

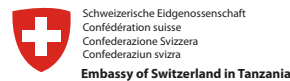
United Republic of Tanzania
**Ministry of Health, Community Development,
Gender, Elderly and Children**



Mid Term Review of the Health Sector Strategic Plan IV 2015 - 2020

Main Report

30 September 2019



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Table of Contents

Table of Contents	3
Acronyms	6
Executive summary	10
Mid Term Review Objectives and Process.....	10
Health Service Delivery.....	10
Performance Indicators.....	10
Quality systems.....	10
Package of Interventions by Levels of Care.....	11
Health Service Provision by type of Service	12
Health Care Support Systems	13
Human Resources for Health (HRH).....	13
Essential Medicines and Health Products	14
Infrastructure, Transport and Equipment	14
Monitoring and Evaluation Systems in Health Sector.....	15
Information and Communication Technology and e-Health.....	15
Health Financing	16
Governance and Management of Implementation HSSP IV	16
Conclusions.....	17
Recommendations MTR HSSP IV	18
1 Introduction.....	20
1.1 MTR Objectives and Process	20
2 Government Policies and Strategies.....	25
2.1 General Policy Framework.....	25
2.2 Health Sector Policy and Strategy Framework.....	26
3 Service Delivery	28
3.1 Performance Indicators	28
3.2 Quality systems	32
3.3 Package of Interventions by Levels of Care	33
3.3.1 National Essential Health Care Intervention Package	33
3.3.2 Community Health	34
3.3.3 Council Health Services.....	35
3.3.4 Regional Referral Level	36
3.3.5 Zonal and National Level, including International referral	37
3.4 Health Service Provision by type of Service	38
3.4.1 Nutrition Services	38
3.4.2 Reproductive, Maternal, Newborn, Child & Adolescent Health	38
3.4.3 Communicable Diseases	42
3.4.4 Non Communicable Diseases (NCDs)	43
3.5 Emergency Preparedness and Response	44
4 Health Care Support Systems	46
4.1 Human Resources for Health (HRH)	46
4.1.1 HRH planning and management	46
4.1.2 Distribution of staff	47
4.1.3 Performance management.....	49
4.1.4 Information and research	50
4.1.5 HRH development	50

4.1.6	Nursing and Midwifery Services.....	51
4.2	Essential Medicines and Health Products.....	52
4.2.1	Stewardship from the national level.....	53
4.2.2	Planning, Quantification, Costing, Procurement and Monitoring Supply Chain.....	53
4.2.3	Research and Production.....	55
4.3	Infrastructure, Transport and Equipment.....	55
4.3.1	Infrastructure.....	56
4.3.2	Maintenance of equipment.....	56
4.3.3	Transport and Ambulance Services.....	56
4.4	Monitoring and Evaluation Systems in Health Sector.....	57
4.4.1	HMIS.....	57
4.4.2	Other Data Systems.....	58
4.4.3	Operational Research.....	59
4.4.4	Use of Data and Knowledge Management.....	59
4.5	Information and Communication Technology and e-Health.....	60
5	Health Financing.....	62
5.1	Health Financing Strategy 2015-2025.....	62
5.2	Single National Health Insurance.....	63
5.3	Minimum Benefit Package (MBP).....	64
5.4	Financing Public Health Activities.....	64
5.5	Resources for Health.....	64
5.5.1	Budget trends.....	64
5.5.2	Innovative financing.....	66
5.6	Financial Management System.....	67
6	Governance and Management of Implementation HSSP IV.....	69
6.1	Governance in the Tanzanian Health Sector Context.....	69
6.2	HSSP IV Strategic Plan.....	70
6.3	Specific Areas for Action on Implementation Management and Governance.....	71
6.3.1	Decentralisation by Devolution.....	71
6.3.2	Social Accountability.....	71
6.3.3	Performance Management.....	72
6.3.4	Partnerships.....	72
6.4	SWAp Co-ordination and Management.....	73
7	Analysis HSSP IV strategic objectives.....	75
7.1	Quality.....	75
7.2	Equity.....	76
7.3	Gender.....	79
7.4	Community Partnership.....	80
7.5	Modern management and partnerships.....	81
7.6	Social determinants.....	83
8	Conclusions in the context of Reference Frameworks.....	84
9	Recommendations.....	86
9.1	Recommendations for HSSP IV Going Forward.....	86
9.2	Recommendations to Inform HSSP V.....	91
9.2.1	Timeframe for Preparation of HSSP V.....	91
9.2.2	Themes for HSSP V.....	91
	Annexes.....	94
	Annex 1 Reports.....	95
	Annex 2 References used.....	96

Tables

Table 1 Regions visited during MTR HSSP IV	24
Table 2 Key performance indicators HSSP IV (source MTR analytical report 2019)	31
Table 3 Human resources per type of facility (source MOHCDGEC 2019)	47
Table 4 Number, percentage distribution and density per 100,000 population, 2018 (source MTR analytical report)	56

Figures

Figure 1 HSSP IV MTR conceptual framework	21
Figure 2 WHO integrated people oriented health services	22
Figure 3 Time frame MTR HSSP IV.....	23
Figure 4 Composite indicator RMNCAH performance in Tanzania 2015 – 2018	39
Figure 5 Human resources (all cadres) per 10,000 population per region (source analytical report MTR)	48
Figure 6 health workers - health facility density (source analytical report MTR)	48
Figure 7 RMNCAH performance per health workers density (source analytical report MTR)	49
Figure 8 Health share of the government budget.....	64
Figure 9 Compositions of Health Sector Budget (Recurrent vs Development).....	65
Figure 10 RMNCAH performance versus health systems inputs	76
Figure 11: RