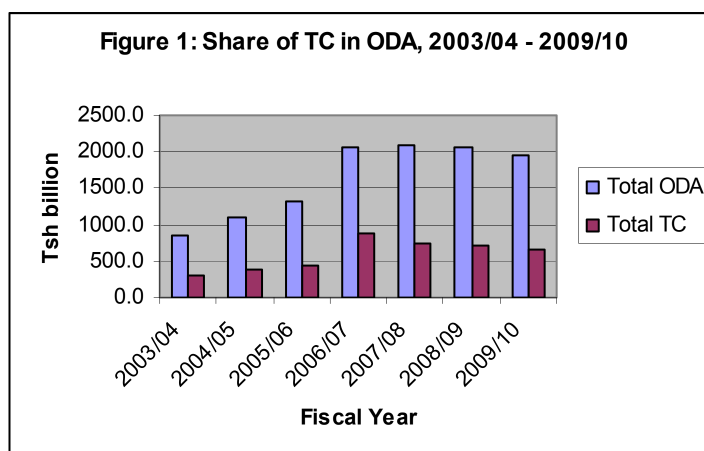
Box 1: Conditions Necessary for TC Effectiveness

- *Planning:* necessary conditions are in place to ensure willingness and ability for country-led planning of sector/thematic capacity development.
- *Design:* necessary conditions are in place to allow sufficient flexibility in TC design and provision to attain the expected results.
- *Change Management:* necessary conditions are in place for sustaining organisational change management process and expected results.
- *Implementation:* necessary conditions are in place for ensuring country-led control and management of TC.
- *Complementarities:* necessary conditions are in place for ensuring that TC provision will complement various forms of CD support and development assistance in achieving expected results.
- *Organisational Learning:* necessary conditions are in place for ensuring that organisation can learn and change in order to achieve expected results.

2. OVERALL SITUATION ANALYSIS AT NATIONAL LEVEL

2.1. TECHNICAL COOPERATION TRENDS AND PATTERNS

Making robust analysis of TC trends and types is not possible in Tanzania due to lack of reliable data on TC. Firstly, development assistance (aid) data in MTEF has not been able to capture the full picture of entire aid, in spite of relatively better coverage in recent years. Secondly, most of the past aid data has not provided disaggregated information on TC. Partial information on TC became available from 2006, when DPs started to submit aid data to the MTEF process in which a newly added category for free standing TC was incorporated. Even so, the MTEF submission has not been able to clearly disaggregate TC/TA that is provided as subcomponents of larger aid projects. *Thirdly, in the Tanzanian context where an increasing proportion of aid is being provided through budgetary aid instruments, such as general budget support and sector/common basket funds, quite large parts of CD are financed using those budgetary aid mechanisms.* This situation made it virtually impossible for this study to disaggregate TA, training and other TC-related activities through the analysis of voluminous MTEF of all MDAs and LGAs within the limited time available. As a result, the estimated volumes and patterns of TC for CD included in this review are, at best, crude indicators. In future, priority should be given by both GoT and DPs to ensuring transparency in the delivery and accounting of TC expenditures in the key government and aid mechanisms, including MTEF.



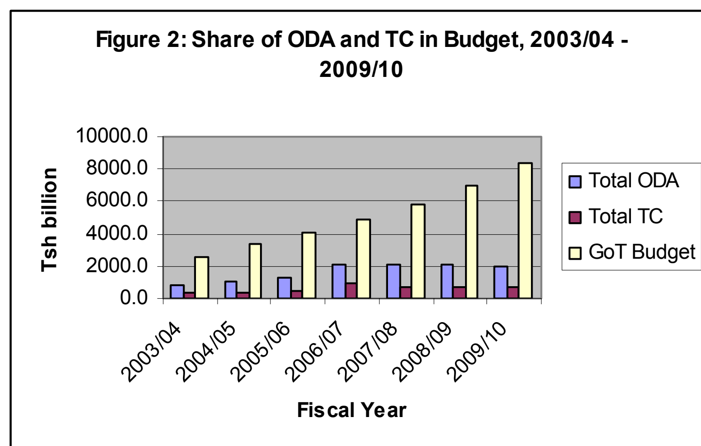
Source: calculations based on information in MTEF and TAS implementation reports of various years

The role of DPs in supporting locally-owned processes and systems to support improvements in CD in the public sector has been considerable. However, due to quality problems in the past TC

data, the TC data contained in the TAS implementation reports and MTEF documents for 2003/04 to 2007/08 was used to gauge the role and commitment of DPs in supporting CD. Even in these two ODA frameworks, transparency on TC support by DPs is still dubious. Notwithstanding, this is, perhaps, the best basis for analysing the amount, patterns and trends of TC for CD in the country during the review period.

The national budget is financed by GoT and DPs. The latter provide assistance through ODA. TC is often subtly embedded in ODA. Its share of ODA is estimated to average 36 percent during 2003-2007. DPs usually provide TC through the ODA delivery mechanisms (see below). The annual amount of TC virtually doubled, in current terms, between 2003 and 2009. However, it should be emphasised that the estimates in the outer years are only indicative projections, which are likely to change significantly. TC logically kept pace with the increase in ODA (Figure 1). In absolute terms, TC is estimated to amount to 0.5 trillion shillings by 2010, when total ODA amount will exceed two trillion shillings. A key factor of TC's relatively slow growth could be the difficulty of reflecting TC support in ODA due to low predictability and less transparency. The cumulative effect of such factors is that TC for CD is apparently not accorded the focus and priority it deserves within the context of ODA, in which it is usually embedded. It is often considered as residual.

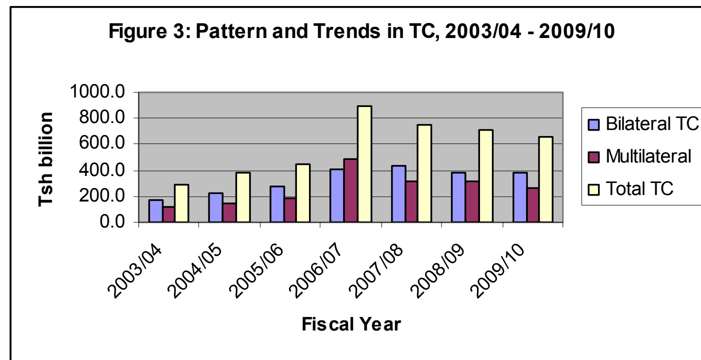
Figure 2 shows the pattern and trends in financing the national budget during 2003/04-2009/10. It is evident that ODA continued to play a key role in financing the national budget. The relatively large share of ODA in the national budget in the past, suggests that TC might have equally played a significant role in the country's capacity development. Needless to emphasise, CD is financed by both TC (from DPs) and GoT contributions. However, the TC role may be declining, leaving GoT contributions to play a significantly increasing role in financing CD. This may not happen if ODA and TC increase more significantly than projected. Local training and local experts account for the bulk of GoT contribution to CD.



Source: calculations based on information in MTEF and TAS implementation reports of various years

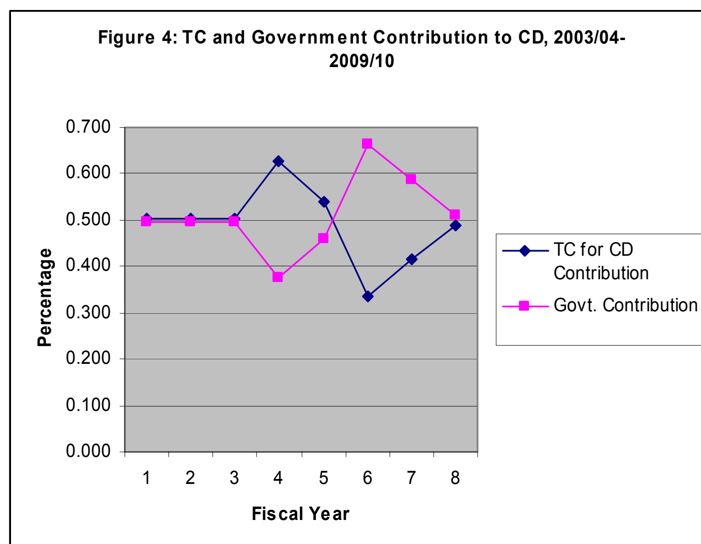
The amount of GoT contributions allocated to CD is not known. It was not possible to discern from the MTEF, TAS/JAS and national budget documents the amounts allocated to CD. However, it was assumed that the bulk of TC is earmarked and used for CD, especially through foreign consultants, experts, and training scholarships.

Figure 3 depicts the TC patterns and trends during 2003/04-2009/10, *though the estimates for years after 2007 may less reliable, but illustrative*. However, unlike multilateral TC, bilateral TC has inherent higher risks and is more subject to political whims of individual DPs. This perhaps explains the instability of TC during the review period as depicted in **Figure 4.** In addition, the separate presentation of multilateral and bilateral TC is justified by the perception that the design and delivery of the former tend to be more flexible than that of the latter. For example, bilateral DPs tend to prefer TC either tied to a project or free-standing.



Source: calculations based on information in MTEF and TAS implementation reports of various years

Figure 4 suggests that the role of GoT and DPs in financing was quite erratic. This seemingly fluctuating TC might be due to the imprecise nature of aid projections, rather than reflecting reality. However, the instability in aid and TC flows is a well known problem in Tanzania. It is currently being addressed under the JAST, to make development assistance and TC more predictable and effective. Since most CD is medium- to long-term in nature, GoT has found itself being compelled to fill any gaps left by falling disbursements from TC. Hence the peaks and dips depicted in **Figure 4.**



Source: calculations based on information in MTEF and TAS implementation reports of various years

It was not possible to analyse and present TC by types, such as consultants, experts, training, and scholarships, because these are not specified in the databases used for the review. This data shortcoming must be addressed in the near future, possibly through the ongoing effort to formulate a national policy framework for TC.

2.2. POLICY ENVIRONMENT FOR TECHNICAL COOPERATION

Tanzania's long term development agenda is laid out in Vision 2025. This Vision has been operationalised through two successive medium term strategies, starting with the Poverty Reduction Strategy (PRS) and its successor the current National Strategy for Growth and Reduction of Poverty (NSGRP) – popularly known by its Swahili acronym: MKUKUTA. The distinctive feature of MKUKUTA is that the priority development objectives and targets are grouped into three multi-sector clusters of outcomes, namely (i) growth of the economy and reduction of income poverty; (ii) improvement of quality of life and social wellbeing, and (iii) governance and accountability.

Box 2: MKUKUTA Goals and Priorities

MKUKUTA was completed in June 2005 for implementation over the period 2005-2010. It is the successor to the Poverty Reduction Strategy Paper. It puts into operation Tanzania's *Development Vision 2025*. It emphasises growth and long term strategy for development and poverty reduction, as well as reducing the country's aid dependence. MKUKUTA focuses on equitable growth and governance. It is an instrument for mobilising efforts and resources towards targeted poverty reduction outcomes. MKUKUTA includes targets and poverty reduction outcomes which are consistent with, but more ambitious than, the Millennium Development Goals (MDGs). It is based on an outcome-oriented approach with emphasis on cross-sector collaboration and inter-sector linkages and synergies.

MKUKUTA was formulated using extensive consultations within government, with Parliament, civil society, faith based groups, private sector, districts and villages, and development partners. Its underlying principles include: national ownership, political commitment to democratisation and human rights, maintenance of macroeconomic and structural reforms, building on sector strategies and cross-sector collaboration, building local partnerships for citizens to engage in policy dialogue, harmonisation of TC, equitable sharing of benefits, sustainable development, strengthening of macroeconomic links and decentralisation, and mainstreaming cross-cutting issues.

MKUKUTA identifies three clusters of broad outcomes: (i) growth of the economy and reduction of income poverty; (ii) improvement of quality of life and social wellbeing, and (iii) governance and accountability. Each cluster has a set of goals and targets, as well as related cluster strategies. GoT recognises that the monitoring and evaluation of MKUKUTA are vital in promoting accountability and in assessing developmental effectiveness. Tanzania has made considerable efforts to develop its monitoring and evaluation systems and practices, including the strengthening of the statistical system, although considerable work remains to be done.

Development and implementation of MKUKUTA are being undertaken in the context of significant cross-cutting and sector reforms, including the overhaul of national planning and budgeting systems. These changes are intended to facilitate results-based management, increased domestic accountability and greater alignment and harmonisation of external financing. GoT has prioritised capacity development in all MKUKUTA clusters to boost ownership of not only the policy content but also of the instruments and processes for effective implementation of MKUKUTA.

The existence of the strategic development frameworks (MKUKUTA) and the ongoing reforms constitute a reasonably solid policy platform for provision of TC in the country. The DPs are therefore supporting these reform programmes through development assistance and TC. Box 2 summarises the main features of MKUKUTA.

Within the overall policy framework of Vision 2025 and MKUKUTA, government has also been strengthening sector and thematic policy and the programme framework. In terms of national systemic capacity development, the government is striving to strengthen cross-cutting core reform programmes such as the Public Service Reform Programme (PSRP) and Local Government Reform Programme (LGRP), many of which have their origin in mid-90s. Also, GoT has also been strengthening policy and programmes at sector level such as the Health Sector Reform and Agricultural Sector Development Strategy/Programme. As the names suggest, these sector policy and programmes strongly feature sector reforms in close linkage with public sector-wide crosscutting core reforms.

The reforms programmes are essentially change management processes embedding CD. They focus on CD-enhancing interventions, but their impact is inherently long-term. Nevertheless, the impact of the reforms, in terms of achieving MKUKUTA cluster outcomes, has been evidently considerable, albeit vulnerable and fraught with strategic challenges. For example, regarding cluster 1, Tanzania's economic growth since 2000 has averaged 5.8 percent, reaching 6.8 percent in 2005. Agriculture, where the majority of the poor are found, grew more slowly, at an average annual rate of 5.1 percent. All these growth rates are high by regional standards.

Decentralisation of service delivery, as engendered by the ongoing LGR, has critical implications for the direction of capacity development in this country and hence the delivery of TC at national, districts and grassroots levels. The decentralisation of planning and implementation of public programmes and services from the central Government ministries to Local Government Authorities (LGAs) has dramatically altered the institutional framework for providing public services in the country. The LGAs are increasingly playing larger roles and responsibilities in public service delivery (including agricultural and health services) to local communities. These larger roles are also complemented by more discretionary financial resources transferred to LGAs through the Block Grant System and the Local Government Capital Development Grants (LGCDG) System. Under both systems, all LGAs receive a capacity building grant irrespective of whether they meet the minimum conditions for accessing the other grant top-ups. This grant is used for CD activities to enable respective LGAs meet the minimum conditions and to improve the performance criteria in subsequent years to access higher resource transfers.

There are several challenges facing the decentralisation process in the country. These challenges are partly inherent in the infancy of the decentralisation process and partly due to structural problems. The key teething challenges include: continuing mismatch between responsibilities and funding in spite of proportional and absolute increase of discretionary financial resources in recent years, competition for resource allocation and institutional

capacity failure. Included in the latter are underutilisation of existing capacity and often lack of strategic capacity development plans at LGA level. During the perception survey, most respondents acknowledged that capacity underutilisation in the public sector in general and in the LGAs is still pervasive. On average, it was reported that most workers put in six hours of productive work day. This implies about 70 percent capacity utilisation. The causes of this low rate of capacity utilisation may be complex and require detailed investigation.

2.3. OVERALL OPERATIONAL ENVIRONMENT FOR TECHNICAL COOPERATION

Tanzania is considered a leader in coordination and harmonisation of development assistance (in which TC is embedded), with joint GoT-DP commitments, undertakings and activities dating back to 1997. GoT has taken initiatives to revamp its relationship with DPs with a view to enhancing its ownership of and leadership in the national development agenda and process. As a sequel to the Helleiner Report's (1995) recommendations on how development assistance could be improved, GoT and DPs agreed in 1997 to implement the recommendations. They agreed to redefine the development cooperation relationship with respect to: (i) managing development assistance, (ii) local ownership of the development process to include other stakeholders, (iii) enhancing transparency and accountability in delivery and utilisation of development assistance, and (iv) GoT to provide leadership in designing and managing the development process – all with a view to enhancing both domestic resources and aid effectiveness. These roles were clarified and refined in the Tanzania Assistance Strategy (TAS) launched in 2002. Following the end cycle of the TAS implementation and its review in 2005 and the introduction of MKUKUTA, the GoT and DPs working with other stakeholders started the formulation of a Joint Assistance Strategy for Tanzania (JAST), which succeeded the TAS and started its implementation in July 2006, and for which the MoU was signed in December 2006. JAST provides a five-year framework that guides the management of development cooperation.

Meanwhile, both GoT and DPs have collaboratively designed and implemented several mechanisms for enhancing the delivery, planning, coordination, harmonisation, utilisation and monitoring of development assistance in the country. TC has been partly piggy-backed onto these mechanisms as it does not have its own mechanisms for these purposes. This raises the question as to whether TC management mechanisms can be separate from the development assistance management mechanisms! The mechanisms have included the TAS process, JAST process, General Budget Support (GBS) process, Sector-wide Approaches (SWAps), Sector/Common Basket Funds (SBF) process, Joint Implementation Reviews (JIRs), Public Expenditure Reviews (PER) and Joint Programming. In addition, at the working or sector level, several Joint Working Groups have been established. All these various mechanisms have provided frameworks for enhancing development assistance (and, hence, TC) coordination and transparency as well as for promoting harmonisation, partnerships, country ownership and leadership in the development process. For example, the JAST process provides a five-year rolling framework that articulates the national

development priorities, policy framework for managing external resources, best practices in development cooperation, framework for monitoring its implementation, and priority interventions. The JAST has moved development cooperation management to a higher level by consolidating country ownership, leadership and accountability in accordance with the domestic and international commitments for development and aid effectiveness, including the Tanzania Assistance Strategy (2002), the Monterrey Consensus on Financing for Development (2002), the Rome Declaration on Aid Harmonisation (2003), the Marrakech Memorandum on Managing for Results (2004) and the Paris Declaration on Aid Effectiveness (2005). It also provides similar opportunities to TC.

To enhance the effectiveness of the development cooperation relationship (including the management of external resources of which TC is part), a Development Partners Group (DPG) has been established to support GoT coordination efforts including the preparation of a results-based Joint Programming Document (JPD). JPD is essentially a DP response to Tanzania's results-based Poverty Reduction Strategies (MKUKUTA) and the JAST. It provides a common framework for DPs to provide and align their support (external resources) with the GoT national budget process and priorities. The JPD's objective is to reduce transaction costs to GoT, and to continue improving the alignment of development partner support with MKUKUTA**.** The JPD reflects DPG planned support and commitments to Tanzania on TC effectiveness over the remaining years of MKUKUTA implementation.

There are currently several mechanisms for delivery of TC in Tanzania. These include the following forms of external support:

- Free standing TC;
- TC provided as a sub-component of large project financing;
- TC provided through pooled funding;
- TC provided as part of the sector/common basket funding.

Among these, TC delivered within an individual project framework is still the most common and often a preferred modality among many DPs in the country. It is estimated that nearly 40 percent of the total TC to Tanzania is still tied to the project delivery modality. Free-standing TC and studies (analytic work) are still a major form of TC delivery among UN specialised agencies as well as some bilateral TC agencies. TC support to sector programmes has become popular with the onset of sector reform programmes after 1996. Sector programme support is underpinned by *Sector-Wide Approaches* (SWAps) for development planning and financing. SWAps have, in turn, engendered *Sector Basket Funds* (SBFs) as a mechanism for pooling and coordinated financing of sector development programmes. There are currently 14 SWAps with operating SBFs in the country. Most of these are associated with the ongoing cross-cutting and sector reform programmes.

Most DPs are, to the extent permitted by their own mandates, increasingly using government treasury, procurement, and financial management systems, and are applying programme-based approaches aligning their financial support behind GoT strategies and programmes in health, education, transport, public sector reform, public financial management reform, water, HIV/AIDS, Local Government, forestry, private sector reform, and agriculture.

Effective aid requires not only transparent accountability, but also enhanced systems for monitoring and evaluation as well as reporting at country and programme levels. In close collaboration with other stakeholders (DPs, etc.), the GoT has put in place various processes and mechanisms for transparency and accountability. These include: the annual Public Expenditure Review (PER), the GBS and MKUKUTA processes. These processes are supported by Performance Assessment Framework (PAF) for GBS, Public Expenditure and Financial Accountability Review (PEFAR), Budget Process including Budget Guidelines and Budget Execution Reports, MKUKUTA review and MKUKUTA annual implementation report, and sector and core reforms reviews. These processes provide the main avenues for information generation, detailed discussion and dialogue on all issues concerning the management of development processes including management of public resources. In addition, there is the Independent Monitoring Group (IMG) for enforcing mutual accountability. Furthermore, the JAST contains a performance assessment and monitoring framework. At the sector and programme level, Joint Implementation Reviews (JIRs) are abounding.

The existence of the strategic development frameworks and the ongoing reforms has been and will continue to provide platforms for sustained and systemic capacity development effort in the country, where TC is expected to play a strategic role. The importance of these reforms on TC for CD is illustrated by the PSRP, which is considered to be a good basis for linking reforms with TC. What makes Tanzania a leader in development assistance planning, coordination, and harmonisation? It is the high degree of mutual trust, collaboration and understanding that pervades the GoT-DPs relationship in development assistance. This relationship is exemplified by **country-leadership in linking TC with reform programmes.** This case is illustrated by Tanzania's ***Public Service Reform Programme.*** This illustration also provides useful insights into the lessons being learned in the process of providing TC at country-level.

The Public Service Reform Programme (PSRP) epitomises country-leadership in linking TC with reform programmes. Reform programmes do provide enhanced environments for effective TC. The PSRP is a *unique* successful change management intervention covering the entire public sector in Tanzania. The PSRP is managed by the President's Office - Public Service Management (PO-PSM). At inception, it was implemented through a project implementation unit, but now it has been mainstreamed within the Government systems and structures. PSRP is a *comprehensive and top-down approach* to change management. Its design, at inception, relied on a *transplantation approach*; consisting of the application of a

package of ideas or practices of the "new public management" (NPM) developed for high income countries. GoT also adopted a *rough sequencing strategy* which tried to build both longer and shorter term horizons into the implementation of the PSRP.

Another important element of PSRP was the *limited use of financial incentives*. The PSRP, in practice, gave little emphasis to financial incentives, though some effort has been made to boost salaries. Financial incentives, at least at the individual level, were used to retain staff and to ensure some sense of compliance. They lagged and did not lead or drive reform behaviour. Nevertheless, financial incentives at individual level remain the most daunting issue of the PSRP implementation. They may be at the root of the generally observed capacity underutilisation in the public service sector.

What has been the role of TC in PSRP? In general, the role played by TC in the PSRP has been positive. Several reasons account for this outcome (based on Baser and Morgan (2007)):

- Existence of a broader partnership between the GoT and the DPs based on mutual trust and collaboration after reaching a crisis point in the mid-1990s. Both sides agreed to have GoT play a more decisive role, with the role of the DPs shifting to one of support and facilitation.

- A spirit of greater openness began to characterise most GoT-DPs interactions, including TC.

- The TC relationship itself and its development outcomes were independently monitored.

- GoT and the main TC providers for the PSRP established a Joint Consultative Committee which functioned effectively.

- The major participating DPs, the World Bank and DFID, accepted the PSRP for what it was likely to be - a comprehensive, long-term programme of reform that would need 15-20 years of steady, patient and flexible support, much like reform efforts in high income countries.

- Quiet persistence, both within GoT and the DPs, paid off and reinforced the sense of a longer-term partnership. This different sense of time represented a departure for many of the DPs and points to the need for adaptation on all sides if such complex programmes are to be effective.

- Both GoT and the DPs refrained from imposing arduous reporting, monitoring and measurement schemes until such times as the PSRP staff were in a position to design and manage them.

- There also appears to have been an acceptance within the DPs of the GoT's capacity for self-organisation and self-correction. Situations in the PSRP that appeared to be a

'mess' in the short term were therefore seen to have a good chance of evolving through adaptation into productive gains in the medium or long term.

- The stability of the Tanzanian staff was matched by that of the staff of some DPs. For example, some Bank staff had been working on the PSRP since its inception. Organisational trust and commitment amongst organisations were reinforced by those between individuals on both sides. The connections between key individuals were also reinforced by the decentralised organisational structure of the local DP offices. This structure also generated the contextual knowledge that supported the reform programme.

- Appetite for the reform was and is still very high at both the leadership and the rank and file levels of the public service, which attracted many DPs.

Notwithstanding these successes, PSRP still faces a number of challenges. The key ones relate to pay incentives and capacity utilisation. Pay for personnel at middle and low levels is still considered low, leaving the majority of public servants trapped in a low-pay-low-morale vicious circle. Associated with this is the issue of general low capacity utilisation in the public sector. Despite the PSRP performance-based innovations, low capacity utilisation at personal and organisational levels is still a daunting problem in the civil service. However, it is important to acknowledge that GoT has a Medium Term Pay Policy that has two hallmarks: (i) defining medium term targets for enhancing salaries of professional cadres, and (ii) emphasis on rapid enhancement of pay for personnel with managerial, professional and technical skills and responsibilities, to increase prospects for government to compete in recruitment and retention of such personnel. PSRP aims to address a series of long-term problems (including capacity) within the public service. These are reflected in the programme's long-term objectives and are very much appreciated by DPs.

2.4. OVERALL FINDINGS ON EFFECTIVENESS OF TC AT NATIONAL LEVEL

The findings of the foregoing review were complemented by the results of a perception survey involving 27 government officials across five MDAs. Appendix 1 presents the results of the perception survey which consisted of 16 leading questions pertaining to TC for CD. The survey, however, was limited by its small sample size and the survey population not being very knowledgeable about what CD constitutes.

The foregoing review of TC has revealed that Tanzania has, over the years, developed a reasonably solid policy environment, exemplified by PRS and MKUKUTA. Also, it is noteworthy that Tanzania has been executing and is now further consolidating broad core reforms which cut across all sectors and various levels of government. These reforms provide a good platform for sustained and coherent national capacity development, in spite of outstanding reform challenges. Similarly, Tanzania has, over the years, developed various

processes and systems for effective relationships with its development partners. This section summarises these findings.

The availability of articulated development strategies (MKUKUTA) and comprehensive cross-cutting and sector reforms after 1996 – largely country-owned and led - have greatly facilitated the development of mutual trust and collaboration underpinning the relationship between GoT and DPs. This relationship is now the bedrock of the opportunity for further improving the effectiveness of TC in Tanzania.

Notwithstanding the cordial TC relationship between GoT and DPs, designing and implementing an articulated **Technical Assistance Policy Framework** would enhance the effectiveness of TC by providing guidance and focus in the provision of TC by DPs and its use by GoT. Such a framework should be developed jointly by both GoT and DPs through consultative approaches.

The bulk of the planning and implementation of Tanzania's development strategy and reform programmes was and continues to be done by local personnel, using broad consultative approaches (involving stakeholders and non-government organisations) and assisted by TA experts in key areas (e.g., technical studies).

Box 3: Ranking of Three Key Factors that make TC Contribution to CD Most Effective

(i) TC linkage with other forms of support (e.g., infrastructure and equipment support);

(ii) Organisations with commitment to change and reform;

(iii) TC effectiveness in increasing learning and reflection within organisation and in facilitating change.

Source: Perception Survey

By implication, TC has proved effective in contributing to improvements in both sector and organisational performance and results. This was also confirmed by the perception survey (**Appendix 1**).

According to the perception survey, the key factors that make TC contribution to CD most effective are summarised in **Box 3,** and those that impede TC effectiveness are specified in **Box 4.**

Box 4: Ranking of Three Key Factors that Impede or Undermine Contribution of TC to CD

(i) Lack of country-led CD plans at sector or MDA level;

(ii) Lack of capacity assessment in targeted organisations;

(iii) Weak commitment to change at national and organisational level.

Source: Perception Survey

Preparation of specific capacity development plans at national or sector level has received little attention and where it has been done (e.g., in the context of the PSRP and sector reforms), it has neither been comprehensive nor was it preceded by capacity assessment. In the perception survey, it was highlighted as one of the three main factors undermining TC in effectively contributing to capacity development in the country **(Appendix 1).**

Preparation of capacity development plans at organisational level would not be sufficient for improved TC, unless the issue of capacity underutilisation is addressed simultaneously. The perception survey confirmed that only about 70 percent of the eight-hour work day is productively utilised at middle and low levels of organisational hierarchy. This is understood to be because many employees of the lower and middle hierarchy have to find and pursue other money generating activities in order to maintain their livelihood.

Political commitment and willingness to change at national level and technical leadership for change management at organisational level have critically contributed to the country's capacity to successfully pursue its development goals for growth and poverty reduction. Both the political commitment and technical leadership have attracted and sustained TC by DPs. The importance of commitment to change and reform in TC effectiveness was also strongly confirmed in the perception survey.

Pooling TC funds from several DPs is already taking place in most SWAp operations with basket funds. This has increasingly become popular with GoT as it is considered more effective in capacity development than discrete TC from a single DP. The envisaged *division of labour* among DPs, enhanced sector reviews and M&E should boost the rationale for *basket funding* as a mechanism for pooling TC funds.

Similarly, the PSRP case also illustrates that by improving the work environment (e.g., state-of-the art equipment and computers); TC can be effective in improving staff morale and performance, even where financial incentives are still lagging behind. This was also strongly supported in the perception survey.

Also illustrated by the PSRP case are the following findings and conclusions, all of which were confirmed by the perception survey:

- TC has proved effective in increasing learning and reflection within MDAs that were responsible for facilitating change.
- TC can be effective when designed or delivered with flexibility to respond to changes in organisational priorities and needs.
- TC can be more effective when it focuses on the needs of the entire organisation rather than specific groups of individuals.
- The effectiveness of TC in capacity development cannot be reduced simply by trained individuals leaving the organisation, since TC also builds organisational capacity to attract new experts in the domestic labour market.

- Individual consultants perform better when their supervisors regularly monitor their performance and know how and when to deploy them appropriately.
- TC does not necessarily create a risk of foreign or local experts substituting for technical staff within their organisation, since, in most cases, private sector experts (local and foreign) can complement an organisation's staff within the context of the domestic labour market.
- Capacity utilisation is critical to effectiveness of TC for CD, but its extent or level is governed by factors that require time (e.g., mindset and cultural change).

3. OVERALL SITUATION ANALYSIS IN THE AGRICULTURAL SECTOR

3.1. AGRICULTURAL SECTOR POLICY AND STRATEGIC CONTEXT

Following the formulation of the Vision 2025 and the Poverty Reduction Strategies, GoT in 2001 formulated the Agriculture Sector Development Strategy (ASDS). The ASDS was underpinned by the Agriculture and Livestock Policy (1997) and the Cooperatives Development Policy (1997). The ASDS sets the broad objectives and targets to be attained in the long term in order to improve productivity, profitability, food security and higher farm incomes in the agriculture sector.

To operationalise ASDS, GoT developed the Agriculture Sector Development Programme (ASDP) for implementation in 2006. The programme is a sector-wide approach to planning, implementing, coordinating and monitoring agricultural development in the country. ASDP establishes operational linkages between the Agricultural Sector Lead Ministries (ASLMs) and other national stakeholders. It also embeds more effective management systems. It provides the linkage between the demand-driven, field-based district agricultural development plans (DADPs), and the allocation and monitoring of national and international spending in agriculture.

The ASDP is underpinned by national policies supporting, in particular; (i) a focus on poverty reduction; (ii) the decentralisation of many public sector responsibilities to Local Government Authorities (LGAs); (iii) increased participation and involvement of local communities in decision making; and (iv) a shift towards increased private sector participation in production, marketing, processing and service delivery.

Other sector policies underpinning ASDP include the Local Government Reform Programme (LGRP), which aims at improving the delivery of quality services to the public through decentralisation. The LGRP facilitates the current move from centrally planned agriculture to locally planned agriculture. The Land Policy (1995) provides a framework for stronger local control of land resources, especially by villagers, and establishes the basis for more effective land markets. Micro-Finance Policy (2000) provides a framework for the provision of financial services to households, smallholder farmers, as well as small and micro-enterprises in both rural areas and the urban sector. The Small and Medium Enterprise Policy (2002) aims at promoting income generating activities and supporting diversification

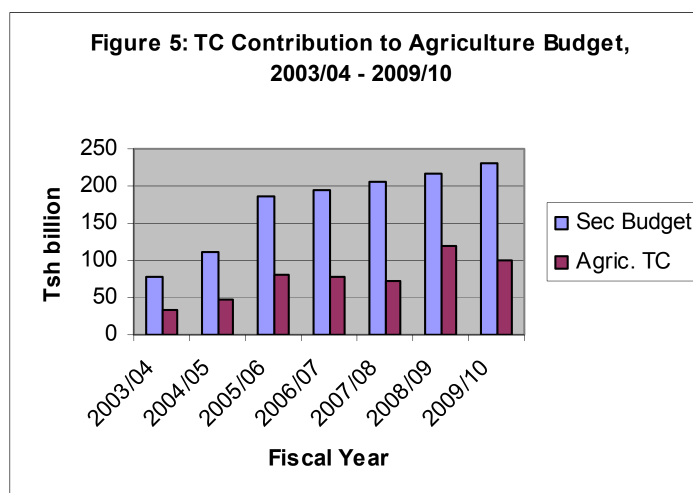
of private sector activities. It also includes development of commercial opportunities in marketing and processing agricultural produce.

Capacity development is recognised as crucial in the overall implementation of ASDP and other sector policies. Apart from using government budget resources, technical cooperation stands out as an important source for local capacity development. For the past ten years, as evidenced by interviews with government officials and a few DPs, the agriculture sector has received considerable amounts of TC both from bilateral and multilateral development partners. TC has traditionally been sought on demand through discussions with individual bilateral and multilateral partners. However, in recent years, the bulk of TC in agricultural sector is delivered through the ASDP basket fund. Funds for CD are also available through the national budget which includes GBS.

Overall decision making in procurement and management of TC is still dependent on the nature and source of TC. In general there are no clearly stated policies and strategies for capacity development and use of TC. To the extent that the ASDP provides a sector-wide framework for various interventions in agriculture, it has facilitated alignment and harmonisation of the sector's development activities. But it still falls short of providing a comprehensive strategy/plan for managing TC for CD in the sector. The Agricultural Sector Basket Fund (ASBF) provides a potentially effective mechanism for TC pooling in the agricultural sector. However, not all DPs have subscribed to ASBF. Some DPs are still channelling their TC contributions through the traditional project approach.

3.2. TRENDS AND PATTERNS IN TECHNICAL COOPERATION

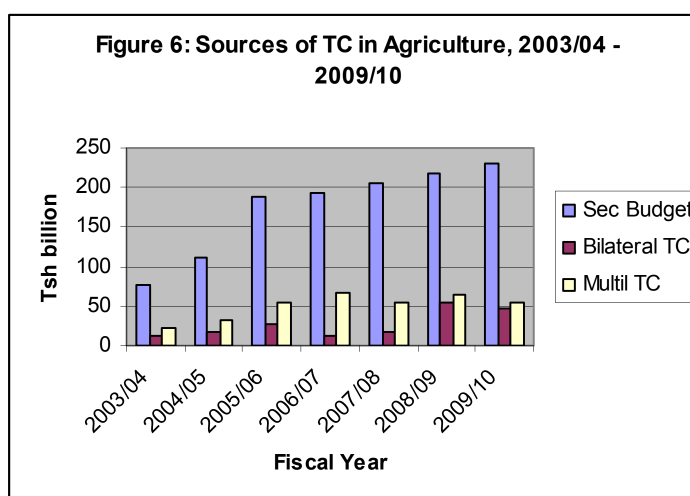
The agriculture sector has received considerable TC over time. This is evidenced by the numerous projects and programmes undertaken in the agriculture sector by both multilateral and bilateral development partners over the past ten years. However, getting the right data and information for TC was difficult both at sector and national level. The only data that was used to gauge the amount of TC received at the sector level was from the projected estimates in MTEF. Since MTEF is proving to be a useful planning and budgeting tool, then the TC estimates derived from it are equally useful for the review purpose. MTEF actual and projected estimates indicate that during 2003/04–2009/10 the sector received TC totalling Tsh. 532.0 billion or approximately



Source: Own calculation based on information in MTEF and TAS implementation reports of various years

Tsh. 76 billion per year. Overall contribution of TC to the agriculture sector during 2003/04–2009/10 is presented in Figure 5.

The pattern and trends of TC in the agricultural sector are presented in Figure 6. The major sources of TC received by the agriculture sector in the period of seven years are given. Data indicates that multilateral DPs consistently outperformed bilateral DPs during the review period.



Source: MTEF and Agricultural Sector PER (2006)

It should also be noted that the average share of the sector in the total government budget over the past four years was just 3.7 percent (Table 1). This budget allocation is still small compared to the committed expenditure level by the African countries under the Maputo Declaration. The Maputo Declaration stipulates that the agricultural sector allocation should be at least 10 percent of national budgetary resources. Increased allocation to the agriculture sector is deemed important in order to be able to achieve the ASDP and MKUKUTA cluster targets.

A close examination of the scoping exercise for the agriculture development partners group (2006), prepared by IFAD, shows an increasing trend of TC targeting the private sector in increasing productivity, agriculture investment, rural food security, microfinance and marketing. Another important change in TC is the drive to build capacity at different levels of implementation as guided by the LGRP and participatory approaches of planning introduced by GoT. Many programmes and projects in the agriculture sector entail a basic component of capacity building.

Table 1: Share of Agriculture Sector within MTEF (Tsh billion)

	2003/04	2004/05	2005/06	2006/07
Total Gov't Budget	2,607.1	3,347.3	4,031.3	4,850.0
Sector Allocation	76.5	111.4	187.0	194.8
Sector to Total Budget	2.9%	3.3%	4.6%	4.0%
Annual Growth: Total Gov't Budget	n/a	28%	20%	20%
Annual Growth: Agriculture Sector	n/a	46%	67%	54%

Source: Agriculture PER (2006)

3.3. TECHNICAL COOPERATION COORDINATION MECHANISM

Underlying ASDP is the need to ensure effective coordination of development assistance to agriculture and to monitor DP compliance to the agreed framework. DPs are required to collaborate with other financing agencies and stakeholders in the formulation and financing of planned activities; making available technical and financial resources.

Coordination of aid at sector level is guided by the sector-wide approach under the auspices of ASDS and ASDP. The national budget (domestic resources) and the ASDP basket funds are the core funding mechanisms for CD in the sector. As in other sectors, GoT is making an effort to make all ODA, including TC, go through the national budget process. This is being undertaken through the MTEF process assisted by the Strategic Budget Allocation System (SBAS), which is the IT tool for resource allocation in line with MKUKUTA priorities.

The formulation of the ASDP and its subsequent implementation process provide a vivid example on the existing coordination mechanism. ASDP formulation was supported through the creation of a basket fund. During the formulation process, technical assistance was, to a large extent, demand driven and procurement followed the established local procurement regulations. Under ASDP, DPs, in collaboration with GoT, have carried out a capacity development assessment for effective implementation of ASDP. Further efforts are still needed to transform the assessment into a workable capacity development plan. However, only a few DPs have increasingly delivered their financial support through the ASBF. These include the WB, IFAD, Japan and Irish Aid.

The bulk of TC in the agricultural sector is still provided through projects and free standing programmes. Provision of TC in this context is still dominated by project implementation units and procurement is, in most cases, done by the donor agency. Identification of TC gaps and needs is, in most cases, done jointly by GoT and the respective DP. Specific examples of project/programme technical support include the African Development Bank (AfDB - District Agriculture Sector Investment Project); Danida (District Agriculture Development Support); EU (Stabex funds); USAID (Private Enterprise Support activities, coffee and tea projects). The pertinent question here is to what extent identified TC needs within a project context reflect sector capacity needs. Management and monitoring of TC under the GoT ownership have proved to be difficult, due to lack of transparency and accountability from some DPs. In order to attract more DPs to subscribe to the SWAP, more effective coordination, openness (in reporting), flexibility and accountability in ASDP are required by all stakeholders. Once the M&E for ASDP is in place and being strengthened, it has the potential for boosting DPs' support to ASBF, if effectively implemented.

Monitoring and evaluation of TC in the agricultural sector is still in its infancy and suffering from several teething problems. Many DPs normally conduct their own M&E to meet their mandated reporting requirements. The ASLMs as such do not regularly monitor and evaluate TC, despite the existence of the M&E system for ASDP. The overall operational environment of TC in the agricultural sector is summarised in Table 2.

3.4. COMPLEMENTARITIES OF TC WITH OTHER INSTRUMENTS OF CD

Does TC complement other instruments of CD in agriculture? Data to answer this question was not available. However, interviews with GoT and DP officials revealed the following complementarities:

- There is some networking going on between Tanzanian agricultural projects/programmes (e.g., KATC, TACRI, TRIT) and other institutions in the EAC and SADC countries.
- There are strong complementarities between TC and sector reform programmes in the country, where the former normally acts as the source of technical and professional staff.
- There is considerable staff "poaching" by the private sector from the public sector within the domestic labour market.
- Conversely, CD in the private sector complements CD in the public sector, given the increasing tendency in the public sector to contract out to the former some non-core activities, e.g., studies, audit.

Table 2: SWOT Analysis of the Operational Arrangement for Agricultural Sector

Strengths

- Existence of a coherent and articulated agricultural development strategy (ASDS).
- Existence of the Agriculture Sector Development Programme (ASDP).
- Existence of the ASBF for coordinating and managing aid and TC in the agricultural sector.
- Strong political commitment at national and sector level.

Weaknesses

- Non-existence of Technical Cooperation Policy at national level.
- Lack of capacity development plans or roadmaps at sector and MDA levels.
- Weak capacity at sector level to plan, manage, monitor and evaluate TC.
- Weak leadership at sector level and within several MDAs or ASLMs.

Opportunities

- Start of national TA policy formulation process as one of the priority JAST activities.
- Ongoing public sector reforms (PSRP, PFMRP, LSRP, LGRP) provide coherent frameworks for sector capacity development plans.

Threats

- Continuation of DPs' practices and TC delivery modalities that undermine country ownership and leadership in setting the development agenda and processes.
- Perceived risks in the enabling environment (e.g., corrupt and poor governance practices by government officials).
- Unpredictable TC flows by DPs.
- Aid fatigue on the part of DPs.

Source: Views collected through interviews with government and private sector officials and from the perception survey conducted during the study.

3.5. OVERALL FINDINGS ON EFFECTIVENESS OF TECHNICAL COOPERATION IN AGRICULTURE

Underlying the importance of TC is its effectiveness in developing capacity in the agricultural sector. In analysing the effectiveness of TC, a random perception survey, involving twenty government officials in the ASLMs, was conducted. **Appendix 2** presents a summary of the survey results.

The perception survey findings indicated that respondents strongly agreed that TC was more effective when organisations and donors work together on the basis of a capacity needs assessment. There was also a consensus on the need for demand driven TC, flexibility and more aligned and harmonised TC. The survey also indicated that respondents favour management and procurement to be controlled by the respective sector organisations. Respondents also strongly agreed that TC is more effective when it is linked to other forms of support, such as infrastructure and equipment provision. In regard to employment of consultants, respondents agreed that local or regional consultants have proved more effective than international ones because they understand the country context better. There was also a general consensus that long-term consultants have proved to be more effective than short-term consultants. Last but not least, the survey showed that consultants perform better when they are fully monitored by the beneficiary organisation. However, respondents partially disagreed that TC creates a serious risk of foreign or local experts substituting for technical staff within their organisations.

3.6. CONDITIONS IMPEDING TC FOR CD IN AGRICULTURE

Factors impending TC effectiveness are bad practices. In the agricultural sector there are various conditions which impede effective TC for CD. First and foremost, the agricultural sector does not have a comprehensive capacity development plan. This shortcoming was also echoed by the APER (2006), which called for a need to undertake capacity needs assessment for the sector. Likewise the perception survey indicated the lack of a comprehensive and participatory capacity development plan for the sector as a major obstacle. As an effort to address the above problem, the joint GoT-DP Agriculture Group commissioned a diagnostic study on capacity building for the implementation of ASDP in 2006. The results of the study outlined the capacity needs of each level of ASDP implementation. It is still not clear whether the GoT will use it to develop a sector roadmap for CD in agriculture. However, this study did not examine the issue of capacity underutilisation in the sector.

The plethora of ministries (i.e., the ASLMs) dealing with the agriculture sector poses coordination and harmonisation problems in the sector. TC is still coordinated by individual ministries, except the TC earmarked for the ASDP basket fund. The problem of poor coordination is compounded by ineffective leadership within the ASLMs. In MAFC, the unit responsible for aid coordination is virtually a single person shop. Similarly, there are no effective strategies or mechanisms for managing coordination and harmonisation of TC even

within the ASDP framework. For example, there is no system to monitor and evaluate TC in agriculture. The recently adapted M&E system for ASDP is potentially helpful in this. The perception survey also indicated that lack of effective coordination is a problem in developing a comprehensive capacity development plan. The framework for coordination is there under ASDP but the implementation is still difficult in practice.

Scholarships and training under TC have helped to create a stock of qualified manpower, especially at the MDA level. For example, MAFC has more than 12 masters' graduates in its Policy and Planning Division. But to what extent has this contributed to sustainable capacity development in the sector? The perception study indicated that there was no adequate mechanism for training beneficiaries to transfer knowledge to others so that the acquired capacity is not individualised but institutionalised. Some government officials interviewed indicated "that there is often no room to apply the knowledge and skills gained" hence institutionalising of skills and knowledge becomes difficult. Maintaining institutional memory is important for sustainable capacity development. In addition, full utilisation of the trained staff is still a problem.

Although DPs are increasingly moving into the basket funding mechanism, some DPs still prefer to provide TC as a free-standing operation that is often project based. It is generally considered that TC tied to source usually undermines government efforts for capacity development. This is consistent with the perception survey result that pooling TC funds from a number of DPs is more effective in building capacity than separate and stand-alone TC from a single donor.

Effectiveness of TA experts in the agriculture sector is difficult to judge, since TAs' impact has been divergent depending on the design and actual implementation of the Terms of Reference of the TA experts and integration of TA within the Government system. Regardless of modality of providing TA, TA experts can attain CD objectives. However, as a Government official confirmed, CD can best realise its potential benefit where the government/sectors participate in the design, formulation and implementation of the respective programme/project. In the agriculture sector, successful TA support has been provided by extending expertise to the local staff, for example, by FAO, Marketing Development Bureau, Project Preparation and Monitoring Bureau, by World Bank through implementation of research extension and training programmes, by Japan through design, construction and implementation of irrigation schemes, and by Danida through capacity building programmes as well as through seed multiplication and irrigation programme management and gender issues. Grant-supported projects by Korea, China and the Netherlands (on-farm participatory research programme in the Western and Northern zones) have also contributed to this result.

However, Government has experienced difficulty in benefiting from TA experts when they are provided through donor-driven processes, although this has been much improved and there are more supply-driven processes in the sector. In addition, ineffectiveness of TA experts has been felt when TA is given a significant pay package, which creates a huge pay

gap between the TA and the local counterpart, which may demoralise the willingness of the local counterpart to learn from the TA experts[1].

Poor working environment, in terms of infrastructure and equipments at the sector and organisational levels, is also an issue of concern. Government officials interviewed indicated that "poor working tools and office infrastructure undermine morale and work effectiveness". Much is needed to be done to update equipments and infrastructure. Evidence from the agriculture sector has shown that TC accompanied by other support has proved to be more effective in capacity building through effective implementation of required interventions. Specific examples include sector programmes funded by the WB, IFAD, Japan and Irish Aid. The perception survey results also strongly confirm the above conclusion.

Lack of broad based participation in capacity development also stands out as an impeding factor. Existing capacity development initiatives have not encompassed all stakeholders. Discussions with the private sector represented by the Agricultural Council of Tanzania revealed that the private sector has not been included in many of the existing capacity building initiatives. For example, even within the ongoing ASDP, training has been supply-driven rather than demand-driven. Results from the perception survey also point out that effective capacity development should involve the grassroots. Specifically one respondent stated that "capacity development has not been effective because many initiatives have not involved the grass roots at district level."

Government incentive structure and regulations do not create a conducive environment for sustainable capacity development. Incentives in terms of salaries and other fringe benefits are not adequate to retain competent manpower and boost working morale of remaining civil servants. Civil service reforms especially related to freezing employment have created a succession problem at sector level. Results from the perception survey show that poor financial incentives limit retention of capacity at sector level. Interviews with government officials at MAFC cited the prevailing succession plan as not adequate in terms of facilitating capacity development. The attrition rate due to retiring is greater than the rate of new recruits. This imbalance has the potential of affecting capacity development at MAFC.

Despite the introduction of an annual work plan and performance evaluation system for all professional staff, most staff below assistant directors have not been fully utilised. During the perception survey, several professionals stated that "pay incentives are still inadequate at all levels below assistant director and these force people to go 'moonlighting'". This indicates that there may be a strong relationship between pay incentives and capacity utilisation.

[1] A Government official claimed that the local counterpart's workload is sometimes greater than the TA expert's and that the former might be more qualified and skilled than the latter.

Inadequate leadership at sector level results in poor supervision of TC. In certain cases even appointments to understudy TAs are not always the best. Lack of effective coordination is also, to a certain extent, attributed to inadequate leadership. Interviews with several development partners and the private sector supported the above assertion. Interviews with MOFEA official also indicated lack of effective leadership at sector level. The government officials at MOFEA argued that leaders at national and sector level "should be aggressive and innovative in managing TC for CD."

Inadequate and unpredictable financing for capacity development programmes has been linked to the unpredictability of aid resources in the past. One of the respondents in the perception survey indicated "that untimely release and inadequacy of resources is a stumbling block in guiding TC for CD in agriculture".

3.7. CONDITIONS FACILITATING TC FOR CD IN THE AGRICULTURAL SECTOR

Factors facilitating TC effectiveness are good practices. The existence of a SWAp and a functioning basket funding mechanism in agriculture have facilitated relatively effective TC. It is important to point out that even those DPs who still stick to using the traditional project approach are gradually aligning their TC support to existing sector strategies. Peer pressure among DPs may be at work.

Institutional changes experienced in the agriculture sector, due to various reforms, have engendered new responsibilities for different stakeholders. Capacity needs are now being examined at different levels of implementation, contrary to the past when capacity development was only concentrated on civil servants. In particular, decentralisation of decision making to local government authorities under the LGRP has stimulated acute needs for CD at grassroots level. In line with the above, central government provides the bulk of recurrent and development budget to LGAs. Recurrent expenditures are provided through the Agriculture Extension Block Grant (A-EBG) and Agriculture Capacity Building Grant (A-CBG). Development expenditures are channelled through District Agriculture Development Grants (DADGs) and District Agriculture Development Plans (DADPs). Examination of TC programmes over the past five years indicated a significant shift of TC for CD to the district level.

Availability of pooled funds for TC under the ASDP has stimulated CD-related activities in the agricultural sector. Utilisation of these funds to finance priority capacity needs in the sector has been an important step towards sustainable capacity development. However, proper and effective utilisation of TC is still limited by the lack of capacity development plans under the auspices of the ASDP. The perception survey results also revealed that there was lack of proper management of resources and inadequate comprehensive capacity development plans for the sector.

Existence of government owned national and sector polices and strategies have facilitated TC in agriculture. This condition helps in focusing the required capacity to meet set objectives. MKUKUTA, Vision 2025 and ASDS/ASDP outline the need for capacity development at the sector level. The existence of government owned strategies have been acknowledged by both GoT and DPs as a starting point for developing a comprehensive capacity development plan for the sector.

The existence of mechanisms for managing external assistance, like the JAST and GBS, has greatly helped by piggy-backing the delivery of some TC. Government preferred aid modality is GBS. Similarly, the existence of the SWAp and ABSF at sector level has guided DPs to align and harmonise their assistance to sector goals and objectives.

Using basket funds such as ASDP and APER for TC/TA appears to be proving effective. It allows MAFC to source TA competitively in accordance with actual needs. Government officials interviewed indicated favouring pooling of funds as it gave them flexibility and ownership in procurement, managing and monitoring of TA. However, a few DPs interviewed indicated that they were not fully committed to the system, citing GoT’s inadequate capacity for procuring and managing TA effectively.

4. OVERALL SITUATION ANALYSIS IN THE HEALTH SECTOR

4.1. REVIEW OF HEALTH SECTOR POLICY AND STRATEGIC CONTEXT

The health sector development in Tanzania has been carried out by GoT, NGOs, DPs, religious organisations, and local individuals and communities. TC has particularly played an important role for CD. Both bilateral and multilateral DPs have provided TC to the sector.

The national health policy of 1990 was reviewed in 2007 to make the health sector development consistent with the cluster goals and targets of MKUKUTA and the MDGs. These goals and targets are operationalised by the Health Sector Strategic Plan (HSSP) which specifies the priorities and the means of achieving them in the health sector. However a national policy on TC is not yet in place to guide HSSP priorities in CD.

The health sector reforms supported by the Sector-Wide Approach (SWAp) have provided a platform for sector-wide CD. Within the health SWAp framework a Health Sector Basket Fund (HSBF) has been put in place as a financing mechanism for the entire health sector. The majority of DPs disburse their financial support into the HSBF. From this fund, capital and recurrent expenditures for the various components of the health SWAp, including the procurement of TC, are drawn. Most of the health SWAp components (e.g., cost sharing programmes like the National Health Insurance Fund (NHIF), TB & Leprosy) embed CD.

According to the Health Sector Reform Programme and responses during interviews with MOHSW officials, the key priorities for TC for CD in the Tanzanian health sector include the following:

- Human resource development for providing quality health services to the population.
- Improving managerial capacities of health managers at national, regional, district, village and community levels.
- CD plans and implementation at organisational level.
- Providing appropriate equipments and drugs at health facilities.
- Recruiting technical expertise that is not locally available.
- Improving health infrastructure and work conditions.

The major component of the health SWAp programme is the capacity building of national health systems, including decentralised health planning, financial management, procurement and medical supply and the Health MIS. With the advent of SWAps, these capacity building activities have been increasingly financed through HSBF and the government regular budget, including resources from GBS, though there is still some ongoing free-standing TC in these areas. The health SWAp also contains several sub-components with specific public health issues, such as TB, Leprosy, Immunisation, Malaria Control, Reproductive and Child Health - most of which have been supported by various types of TC with CD objectives. Initially, these programmes were mostly managed by donor supported vertical projects; the role of government in these programmes has become greater in recent years. In these programmes, more and more regular review meetings, approval of annual work plans and implementation reviews are being done under the leadership of the government in partnership with DPs. A SWOT analysis in relation to TC was carried out for the health sector: the results are summarised in Table 3.

Table 3: SWOT Analysis in the Health Sector

Strengths
▪ The existence of the revised National Health Policy 2007, that provides conducive environment for TC for CD to all sector stakeholders.
▪ Existence of the Health Sector Reform Programme has provided the basic framework for reforming the delivery of health services in Tanzania.
▪ Existence of operational HSBF mechanisms for funding health services.
▪ GoT political commitment to support CD in the health sector.
▪ Existence of a well established training system for all allied health professionals.
▪ Devolution of responsibility from the centre to LGAs.
Weaknesses
▪ Lack of national and sector TC policy framework.
▪ Inadequate number of professional staff to deliver health services.
▪ Inadequate training infrastructure to address CD requirements in the health sector.
▪ Poor employment incentives that lead to frustration and low morale.
▪ Inadequate database for monitoring effectiveness of TC for CD.
▪ Inadequate managerial capacities affecting planning including TC for CD.

Opportunities

- The start of TA policy formulation by GoT at the national level.
- GoT willingness to collaborate with DPs in TC for CD and willingness of DPs to provide TC for CD.
- Partnership that exists among health sector stakeholders.

Threats

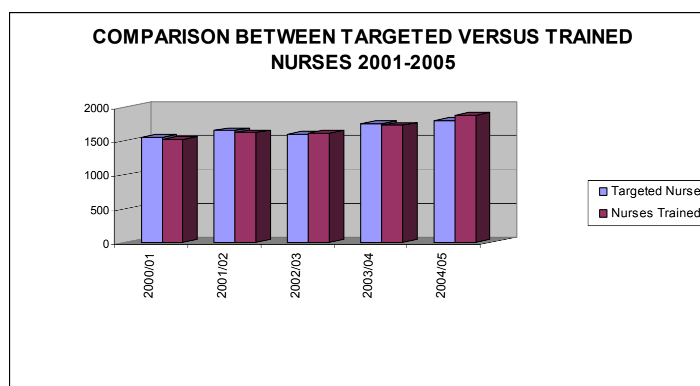
- Brain drain of health professionals to other countries and international organisations.
- Inadequate budgetary resources for implementing CD activities at sector and organisational levels.
- Relatively high dependence on TC.
- Low predictability of development assistance in which TC is embedded.

Source: 1) Joint External Evaluation of the Health Sector in Tanzania, DSM 2007 and 2) Interview responses from senior GoT officials at all levels.

4.2. TRENDS AND PATTERNS IN TECHNICAL COOPERATION IN THE HEALTH SECTOR

The health sector registered impressive growth, in terms of the number of health facilities and number of treatments. Today, almost every village has a dispensary and almost every district has a district hospital and every region has a regional hospital; private health facilities including those belonging to FBOs are abounding. There are four national referral hospitals.

Figure 10: Comparison Between Targeted vs. Trained Nurses in Tanzania



Source: MOHSW 2007

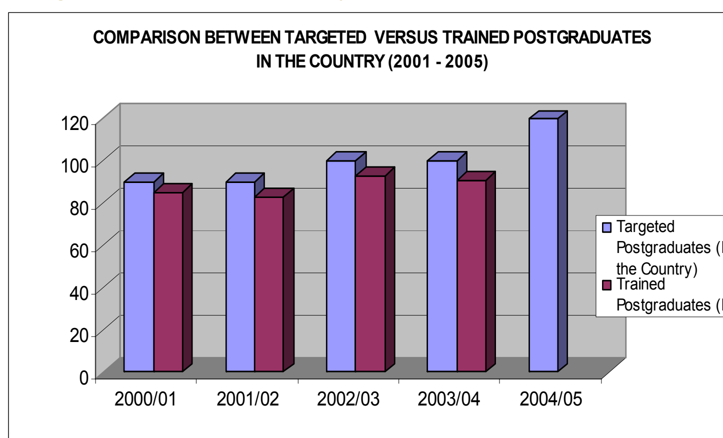
The health sector has been one of the major recipients of public finances (both domestic and external) in the country. Resources[2] to the sector increased from USD 143.6 million in FY 1999/00 to 427.5 million in 2005/06 (see the Joint External Evaluation of the Health Sector in Tanzania: 1999-2006 Report – November 2007). In FY 2005/06, the external component

[2] This includes resources managed by MOHSW, PMO-RALG, Regions and LGAs (excluding HIV/AIDS)

(ODA) constituted 45% (i.e. USD 192.4 million, equal to Tsh 227,079.4 million[3]) of the total funding to the health sector.

Out of the external component, TC is estimated at USD 36.6 million (equal to 19%)[4]. TC in the health sector has been provided through the Health Basket Fund and specific projects supporting the sector, as well as individual DPs, to carry out specific tasks (the breakdown was not available).

Figure 11: Comparison Between Targeted vs. Trained Postgraduates in the Country (2001-2005)



Source: MOHSW 2007

The health sector's performance in meeting targets for health human resource targets within priority programmes has been generally impressive. There has been considerable improvement in the sector's human resources. This is revealed in Figures 10 and 11.

4.3. COORDINATION MECHANISMS OF TC IN THE HEALTH SECTOR

As in the agricultural sector, TC is provided in various forms, including the TC procured through government's own budget which contains donor GBS funds, HSBF and global funds, TC provided as part of project financing, and free-standing TC.

The Health Sector Basket Fund (HSBF) together with the Health SWAp committee plays a key role in coordinating aid in the health sector. The HSBF, managed by the Finance and Accounting Division of MOHSW, is a mechanism whereby funds are disbursed by DPs into a joint pool to meet the cost of health services. The HSBF, like other sector basket funds, is based on a sector-wide approach financing various health SWAp components which are jointly planned and agreed by GoT and DPs. Implementation of HSBF support is reviewed and revised annually during the Joint Implementation Review (JIR), while the entire health sector support including basket funding and projects is coordinated and reviewed through the Health SWAp Committee.

A Selection Committee for Scholarships exists to control and oversee the selection of health professionals for joining various training courses both within the country and abroad. The

[3] USD 1 = Tsh 1,180.4 - average exchange rate for 2005/06

[4] The estimate is based on information and calculation from data provided during the survey for monitoring the Paris Declaration on Aid Effectiveness (2005) carried out in 2006

committee was formed as a way of streamlining the selection of students for various courses that are sponsored by the MOHSW.

4.4. COMPLEMENTARITIES OF TC WITH OTHER INSTRUMENTS

In the health sector, there are complementarities between the CD interventions of the different stakeholders. The key stakeholders in the health sector include GoT, LGAs, local communities, DPs, private sector, NGOs and FBOs. These take various forms, including funding schemes or grants, capacity development, infrastructure development, knowledge sharing, donations and technical advice. For example, the majority of private and NGO health facilities have largely benefited from the availability of government trained health personnel and specialists. Also, as a matter of policy, GoT provides earmarked subventions to non-government health facilities, especially those designated as district hospitals.

The medical referral system in the country facilitates complementarities among the health stakeholders. Under this system, health facilities in a district refer or transfer complex medical cases (patients) to the district hospital, which, in turn, transfers more complex cases to the regional hospital. The regional hospital, in turn, transfers complex cases to the nearest national referral hospitals. Similarly, specialists resident at referral hospitals make itinerant visits to district and regional hospitals or health facilities in neighbouring districts/regions. This should enhance capacity utilisation of health specialists at regional and referral hospitals, although such complementarities have not always been experienced due to emergency medical cases as well as to lack of specialists at referral hospitals.

4.5. OVERALL FINDINGS ON EFFECTIVENESS OF TC IN THE HEALTH SECTOR

Two types of lessons emerge out of the review of the health sector in Tanzania. First are the lessons about factors that facilitate sustainable capacity development. Second are the lessons about factors that impede or reduce sustainable capacity development. While the bulk of both factors apply universally, some of them may be specific to the health sector in Tanzania. These findings were, by and large, confirmed by the perception survey conducted in the health sector (Appendix 3).

Factors facilitating sustainable capacity development in the Health Sector:

- Political commitment to change management through reforms at sector and organisational levels has been critical to capacity development in the health sector.
- Reasonably effective sector aid coordination underpinned by a SWAp with a basket fund.
- GoT’s own contribution to capacity development in the health sector was equally important.

- TC has played a crucial role in capacity development in the health sector, as evidenced from MOHSW officials interviews.
- GoT and LGA ownership and leadership in planning and implementing health interventions has been critical to TC effectiveness.
- There are no "quick fixes" and long-term commitment to supporting health interventions by DPs is the only plausible way of providing TC for CD.

Factors impeding sustainable capacity development in the Health Sector:

- The lack of a national TC policy is an enigma to both GoT and DPs as it makes the TC relationship between GoT and DPs dubious at best.
- Inadequate pay incentives and poor working infrastructure have encouraged brain drain amongst highly qualified health professionals.
- Weak complementarity between TC for CD and support for infrastructure, especially at health training institutions and hospitals, leading to critical bottlenecks in capacity development processes.
- Dualism is still apparent between the operations of the public health sector and the private health sector, leading to unnecessary duplication in the delivery of specialised health services. A classic example of this dilemma is the planned government heart surgery facility, when there is already a private heart surgery facility in the country.

5. DETAILED ANALYSIS OF GOOD PRACTICES AND LESSONS LEARNED

5.1. DETAILED ANALYSIS OF TC CASE STUDIES

Six TC case studies are presented in this chapter. Each represents a main theme, even though most of them may represent more than one theme. Three cases are within agriculture (1, 5 and 6) and another three in the health sector (2, 3 and 4). The cases are organised on thematic basis as follows:

- TC Case Study 1: Country-Led TC Planning
- TC Case Study 2: Flexible and Responsive TC Design
- TC Case Study 3: Organisational Change Management
- TC Case Study 4: Country-Led TC Implementation and Management
- TC Case Study 5: Complementarity of TC and Other Support
- TC Case Study 6: Organisational Learning and Sustained Change

5.2. CASE STUDY 1: AGRICULTURAL SECTOR DEVELOPMENT PROGRAMME (ASDP)

ASDP epitomises government leadership and ownership in policy formulation and strategic planning with TC support. ASDP is essentially a SWAp operation that was designed in 2004 to operationalise the Agricultural Sector Development Strategy (2001). ASDP is being implemented by four ASLMs. These include the Ministry of Agriculture, Food Security, and Cooperatives (MAFC), Ministry of Livestock and Fisheries (MLF), Ministry of Industry, Trade and Marketing (MITM) and the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG). The case best describes country-led TC planning, implementation and management.

ASDP is the implementing vehicle for priority interventions specified in the ASDS. Its design process initially included a team of various specialists from the ASLMs, who were supported by a few local consultants in special areas. The resulting draft ASDP report was reviewed by a Committee of Directors from the ASLMs. The revised ASDP report, incorporating the

comments of the Committee of Directors was submitted to the Food and Agriculture Sector Working Group (FASWOG) consisting of representative from GoT, DPs, farmers' organisations and NGOs. The revised draft of ASDP was presented and discussed at a workshop with wider participation from all major sector stakeholders. The resulting draft report was eventually submitted to the major DPs in agriculture for financing. The DPs decided to jointly appraise the draft ASDP report in 2004. The resulting Appraisal Report was the basis for supporting the ASDP as a SWAp operation.

The entire ASDP formulation process was supported by GoT and TC, mainly in the form of local consultants, technical studies and workshops. Most of the TC was made available by several DPs from their existing free-standing or project TC resources. Under ASDP, the bulk of TC is delivered through pooled funds in the ASDP Basket Fund. GoT uses the pooled funds to develop capacity by sourcing competitively technical assistance, short term training, awareness seminars and study visits. DPs contributing to the ASDP basket fund include the WB, EU, IFAD, Japan and Irish Aid. Nevertheless, some of the TC for ASDP implementation still comes from discrete project or self-standing TA sources. For example, JICA-RADAG has played a considerable role in supporting ASDP implementation, with special reference to the design and implementation of ASDP monitoring and evaluation framework.

Evidence of successful capacity development. TC provided was mainly in terms of technical assistance and financial resources for managing the ASDS formulation process. The use of TC in the ASDS formulation assisted GoT in developing more focused strategies and prioritising policy interventions in the agriculture sector. More important were the analytical inputs of consultants employed to assess the constraints and opportunities facing the agricultural sector in the country. Through the ASDP, a sector-wide approach has been adopted. Different stakeholders have assumed new responsibilities and roles. For example, the role of the central government is now limited to policy formulation, regulation and creating an enabling environment for agriculture sector growth. Planning and implementation of agriculture interventions is now undertaken by local governments in collaboration with the private sector and civil society (i.e., farmers' organisations and community-based organisations).

The changing roles and functions of different stakeholders have, however, ushered in new demands for capacity development. In response to these, new coordination mechanisms have emerged. They include the Tanzania Farmers' Council (TFC), the National Steering Committee (NSC), the joint Food and Agriculture Sector Working Group (FASWOG), the Agriculture Sector Advisory Committee (ASAC) and the Annual Conference of Agriculture Stakeholders (ACAS), which will be chaired by the President of the United Republic of Tanzania. DPs, under the auspices of the Development Partner Group, have committed themselves to a division of labour (DoL) mechanism for harmonising their TC interventions in the agricultural sector.

Relationship between TC and CD output. Categories of TC delivered in this case study were mainly in terms of TA and financial resources to manage the policy formulation process. Technical assistance provided in terms of local and international consultants enabled civil servants in the ASLMs to learn new skills and knowledge through on the job training. Capacity to manage TAs has also been enhanced in ASLMs, since procurement and monitoring of consultants is done by sector ministries. This is evidenced by the regular use of local consultants in sector ministries' operations (e.g., agriculture sector reviews, agriculture public expenditure reviews and training in the ASDP framework). At the sector level, the change in public orientation has created a platform for more involvement of other stakeholders, particularly the private sector. A more specific example of CD output is the participatory training undertaken at district level. Training of district level staff has been undertaken by sector ministry officials in collaboration with local consultants. The extent to which training has built capacity is difficult to determine at this stage. However it is important to point out that TC interventions in this case have not been able to develop capacity for private service providers.

Implementation arrangement and process. The development of both ASDS and ASDP was done in a participatory manner, involving all key stakeholders. These included the ASLMs, private sector representatives, DPs and other non-government actors. Stakeholders were consulted through surveys, documented opinions and validation workshops. Extensive consultations and dialogue between GoT and DPs are a continuous process that is complemented by annual JIRs.

Analysis of country conditions that facilitated success. Country conditions that helped achieve success include: existence of national policy and strategies at both national and sector level; political commitment and good leadership at the national level; the existence of JAST and cordial relationships between development partners and the government.

Development partners role in achieving success. DPs supported the GoT in developing and implementing both ASDS and ASDP through TC. DPs' agriculture experts participated in giving advice and analytical inputs at different levels of the process. They also provided pooled funds for employing technical assistance. Some DPs, like FAO and JICA, also provided free-standing technical assistance. DPs active in agriculture coordinate through FASWOG. The group has gone a long way in aligning and harmonising TC support to agriculture. With the exception of AfDB and Danida, all DPs have subscribed to the ASDP basket funding mechanism. Even those DPs who are still pursuing a project or programme approach have aligned their interventions to the ASDS priorities.

Lessons learned. This case study provides the following key lessons. They are tentative because they are yet to pass the test of time and replication:

- Government ownership of strategies and policies was critical in the process of developing TC for CD in agriculture. Deriving from this case study was the fact that GoT, through its sector ministries, prioritised and sought demand-driven TC. Hence,

Government ownership of strategies and policies was key in engendering demand-driven TC.

- Pooling funds for TC allowed the beneficiary ministries to procure TA competitively and use it according to identified priorities. This lesson was collaborated with the results from the perception survey. This specifically suggested that employment of consultants who knew the local conditions made TC more effective than otherwise.

- Use of government procurement systems, procedures and regulations facilitated more responsive utilisation of TC for ASDP implementation.

- Flexibility of TC design allowed the government to plan and determine the best utilisation of TC.

- Effective sector coordination, though it is a necessary condition, remains a challenge for achieving enhanced effectiveness of TC in agriculture.

- DPs' willingness to transfer resources from existing project or self-standing TC to supporting the planning process of ASDP was critical.

5.3. CASE STUDY 2: MOROGORO HEALTH PROJECT (MHP)

The MHP exemplifies flexible and responsive TC design. During implementation, MHP experienced several demand-driven changes in its original design. For example, it accommodated changes like extension of the completion date by one year, addition of a resource centre as a new component, and use of local institutes (e.g., Mzumbe University, Ifakara Health Research Centre) for capacity development purpose. These changes were possible because the TC design, supporting the MHP implementation, was flexible and responsive.

The project succeeded in changing health managers' attitudes towards work and in improving the delivery of health services. This case study particularly epitomises two themes, but only the first one is given special emphasis here:

- Flexible and responsive TC design.

- Organisational learning and sustained change.

Health reform is essentially the transformational process from centralised health system to a more decentralised system with the district as the core organ for the planning and management of service delivery and the region as the coordination and technical back-stop office for the district. In spite of the past large effort in operationalising this new way of service delivery at various level including policy formulation, preparation of various guidelines and protocols, mechanisms and tools for decentralised health management, systems for health services, its full operationalisation has been the challenge partly due to

the legacy of the past centralised health management as well as lack of real hands-on experiences of new ways of doing things in more decentralised health service regime.

A situation analysis of health delivery systems in Morogoro, conducted in 2000 by MOHSW and LGAs, revealed that weak managerial capacity was adversely affecting the performance and quality of delivery of health services. As a sequel to this situation analysis, MOHSW in collaboration with the LGAs in Morogoro region, assisted by a DP, decided to implement a model programme in Morogoro region and districts in the region to test and demonstrate in what ways CHMT can fully operationalise and mainstream both already available and new tools and approaches so that they can manage and support front line health workers more effectively and can also collaborate with RHMT in more effective ways.

The programme implemented during 2001 to 2006 consisted of the following three components:

- Improving the health management information system (providing computer skills, data collection and training skills, installation of radio call connection and internet access).
- Coordinating sharing of ideas and experiences among health sector staff in the region.
- Developing management skills and tools (in planning, M&E, management, operational research and data analysis).

The CD for RHMT and CHMTs was focused on improving managerial skills pertaining to programme management, financial management, human resource and material management, knowledge management and coordination. Consequently, there was real change management, in terms of strengthened managerial and operational capacities within RHMT and CHMTs in Morogoro region.

At design stage, MOHSW provided leadership, while the LGAs were at the heart of implementation. The dispatched long term and short term foreign experts played a catalyst role, in terms of providing TC for CD. During implementation, several changes in project design were introduced to reflect changes in assumptions underpinning the original project design. The changes were based on the findings of annual implementation reviews, which were conducted jointly by MOHSW, LGAs and the DP. For example, the project completion date was extended for a year. This flexibility in implementation was critical in meeting new emerging needs of the LGAs which was not in the initial design.

Types of TC provided in MHP included the following:

- TA in terms of external experts was provided throughout lifespan of the project.
- Training to CHMTs and RHMT was provided locally.

- Equipments to facilitate smooth working of the experts were availed (e.g., vehicles, computers and health learning materials.

During implementation, the Regional Administrative Secretary, assisted by the Regional Medical Officer, played a key coordination role. At the same time, the actual implementation of the project on the ground was in the hands of the relevant LGAs. The DP made sure that TC resources were made available on time and adequately. Pooling of TC resources through a project account facilitated harmonisation of project implementation.

The bulk of CD activities under the project were done by local institutions. Specifically, staff training and research were sub-contracted to Mzumbe University, CEDHA, and Ifakara Health Research Centre. Teamwork was fostered and nurtured between external experts and local counterparts in CHMTs and RHMT.

Flexible and Responsive TC Design. According to interview responses with Morogoro RHMT and as reported in the Final Summary Booklet (2007), the MHP had a lot of flexibility in TC for CD at various stages of implementation. The first two years were almost a piloting time, involving a lot of planning and adapting various new implementation strategies. This flexibility permitted accommodation of emerging needs. For example, the following new needs were introduced in the original project design without affecting the development objectives of the project:

- The project closing date was extended by one year, from April 2006 to March 2007.
- An Information Resource Centre component was added to the project three years before the original project closing date after it had been identified as a useful component by RHMT and CHMTs of Morogoro Region.
- The project's complementarity was later strengthened by involving other health institutions in the implementation of the project (Mzumbe University, Ifakara Health Research Centre, National Institute for Medical Research (NIMR), and Centre for Educational Development in Health, Arusha (CEDHA)).

Under MHP, identification of CD priorities was jointly done by MOHSW, LGAs and the DP. Specifically, it involved the Permanent Secretary of MOHSW, Chief Medical Officer in MOHSW, Regional Administrative Secretary, Regional Medical Officer, District Executive Directors and the respective District Medical Officers in the LGAs. The retired CMO summarised the project philosophy as follows: "…the most important achievement is to get people involved in their own problems, by identifying their own problems in planning with council (District) health management teams, so that together they can sort out the problems identified." (Final Summary Booklet 2007).

Flexibly using the logical framework for the project GoT staff involved in the project, with the support of foreign experts, track and accommodate unforeseen changes in outcomes. There was therefore adequate flexibility to accommodate new needs. All RHMT and CHMTs

personnel participated in management training that enabled them to perform their managerial functions better than before. This is sustainable because provision for retraining is in place. Management training was also provided to health facility staff. Training in data management and information sharing was also given priority and a practical M&E system is in place.

Improvements in delivery of health services under MHP attracted more people to seek treatment and advice at health facilities in the region than hitherto. CD under the auspices of the project improved the delivery of health services in the project area.

MPH outcomes: The bulk of CD activities under the project were done by local institutions. Specifically, staff training and research were sub-contracted to Mzumbe University, CEDHA, and Ifakara Health Research Centre. Teamwork was fostered and nurtured between external experts and local counterparts in CHMTs and RHMT. Other MHP outcomes included the following:

- Situational analysis was undertaken.
- Planning was properly done.
- Implementation of the project activities:
  - Meetings e.g. stakeholders meetings conducted regularly
  - Training to build capacity for smooth implementation
  - Monitoring and Evaluation was a regular integrated activity
  - Institutional twinning and networking

MHP major outputs were:

- Reports and publications were regularly produced.
- Trained CHMTs and RHMT for improved performance.
- Improved health service delivery.

Lessons learned from this case study include the following factors which made TC to the project relatively effective. Like in other case studies, these lessons are tentative because they are yet to pass the test of time and replication:

- Flexibility in the project design and implementation was critical to TC effectiveness under the MHP.
- CD under the auspices of the project improved the delivery of health services in the project area.

- Information management and sharing played a critical role in the success of the project.
- The use of local experts and institutions enhanced the complementarity of the project's TC.
- Continued use of local and institutions in CD activities has engendered organisational learning and sustained change in the project.
- Frequent changes in external experts delayed the implementation of the MHP.
- The MHP lacked proper direction at its initial stage and there was a lot of trial and error approach, which delayed the take off of the project plan.

5.4. CASE STUDY 3: ARUSHA MUNICIPAL COUNCIL HEALTH SECTOR REFORM (AHSR)

Arusha Municipal Council (AMC) was upgraded to municipal status in 1988. Arusha is in the northern part of Tanzania. It is located at the foot of Mount Meru. It has a population of 359,054 (population projections in 2007). AMC has 4 hospitals: 1 government regional hospital, 2 voluntary hospitals and 1 parastatal hospital. There are 12 health centres; 5 AMC health centres and 7 privately owned health centres; 42 dispensaries of which 2 belong to FBOs and 40 are privately owned.

Rationale for selection of AHSR. All LGAs in the country are involved in implementing the national Health Sector Reform Programme (HSRP). The AHSR case study embeds three themes, but emphasis is given to the first theme here:

- Organisational change management.
- Complementarity of TC and other support.
- Community-led implementation and management.

AHSR, as part of the HSRP, is critical to the decentralisation process of health services delivery in the country. This process involves organisational change management at district, ward, and village/'mtaa' level. At each level, health boards and committees were established as centres for decision-making and accountability.

Types of TC under AHSR were as follows:

- Training of local health providers.
- Training of municipal health staff in the use of modern technologies and health management.
- Equipments for training purposes.

The HSR and SWAp frameworks have created an environment which enables LGAs and the communities to initiate organisational change management with substantial financial support from GoT and DPs. For example, support for CD is channelled through the Local Government Capital Development Grants (LGCDG) system under the LGRP. Under the LGCDG system, part of the grants is specifically earmarked for capacity development within the LGAs. Other types of grants under the system require matching funds from the LGAs. This has facilitated systematic capacity development at LGA level, in line with set priorities in the comprehensive health plans of LGAs. These plans are consistent with the MKUKUTA cluster goals and targets.

AHSR is managed by the Council Health Board at the district, by Health Centre Committees at health centre level, and by the Ward Development Committees at ward level. At each of the levels there are stakeholder community representatives who ensure the community participation in all decisions related to health services in their areas. This organisational change management is taking place at these grassroots levels within the context of the HSR.

During field visits, it was observed that the necessary conditions for nurturing the fledgling change management are in place. The District Health Board and Ward level meetings usually discuss how to improve the health services. The availability of drugs and improved health services at all levels of health facilities have attracted and led service users to trust the service providers. The availability of IMCI guidelines have contributed to significant changes in management. AMC has a staff training programme based on its training priorities. The training priorities include: HSR, management, research methodology and financial management. These are central to organisational change management. However, a review of HSR may be justified to particularly address the PHC pillars, such as health promotion which is presently not accorded high priority.

Complementarity of TC and other support. AMC officials confirmed that the TC support to AHSR has trickle-down effects on activities supported by other organisations in the health sector. In particular, there is strong synergy between AHSR and activities of other programmes in training. Similarly, some AHSR trained staff are "poached" by other organisations. There is also service complementarity at all levels among health providers in the district. For example, AHSR hospitals act as referral centres for patients from private and NGO health centres and clinics. Similarly, a DP-supported research centre for sexually transmitted diseases at Levolosi Health Centre is linked to all AHSR health facilities. Furthermore, health specialists outside AHSR (e.g., laboratory technologists) from a DP provided training to laboratory staff of Mt Meru Hospital. In addition, medical specialists based at KCMC referral hospital frequently visit AMC health facilities to treat patients.

The cost-sharing mechanism, initiated under AHSR, is the major instrument for ensuring TC complementarity with stakeholders' contribution to the construction of health facilities and delivery of health services by AMC. Under the cost-sharing mechanism, stakeholders as recipients of health services are required to share the cost of health service delivery, except

in cases of pandemic diseases. In the circumstances, TC resources complement stakeholders' contribution to make AHSR operational.

AHSR outcomes included:

- Planning
- Meetings at various levels
- Implementation that involved the following activities:
    - Training of different staff levels
    - Involvement in decision-making by various stakeholders
    - Formation of health boards and health committees at the respective levels
- Monitoring and Evaluation.

AHSR outputs:

- Comprehensive Municipal Health Plan [CMHP]
- Trained staff
- Infrastructure and equipments procured through HSBF with the advice from external experts
- Improved health service delivery.

Lessons learned under the AHRS are tentative because they are yet to stand the test of time and replication:

- Complementarity of TC to AHRS achieved its greatest impact by embracing all non-government health facilities to participate jointly in the delivery of health services in AMC.
- Participation of grassroots institutions and stakeholders in the planning and implementation of AHRS was, and remains, critical to its success in improvement of delivery of health services.
- Availability of medical supplies and drugs financed separately assured that the TC provided to AHRS was adequately utilised – a complementarity benefit.
- Availability of drugs and improved health services at all levels of health facilities have made service users trust the service providers.
- The AHRS has proved to be an effective instrument for implementing the HSR objective of introducing organisational change management whereby the

management and implementation of health services delivery is transferred to the grassroots institutions.

- The AHRS is underpinned by community leadership in managing and implementing all its components, while the communities' role in financing the programme is reduced to nominal cost sharing.
- The AHSR faced the following challenges:
  - Uneven distribution of TC within the municipal catchment area
  - The modern laboratory equipment maintenance may be a future challenge as spare parts are not available locally.

5.5. CASE STUDY 4: THE TANZANIA ESSENTIAL HEALTH INTERVENTIONS PROJECT [TEHIP]

TEHIP exhibits country-led TC implementation and management. GoT was keen to validate the hypothesis that carefully planned investments in health could reduce the burden of disease in the country. The implementation of TEHIP was managed by MOHSW (Box 7). It is consistent with HSR objectives under the health research component. This component has the following research sub-components:

- Evaluating alternative health systems;
- Evaluating behaviour of communities in utilising health services;
- Evaluating mechanisms used to provide health data in Morogoro Rural and Rufiji districts.

TEHIP Objectives. The primary objective of TEHIP was to measure the impact of an evidence-based approach to health planning at the district level. Its objectives consisted of the following:

- Strengthening district health capacity to plan in Rufiji and Morogoro Rural Districts;
- Increasing district health capacity to effectively deliver the selected health interventions;
- Assessing and documenting lessons learned in district health planning and management information systems and processes;
- Measuring the overall impact of delivered health interventions on reduction of the burden of disease.

Types of TC that were provided under TEHIP included the following:

- Two foreign experts;

- Financial support for foreign staff remunerations;
- Equipment and vehicles required by the foreign experts.

Programme Implementation. GoT initiated the development of this programme with TC assistance from two DPs. GoT hired programme staff, including two foreign experts, on a competitive basis. The programme was designed on the basis of evidence-based burden of diseases obtained through baseline studies done by local health research institutions (i.e., Ifakara Health Research Centre and MUCHS).

After the initial training, the relevant LGA staff were now able to plan better and work as a team. On the basis of the baseline studies, the behaviour of the community utilising the health services was determined. Eventually this provided benchmarks for measuring future impacts of the programme.

MOHSW provided leadership at all stages of programme planning and implementation. A Programme Steering Committee, composed of MOHSW, LGA representatives and DPs, was

Box 5: Attributes for Country-Led TC Implementation and Management Associated with TEHIP

MOHSW played the following roles:

- Recognised the importance of and provided leadership in evidence-based planning.
- Targeted investment in TEHIP to reduce the burden of disease.
- Used TC resources to carry out capacity development at all TEHIP levels.
- Recognised the key role of data management and an effective M&E system in measuring the impact of TEHIP.

LGAs played the following roles:

- Carried out the actual evidence-based planning and managing of health services under TEHIP.
- Participated in the design and implementation of an effective M&E and reporting system.
- Ensured information sharing among health sector stakeholders.

Local Communities played the following roles:

- As stakeholders, they participated in the programme planning and implementation in accordance with their needs.
- As stakeholders, they provided feedback through behaviour change.

established to supervise programme implementation. Steering Committee meetings were usually chaired by the PS of MOHSW. Quarterly implementation reports were routinely prepared. Attributes that engender country leadership in TC implementation and management in TEHIP are summarised in **Box 5.**

TEHIP outcomes included the following:

- Experimentation of the hypothesis that investment reduces the disease burden;
- Training in research methods;
- Meetings and conferences;
- Plan preparation and implementation;
- Monitoring and evaluation.

Programme outputs included the following:

- Reports and other publications;
- Trained staff and community;
- Improved delivery and sustainability of public health services;
- Programme scaling up at national level (National Expansion of TEHIP Tools and Strategies).

Programme impact was measured by the following:

- The burden of disease, as measured by incidence of disease and mortality rates, decreased substantially in the programme areas.
- TEHIP was associated with high pay-offs on its investments.
- Under TEHIP health services delivery improved significantly.
- Health users' behaviour changed and became more hospital- and health providers-friendly than before.
- Health providers appreciated the approach of evidence-based planning in improving the delivery of health services.
- TC provided for CD under TEHIP was critical to improving the quality of delivery of health services.

Lessons learned from TEHIP are tentative because they are yet to stand the test of time:

- CD provided through TC for TEHIP was critical in improving the quality of health services through specialised training programmes.

- Improved quality of delivering health services induced behavioural change in local communities who, more frequently than ever before, sought medical assistance for their health problems.
- Sector and local leadership played a critical role in planning the use of TC and in implementing the programme.
- Involving local leadership in programme planning and implementation engendered strong ownership of the programme by the communities.
- Evidence-based planning and implementation, through participatory approaches, enhanced the effectiveness of TC for CD.

5.6. CASE STUDY 5: PARTICIPATORY AGRICULTURE DEVELOPMENT & EMPOWERMENT PROJECT (PADEP)

This case study epitomises capacity development at lower levels (district and villages) that engenders considerable complementarity of TC and other support at the grassroots level. PADEP facilitated participation of villages and communities in agricultural and rural development.

PADEP was conceived by GoT in 2003 with the assistance of a multilateral DP. The project duration was five years, scheduled to end 2008. The project adopted a decentralised approach, involving the LGAs, rural communities and private sector in planning and executing demand-driven agricultural development activities. It therefore promotes decentralised decision making with greater involvement of farmers' groups and village communities in planning, implementation and management of demand-driven subproject investments. In addition, it supports the participation of the private sector, local NGOs and CBOs in the identification, designing and implementation of the subprojects. PADEP is considered as an intervention complementing ASDP and other DP-supported projects at grassroots level.

The project is coordinated by the MAFC at the national level, but implementation on the ground is done by various participating LGAs, communities and farmer groups. The project covers ten mainland regions (Iringa, Manyara, Morogoro, Mtwara, Arusha, Kilimanjaro, Lindi, Singida, Tabora and Tanga.) and Zanzibar. Twenty-six districts are covered in the mainland in the above regions.

The overall development objective of the project is to increase farm incomes and reduce food security, thereby contributing to reduction of rural poverty. The project's immediate objectives are to (i) strengthen capacity of rural communities to plan and implement demand driven agricultural development initiatives; (ii) strengthen the institutional and human capacities at LGA and national level to plan and implement community agricultural development initiatives; (iii) increase agricultural productivity and production by promoting integrated and sustainable use and management of natural resources through

adoption of improved technologies; and (iv) enhance private sector participation in input and output markets, and in the provision of services and rural communities. The project is composed of two major components namely: (i) Community Agricultural Development Subprojects consisting of community investment and farmers' group investment subprojects. (ii) Institutional Strengthening and capacity building at community, district and national level.

The focus of this case study is on the second component for capacity development. This component supports various capacity development activities at all levels of project implementation, namely at community, district and national levels. Activities include training, acquisition of working equipments, improvement of policy and regulatory framework, strengthening technological linkages, provision of technical assistance, advisory services as well as support to public-private partnership. Specifically, at community level, capacity is developed to enable communities to identify, prepare and implement demand driven interventions. At both district and national levels, the emphasis is to strengthen the institutional capacities to coordinate and harmonise community agricultural initiatives with ASDS and MKUKUTA cluster objectives and targets.

This project is supported by a multilateral DP. GoT, LGAs and project beneficiaries (communities) also make contributions. Beneficiaries are responsible for managing their subproject under the supervision of LGAs. Farmers and communities in general are targeted with "smart subsidies".

Empirical evidence of successful capacity development results. Capacity development under PADEP has, to a large extent, demonstrated success. Community level training has enabled farmers and communities at large to identify, implement and manage demand-driven agricultural subprojects. PADEP annual progress reports show a total of 254 villages have been facilitated to carry out participatory planning against 243 villages as per plan. Likewise, farmers groups and community subproject investment committees in all implementing villages have been trained in basic financial management and procurement skills to enable them to properly manage their financial resources and procurement processes. The outcome of training is demonstrated by this capacity at community level in project areas.

The immediate impact of the above training is reflected in the increase of subprojects which were identified, prepared and submitted to the project coordinating unit (PCU) for funding. A total of 1,464 subprojects (116.2% of the plan) were identified, prepared and submitted to the PCU for funding. In addition, various farmers have received training on different technologies related to the subprojects being undertaken. It was estimated that by June 2007, PADEP would have disbursed grants amounting to Tsh 1.8 billion to participating communities and farmers groups for technical assistance and training on technologies.

At the LGA level, capacity development has been undertaken by implementing demand-driven activities which include study exchange visits, staff training on aspects related to

participatory project planning and support to private sector development. In all participating LGAs, district facilitation teams have been trained on DADP planning and implementation framework. Except for a few LGAs, the facilitation role of LGAs was helpful in assisting communities to identify, implement and manage projects. PADEP also supported training and development of DADPs in 61 LGAs in 10 regions. There is evidence that districts which had been under PADEP support demonstrated higher level of capacity to facilitate the DADP preparation process, which is a basic component of ASDP.

Relationship between TC and CD outcomes. At community level, participatory training and technical service provision (TC) in project areas has contributed to various CD outcomes. Literature review and available data from PADEP show these outcomes as increased farmers' empowerment, application of better technologies and increased use of farmer investment grants through better identification of feasible projects. At district level TC has mainly been in terms of training and infrastructure support. CD outcomes are reflected in terms of better participatory skills to district employees through the District Facilitation Team (DFT) and Ward Facilitation Team (WFT). It has been observed (opinion of PADEP official) that districts with PADEP programmes have managed to produce good DADPs as compared to districts without PADEP support. DADPs include projects or development activities supported by other DPs, hence PADEP's complementarity to other support at the district and villages levels.

Implementation arrangements and process. Under PADEP capacity development was seen as an essential ingredient for the project's success. In order to undertake effective capacity development, participatory methods were used to assess capacity needs and plan for interventions at all levels. Capacity development plans were developed at all levels of implementation and therefore created the basis for funding. Funding for district capacity development activities was managed by LGA officials and used to acquire demand-driven capacity development interventions. LGAs were required to contribute 10% of the capacity grant received as counterpart funds for capacity development. The capacity development component, apart from training and technical assistance, also included support services like transport and working tools.

Development Partners' role in the success. The DP agreed to finance this project because of the need to enhance participatory approaches in reducing poverty in Tanzania (community-driven development approach). Likewise the project was a government initiative aligned to sector and national strategies as espoused by the ASDS and MKUKUTA. The DP allowed the government to use its systems, regulations and procedures to run the project. After agreeing on the core principles, the management of the project was solely left to GoT.

Lessons learned. Apart from capacity development achievements realised under PADEP, several challenges have been observed. As a stand-alone project, PADEP has features and guidelines which do not conform to government budgetary procedures. For example, the transferring of funds directly to farmers bypasses the LGA budgetary system. To what extent are PADEP activities integrated into existing sector procedures and objectives? A

PADEP official indicated that the programme was supposed to pilot ASDP, but to what extent this has been achieved is difficult to answer. Sustainability of farmers' and community investment activities is also questionable after the DP funding stops.

Nevertheless, there are some good tentative lessons worth taking from the implementation of PADEP. These lessons are tentative because they are yet to be proven in the long term:

- Untied funds for TC under PADEP improved capacity development in the rural sector in general and in the agricultural sector in particular in participating districts.
- TC for CD under PADEP provided capacity for DADP formulation and implementation and, hence, complemented support provided by other DPs under the auspices of the DADP framework.
- Flexibility to use PADEP funds for TC to finance demand-driven interventions identified through a participatory process catalysed capacity development at grassroots level.
- Development of capacity needs through a participatory process was key to the observed effectiveness of TC for CD under PADEP.
- Capacity development at grass root levels was, and is likely to remain, critical to the success in achieving PADEP's development objective.
- Provision of appropriate and effective capacity development to farmers was the basis for success and sustainability of PADEP's development objective.

5.7. CASE STUDY 6: THE KILIMANJARO AGRICULTURAL TRAINING CENTRE (KATC).

This case study exemplifies characteristics of organisational learning and sustained change. KATC strengthened a public agricultural training institute for innovative service delivery.

The process of establishing KATC was born out of the need to build on what had been achieved in the implementation of the Lower Moshi Irrigation Scheme, better known as the Kilimanjaro Agricultural Development Project (KADC). The success recorded in KADC prompted GoT to collaborate with the DP to establish a rice irrigation training centre. Capacity needs assessment and design of TC was done jointly by GoT and the DP. The running of the centre was done by GoT, while the DP provided technical assistance in training instructors and developing relevant curricula. Training of farmers was also funded by the donor. In addition, working equipments were also provided. Local ownership and leadership characterised the TC design. In the TC design, the farmer to farmer training methodology was adopted and it targeted capacity development at the grassroots level.

KADC facilities were renamed as KATC and the KATC project started in July 1994. KATC is the only institute specialising in irrigated rice cultivation techniques. The main objective of

the project at KATC was to strengthen the technical capability of extension personnel in delivering extension services to farmers who are involved in irrigated rice farming. The basic components of the project include:

- Enhancement of technical capability of trainers;
- Improvement of training materials;
- Improvement of training methods;
- Training of extension personnel and key farmers;
- Improvement of extension methods.

KATC project was implemented in two phases. KATC I lasted from July 1994 to June 2001. KATC II was implemented from October 2001 to September 2006.

GoT contribution to the project was in form of staff salaries, land and buildings. TC assistance was mainly in terms of:

- Enhancement of the technical and pedagogical capabilities of KATC staff;
- Meeting the cost of running residential courses;
- Meeting travel expenses to the model sites;
- Providing equipments to the model sites;
- Replacement of worn out KATC equipment and machinery.

Empirical evidence of successful capacity development results. As a result of its unique training methodology which involves the farmer on the farm, the project has been able to demonstrate the increase of rice yields by smallholder farmers. In all areas where the project is implemented, paddy rice yields averaged between 6 and 7 tons per hectare as compared to the national average of less than 2 tons per hectare. This has been possible because farmers have been able to adopt simple low-cost but yield-enhancing technologies for rice farming.

Through on-farm training and farmer exchange visits, trainers at KATC have been able to empower farmers to increase their rice yields several fold. The KATC model site approach was developed jointly by local trainers and technical assistance personnel.

KATC was able to develop demand-driven courses for farmers and relevant extension officers. These included:

- Key farmers' courses
- Extension Officers (VAEOs) and Irrigation Technicians course;

- Irrigation Technicians and farmers leaders course;
- Farming survey training course;
- Hand tractor operators course;
- Oxenisation course for VAEO.

KATC has been able to establish networks with other established irrigation schemes in Uganda (Doho irrigation project), Kenya (Southwest Kano irrigation project), Malawi (Bwanje valley irrigation project) and Zambia (Sefula irrigation project). This regional networking has enabled to KATC trainers to share experience and learn from other irrigation schemes.

Implementation arrangements and process. Technology transfer is done through three different methods including:

(i) From key farmers to intermediate farmers and from there to all other farmers in the scheme through demonstrations and free exchange of information.

(ii) From the model sites to neighbouring irrigation schemes through the efforts of District councils.

(iii) From the district to other districts and regions through the efforts of Zonal irrigation officers.

Development Partners role in the success. The role of the development partner was limited to the provision of TA and other supporting equipments. TC, in form of TA and training, helped in establishing a demand-driven centre for capacity development at small producer level. Extensive government consultations were undertaken by the donor in implementing this project. This is evidenced by the fact that TC design in the second phase had to be adjusted in order to build more effective capacity development. In KATC phase 1 training was only done at the centre without field work. However in KATC 2 more field work and follow-up visits were emphasised.

The relationship between TC provided and CD output can be summarised as follows: Enhancement of the technical and pedagogical capabilities of KATC staff has produced sufficient quality instructors. The principal of KATC confirmed during the interview that staff training received through respective TC arrangements has developed specialised skills in irrigated rice production. Technical capability of KATC instructors has been enhanced. Paying the cost of running residential courses for farmers and follow-up visits has resulted into building the capacity of farmers in designated project areas. The Agriculture Sector Review (2006) pointed out that paddy yields have increased from an average of 2 tons/ha to 7 tons/ha. This dramatic increase in yields is attributed to the farmer to farmer training method of KATC. Increased rice yields would potentially have an impact on farmers' income. This income effect could not be documented with certainty as data was not

available. Apart from increase in yield, the adoption rate of the new technology by farmers was estimated to be 90 percent (Agriculture Sector Review, 2006).

Lessons learned. Like lessons under other case studies, the lessons learned under KATC are tentative. Although the project recorded impressive yield achievements, certain challenges emerge from this type of TC delivery. One important issue is the financial sustainability of KATC operations after TC support ends. To what extent can KATC provide affordable training to poor farmers and be sustainable without donor support? Another challenge cited by the Head of KATC was that TC delivered was tied to the source of support and that this arrangement inhibited flexibility in acquiring TAs from other sources, including local.

Notwithstanding, this case study provides tentatively notable lessons. The first important lesson is that capacity development among farmers is a long-term process. It took KATC nearly 12 years to reach and sustain the current yield levels in farmer fields. This suggests that the long-term TC support to KATC consolidated and eventually fed into sustainable capacity development at the farm level.

The provision of complementary support (e.g., working equipments and financial assistance) made TC under KATC more effective. It was, for example, notable that the adequate working environment under KATC improved morale of employees and sponsorship of farmers facilitated effective functioning of the training institute.

Capacity development targeting farmers can have high pay-offs in the medium to long term as demonstrated by the high yields of paddy rice under KATC. However, KATC achieved this success because its capacity development (especially training and technology development) was demand-driven rather than supply-driven.

5.8. OVERALL SUMMARY OF LESSONS LEARNED AT SECTOR LEVEL

The review of the agricultural and health sectors and the analysis of the good practices in both sectors have identified several factors which help or impede TC contribution to sustainable capacity development at sector and programme level.

Factors or conditions helping TC to contribute to sustainable CD in sectors and programmes include the following:

- The existence of government owned national and sector polices and strategies. This condition helps in focusing the required capacity development to meet MKUKUTA cluster objectives and targets.
- The ongoing macro and sector reforms have provided the foundation on which TC for capacity development has been anchored.
- The design of innovative mechanisms for managing and coordinating development assistance (namely the JAST, GBS, and SWAps) have helped to mobilise TC for CD in both sectors.

- The design of innovative TC delivery mechanisms (e.g., SWAps and SBF) have helped to mobilise and pool TC resources at the sector and programme level.
- Pooling funds for TC appears to be more effective in allowing the beneficiary sectors to source competitively the required TA and use it according to set priorities.
- Political commitment to change management through reforms at sector and organisational levels has been critical to capacity development in the agriculture and health sectors.
- GoT and LGA ownership and leadership in planning and implementing sector interventions have been critical to TC effectiveness.
- There are no "quick fixes" and long-term commitment to supporting sector or programme interventions by DPs is the only plausible way of providing TC for CD.

Factors impeding TC contributing to sustainable CD in sectors or programmes include the following:

- Although elaborate national and sector policies and strategies exist, comprehensive national and sector strategic capacity development plans have not been developed.
- The absence of a coherent national policy framework for TC to guide sector and organisational CD roadmaps and priorities is a moot paradox.
- Persistence of poor pay incentive structure and work infrastructure in the public sector is deleterious to sustainable capacity development and capacity utilisation.
- Inadequate supervision of TA and counterpart staff at organisational level is still rampant and harmful to effectiveness of TC for CD.
- Lack of effective mechanisms for skills transfer and sharing at organisational level negates sustainable CD.
- Inadequate and unpredictable financing of capacity development activities at sector and MDA level stifles CD.
- Weak complementarity between TC for CD and support for infrastructure, especially at health training institutions and hospitals, leads to critical bottlenecks in capacity development processes.
- Dualism is still apparent between the operations of the public health sector and the private health sector, leading to unnecessary duplication in the delivery of health services. A classic example of this dilemma is the planned government heart surgery facility, when there is already a private heart surgery facility in the country.

6. OVERALL CONCLUSIONS, ISSUES IDENTIFIED, AND RECOMMENDATIONS

6.1. OVERALL CONCLUSIONS

The following conclusions should be regarded as a basis for further stakeholder consultations:

- TC has played a critical role in enabling Tanzania to pursue its development priorities by supporting the implementation of a variety of policy and strategic interventions, including change management in the entire public sector.
- Tanzania's experience strongly suggests that the vision and commitment of the national and sector leadership to change management (reforms) has been the most critical factor for sustained capacity development.
- Capacity development process is not a single-event outcome as all Tanzania's major public sector reforms and capacity building programmes "have evolved out of frustrations and problematic experiences with piecemeal and fragmented donor-supported projects" (KK, 2007).
- TC has proved relatively effective in increasing learning and reflection within MDAs that were responsible for facilitating change.
- TC can be effective when designed or delivered with flexibility to respond to changes in organisational priorities and needs.
- TC can be more effective when it focuses on the needs of the entire organisation rather than on specific groups of individuals.
- The effectiveness of TC in capacity development cannot be reduced simply by trained individuals leaving the organisation, since TC also builds organisational capacity to attract new experts in the domestic labour market.

- Individual consultants perform better when their supervisors regularly monitor their performance and know how and when to deploy them appropriately.
- TC does not necessarily create a risk of foreign or

local experts substituting for technical staff within their organisation, since, in most cases, private sector experts (local and foreign) can complement an organisation's staff within the context of the domestic labour market.

- Tanzania's capacity to formulate and implement, with the help of DPs, coherent and articulated development strategies (MKUKUTA) and reform programmes has been key to building mutual trust between GoT and DPs – essential for underpinning constructive TC dialogue and initiating joint innovative interventions like the JAST.
- Country leadership, defined to include ability to prepare development policy, strategies and reforms and sell them to DPs for support, has been the hallmark of Tanzania's effective aid.
- CD has generally not been a visible component of TC even where it has been the underpinning objective of DP support, making it difficult to monitor and evaluate CD using the available M&E frameworks. The implementation of the JAST Action Plan and Monitoring Framework is the right step towards making TC more transparent in CD.

6.2. ISSUES IDENTIFIED

This review has identified several key issues or challenges pertaining to effective TC in Tanzania. The issues primarily relate to how to overcome the impeding factors for effective TC. These have been specified in overall, sector and case study analyses in the Review and can be summarised as follows:

- The lack of a national TC policy framework is a critical inadequacy and the ongoing effort of GoT to rectify this shortcoming is welcome.
- There is a general lack of capacity development plans based on capacity needs assessment at organisational and sector level.
- Capacity underutilisation is apparent in the public sector and may frustrate current and future capacity development interventions.
- Inadequate complementarity of TC support and other support, with special reference to infrastructure support at organisational and sector level.
- Inadequate pay incentives and poor working infrastructure have encouraged the brain drain phenomenon amongst highly qualified health professionals.
- Poor utilisation of TA at sector and organisational levels, which is often compounded by inappropriate selection of local counterpart staff to understudy TA experts.
- Inadequate and unpredictable financing of capacity development programmes, which is often compounded by lack of strategic prioritisation of CD in MDAs.

- Persistent lack of transparency in delivery of TC for CD by several DPs outside SWAp frameworks (e.g., SBFs) continues to render TC the semblance of being donor-driven and less effective.

6.3. KEY RECOMMENDATIONS

How can the lessons of the good practices be consolidated and expanded to ensure that the necessary conditions for effective TC are in place? There are several options for doing this at national, sector and organisational/programme levels.

Options at national level. The following are highly recommended as joint actions to be undertaken by GoT in collaboration with DPs and stakeholders at national level:

- Preparation of a National Technical Assistance Policy Framework (NTAPF) incorporating the lessons of good practices at national (e.g., JAST and GBS), sector and programme levels. Since several major DPs have their own TC policy guidelines, it is imperative that the NTAPF – to the extent possible - takes these into account for consistency's sake. The NTAPF should be prepared and put in place without further delay, using consultative approaches involving GoT, DPs and other major TC stakeholders. The existing GoT Team for NTAPF should be reconstituted to reflect this.

- The implementation of the JAST Action Plan and Monitoring Framework is the right step towards making TC more transparent in CD.

- TC for capacity development in Tanzania should increasingly focus on LGAs, where most of the development activities to meet both MKUKUTA cluster targets and MDGs have been shifted under the LGRP. This requires increasing the capacity building grants under the LGCDG system, while, at the same time, making their use more effective by strengthening local accountability.

- Given the perception of rampant capacity underutilisation in the public sector, a specific study to examine this issue in detail would be the appropriate starting point. Again, GoT and DPs would need to agree on the timing and funding of this exercise.

Options at Sector and MDA Level. Both GoT and DPs need to make the following actions the focus of TC at sector and MDA level:

- Preparation and implementation of detailed capacity assessment studies.

- Preparation and implementation of capacity development plans or roadmaps based on capacity assessment studies and the findings of the capacity underutilisation study at the national level.

- Mainstreaming of TC into capacity development plans or roadmaps at sector or MDA level (e.g., SBFs, MTEF and Sector Reviews).

- Ensuring that TC for implementing sector or MDA capacity development plans or roadmaps have strong TC complementarity with sector or MDA infrastructure, particularly training and work infrastructure. This can be done during the MTEF and annual budget preparation process.
- GoT and DPs need to adopt some of the prospective good practices, including increased use of pooled aid delivery mechanisms, such as SBFs in SWAp operations.
- TC for capacity development in Tanzania should increasingly be focused on grassroots (village) level operations, where it would enhance productivity and efficiency in production (e.g., agriculture) and delivery of public services (e.g., health services). The existing SWAps and BSFs offer the best opportunities for targeting TC for CD at the grassroots.

Options at Programme Level in Agriculture. Both GoT and DPs need to make the prospective good practices in the TC case studies the main focus of TC at programme or project level:

- Ensure adequate supervision of TA and counterpart staff at organisational and programme level to enhance effectiveness of TC for CD.
- Devise mechanisms for skills transfer and sharing at organisational or programme level.
- Innovative TC delivery mechanisms (e.g., SWAps and SBF) have helped to mobilise and pool TC resources at programme level.
- Capacity development among farmers is a long term process (e.g., it took KATC nearly 12 years to reach and sustain the current yield levels in farmers' fields), suggesting that the long term TC support to KATC consolidated and eventually fed into sustainable capacity development at the farm level.
- The provision of complementary support (e.g., working equipments and financial assistance) made TC under KATC more effective, because, for example, the adequate working environment under KATC improved morale of employees and sponsorship of farmers facilitated effective functioning of the training institute.
- Capacity development targeting farmers can have high pay-offs in the medium to long term as demonstrated by the high yields of paddy rice under KATC. However, KATC achieved this success because its capacity development (especially training and technology development) was demand-driven rather than supply-driven.
- Untied funds for TC under PADEP improved capacity development in the rural sector in general and in the agricultural sector in particular in participating districts.

- TC for CD under PADEP provided capacity for DADP formulation and implementation and, hence, complemented support provided by other DPs under the auspices of the DADP framework.
- Flexibility to use PADEP funds for TC to finance demand-driven interventions identified through a participatory process catalysed capacity development at grassroots level.
- Development of capacity needs through a participatory process was key to the observed effectiveness of TC for CD under PADEP.
- Capacity development at grassroots levels was, and is likely to remain, critical to the success in achieving PADEP's development objective.
- Provision of appropriate and effective capacity development (extension service and technologies) to farmers was the basis for success and sustainability of PADEP's development objective
- Government ownership of strategies and policies was critical in the process of developing TC for CD in agriculture. Deriving from this case study was the fact that GoT, through its sector ministries, prioritised and sought demand-driven TC. Hence, Government ownership of strategies and policies was key in engendering demand-driven TC.
- Pooling funds for TA made TC more effective as it allowed the beneficiary ministries to procure TA competitively and use it according to identified priorities. This specifically suggests that employment of consultants who knew the local conditions made TC more effective than otherwise.
- Use of government procurement systems, procedures and regulations facilitated more responsive utilisation of TC for ASDP implementation.
- Flexibility of TC design allowed the government to plan and determine the best utilisation of TC.
- Effective coordination among the ASLMs remains a challenge for achieving enhanced effectiveness of TC in agriculture.
- DP's willingness to transfer resources from existing project or self-standing TC to supporting the planning process of ASDP was critical and it should be extended to other similar interventions.

Options at Programme Level in the Health Sector. Both GoT and DPs need to make the prospective good practices by the TC case studies in the health sector the main focus of TC at programme or project level:

- Flexibility in the project design and implementation was critical to TC effectiveness under the MHP.
- Staff training under the auspices of the MHP improved the delivery of health services in the project area.
- Information management and sharing played a critical role in the success of the MHP and should be replicated in other similar programmes/projects.
- The use of local experts and institutions enhanced the complementarity of TC under the MHP and ways of replicating this in other projects should be carefully examined.
- Continued use of local experts and institutions in CD activities has engendered organisational learning and sustained change in the MHP and its replication in similar projects should be carefully examined.
- Frequent changes in external experts delayed the implementation of the MHP and should be avoided in other programmes or projects in future.
- Inadequate transparency in TA procurement by MHP management and the DP retarded the effectiveness of TA and it should be avoided in similar projects in future.
- The MHP lacked proper direction at its initial stage and there was a lot of trial and error approach, which delayed the take off of the project plan.
- Complementarity of TC in the AHRS achieved its greatest impact by embracing all non-government health facilities to participate jointly in the delivery of health services in AMC. Opportunities for replicating this in similar projects should be carefully examined.
- Participation of grassroots institutions and stakeholders in the planning and implementation of AHRS was, and remains, critical to its success in improvement of delivery of health services. It offers good opportunities for replication in similar projects in the health sector.
- Availability of medical supplies and drugs financed separately assured that the TC/TA provided to AHRS was adequately utilised
- Availability of drugs and improved health services at all levels of health facilities under AHRS made service users trust the service providers.
- The AHRS proved to be an effective instrument for implementing the HSR objective of introducing organisational change management whereby the management and implementation of health services delivery was transferred to the grassroots institutions. This offers ample opportunities to other similar programmes under the HSR.

- The AHRS was underpinned by community leadership in managing and implementing all its components, while the communities' role in financing the programme was reduced to nominal cost sharing. Can this be replicated?

- The AHSR faced the following challenges, which have implications for other projects under the HSR:

    - Uneven distribution of TC within the municipal catchment's area;

    - The modern laboratory equipment maintenance may be a future challenge as spare parts are not available locally;

    - There are too many free-riders who live outside AMC but use the AHSR health services.

- CD provided through TC for TEHIP was critical in improving the quality of health services through specialised training programmes.

- Improved quality of delivering health services induced behavioural change in local communities who, more frequently than ever before, sought medical assistance for their health problems.

- Sector and local leadership played a critical role in planning the use of TC and in implementing TEHIP.

- Involving local leadership in planning and implementation of TEHIP engendered strong ownership of the programme by the communities.

- Evidence-based planning and implementation, through participatory approaches, enhanced the effectiveness of TC.

APPENDIX 1: SUMMARY OF PERCEPTION SURVEY RESULTS

	Question	Total Score	Average Score	Rating Scale
Q1	Technical cooperation (TC) proves more effective when your organisation and donors work together on capacity development (CD) needs assessment	98	3.6	partially disagree
Q2	Majority of the TC designs are appropriate and well targeted, meeting the demands of sector/thematic development priorities	93	3.4	partially disagree
Q3	TC programmes have proved more effective when the kinds of support can be regularly adjusted to meeting any changes needs of the organisation	92	3.4	partially disagree
Q4	Sector/thematic ministries and organisations are always willing and able to lead the preparation of C D plans without the need of TC	66	2.4	agree
Q5	TC has proved effective in contributing to improvements in both sector and organisational performance and results	61	2.3	agree
Q6	Pooling TC funds from a number of donors is more effective in building capacity than separate stand-alone TC from a single donor	53	2.0	agree
Q7	TC has proved more effective when it focuses on the needs of the entire organisation, rather than specific groups of individuals	59	2.2	agree
Q8	The effectiveness of TC in building capacity is reduced by trained individuals leaving the organisation	70	2.6	agree
Q9	TC proves to be more effective when it is linked to other forms of support, such as infrastructure and equipment provision	83	3.1	undecided
Q10	TC programmes have created a serious risk of foreign or local experts substituting technical staff within their organisation	50	1.9	strongly agree
Q11	TC has proved to be more effective when the procurement process is directly under the control of the sector/thematic organisation	49	1.7	strongly agree
Q12	TC have proved to be more effective when the management process is directly under the control of the sector/thematic organisation	56	2.1	agree
Q13	Local or regional consultants have proved more effective than international ones because they understand the country context better	58	2.1	agree
Q14	Long term consultants have proved more effective than short-term ones because they have time to understand the organisational context and needs	66	2.4	agree
Q15	Consultants have proven to perform better when they are fully monitored by the beneficiary organisation	50	1.9	strongly agree
Q16	TC has contributed in central and sector ministries and organizations in using the 8-hour working day more productively.	44	1.6	strongly agree

APPENDIX 2: SUMMARY PERCEPTION SURVEY RESULTS IN AGRICULTURE

	Question	Total Score	Average Score	Rating Scale
Q1	Technical cooperation (TC) proves more effective when your organization and donors work together on a capacity development (CD) needs assessment	28	1.4	Strongly agree
Q2	Majority of the TC designs are appropriate and well targeted, meeting the demands of sector/thematic development priorities	40	2	Agree
Q3	TC programs have proved more effective when the kinds of support can be regularly adjusted to meeting any changing needs of the organization	27	1.35	Strongly agree
Q4	Sectoral/thematic ministries and organizations are always willing and able to lead the preparation of capacity development plans without the need for TC	38	1.9	Agree
Q5	TC has proved effective in contributing to improvements in both sector and organizational performance and results.	34	1.7	Strongly agree
Q6	Pooling TC funds from a number of donors is more effective in building capacity than separate, stand-alone TC from a single donor	47	2.38	Agree
Q7	TC has proved more effective when it focuses on the needs of the entire organization, rather than specific groups of individuals	27	1.35	Strongly agree
Q8	The effectiveness of TC in building capacity is reduced by trained individuals leaving the organization	32	1.6	Strongly agree
Q9	TC proves to be more effective when it is linked to other forms of support, such as infrastructure and equipment provision	24	1.2	Strongly agree
Q10	TC programs have created a serious risk of foreign or local experts substituting for technical staff within their organization	90	4.5	Partially disagree
Q11	TC have proved to be more effective when the procurement process is directly under the control of the sector/thematic organization	36	1.8	Strongly agree
Q12	TC have proved to be more effective when the management process is directly under the control of the sector/thematic organization	28	1.4	Strongly agree
Q13	Local or regional consultants have proved more effective than international ones because they understand the country context better	43	2.15	Agree
Q14	Long term consultants have proved more effective than short-term ones because they have time to understand the organizational context and needs	45	2.25	Agree
Q15	Consultants have proven to perform better when they are fully monitored by the beneficiary organization	32	1.6	Strongly agree

APPENDIX 3: SUMMARY RESULTS OF HEALTH SECTOR PERCEPTION SURVEY

	Question	1	2	3	4	5
1.	Technical cooperation (TC) proves more effective when your organisation and donors work together on capacity development (CD) needs assessment	**2**	**2**	**1**		
2.	Majority of the TC designs are appropriate and well targeted, meeting the demands of sector/thematic development priorities			**3**	**2**	
3.	TC programmes have proved more effective when the kinds of support can be regularly adjusted to meeting any changes needs of the organisation	**3**	**2**			
4.	Sector/thematic ministries and organisations are always willing and able to lead the preparation of C D plans without the need of TC		**4**	**1**		
5.	TC has proved effective in contributing to improvements in both sector and organisational performance and results	**1**	**1**	**3**		
6.	Pooling TC funds from a number of donors is more effective in building capacity than separate stand-alone TC from a single donor	**2**	**3**			
7.	TC has proved more effective when it focuses on the needs of the entire organisation, rather than specific groups of individuals	**2**	**3**			
8.	The effectiveness of TC in building capacity is reduced by trained individuals leaving the organisation	**2**		**3**		
9.	TC proves to be more effective when it is linked to other forms of support, such as infrastructure and equipment provision	**1**	**4**			
10.	TC programmes have created a serious risk of foreign or local experts substituting technical staff within their organisation	**2**	**1**	**2**		
11.	TC has proved to be more effective when the procurement process is directly under the control of the sector/thematic organisation	**1**	**2**	**1**		
12.	TC have proved to be more effective when the management process is directly under the control of the sector/thematic organisation	**3**	**1**		**1**	
13.	Local or regional consultants have proved more effective than international ones because they understand the country context better	**4**	**1**			
14.	Long term consultants have proved more effective than short-term ones because they have time to understand the organisational context and needs		**2**	**1**	**1**	**1**
15.	Consultants have proven to perform better when they are fully monitored by the beneficiary organisation		**3**	**2**		
	TOTAL SCORE	**23**	**28**	**17**	**4**	**1**

APPENDIX 4: LIST OF PEOPLE MET/INTERVIEWED

	Name	Title	Organisation
1	Dr Deo Mtasiwa	CMO	MOHSW
2	Dr Gabriel Upendo	Retired CMO	EAC
3	Ngosha S. Magonya	Commissioner, External Finance	MOFEA
4	Mrs. T. A. Chando	DAP	MOHSW.
5	Mrs. E. Mwakalukwa	Asst. Director – HRH	MOHSW
6	Mr. J.B. Mwinuka	Asst. Director HRP	MOFP
7	Mrs. R. Kijazi	Assistant Director	POPSM
8	Dr. Faustine Njau	Head of HSRS	MOHSW
9	Mr. Maximillian Mapunda	Senior Economist	WHO – DSM
10	Mr. Richard Mkumbo	Health Economist	MOHSW
11	Dr. Adeline Kimambo	Director	CSSC – DSM
12	Mr. Joseph Kellya	PHS – HSS	MOHSW
13	Dr. A. Hingora	Head of HSPS	MOHSW
14	Dr. Meshack M. Massi	RMO	Morogoro
15	Dr. Godfrey Mrema	Regional Dental Officer	Morogoro
16	Mr. John Mankambila	RHS	Morogoro
17	Mrs. Gutapaka Anna	RNO	Morogoro
18	Mr. Jackson Minja	Regional Laboratory Technologist	Morogoro
19	Allen Malisa	Regional. Pharmacist	Morogoro
20	Dr. F Fupi	Ret. RMO Morogoro region	Private Clinic Morogoro
21	Dr. Kasale	MO	MOHSW – NETTS
22	Mr. Msigula	PSO	MOHSW
23	Mr. Abukari Killapo	Asst. Director	MOFEA
24	Mr. Ishijima Hisahiro	HCP- Advisor	JICA – MOHSW
25	Dr. Said Egwaga	Programme Manager TB & Leprosy	MOHSW
26	Dr. Solomon	Municipal Medical Officer	AMC
27	Mr. Mamuya E. H.	Municipal Health Officer	AMC
28	Mr. Alex S. Mamboya	MHS	AMC
29	Mr. Sangawe P.	Economist	MOFEA

	Name	Title	Organisation
30	Ms. D. Morin		World Bank
31	Dr. Axel Doerken	Country Director	GTZ
32	Mr. Koji Makino	Deputy Resident Representative	JICA
33	Mr. A. Baruti	Director	PO-PC
34	Mr. Januarius Mrema	DPP	MITM
35	Mr. Chacha Nyakimori	ASDP Coordinator	MAFC
36	Mr. Lomasai	ASDP Secretariat	MAFC
37	Dr. Issa Faisal	Director	PO-PSM
38	Dr. Mwatima Juma	IFAD Representative	IFAD
39	Mr. Chitinka	Outcome manager	PMO-RALG
40	Dr. Cyprian Mpemba	LGRP Consultant	PMO-RALG
41	Mr. Charles Wambura	Senior Economist	MAFC
42	Mrs. S. Mlote	Senior Economist	MLDF
43	Mrs. Anna G. Ngoo	ASPS-PO	MAFC
44	Ms. M. Ndaba	Aid Coordinator	MAFC
45	Mr. Laseko	PADEP Coordinator	MAFC
46	Ms. Lilian Mapsa	DAP	MAFC
47	Mr. E. Achayo	DPP	MAFC
48	Dr. Haki	Director of Research	MAFC
49	Eng. Mbogo	DRI	MAFC
50	Prof. B.J. Ndunguru	Executive Director	TRIT
51	Dr. S.B. Meena	Director Research	MLD
52	Mr. Hoshi	Agriculture Chief	JICA
53	Ms. Catherine Joseph	DPP	MLDF
54	Dr. Bisanda	Community Officer	PADEP
55	Mrs. Janet F. Bitegeko	Executive Director	ACT
56	Mr. Simon Mpaki	Programme Officer	ASDP
57	Mr. R.J. Shayo	Principal	KATC
58	Dr. Satoko Emoto	Team Leader, RADAG	JICA
59	Dr. Fuminori Arai	Member, RADAG	JICA
60	Dr. Ippei Itakura	Member, RADAG	JICA

APPENDIX 5: REFERENCES

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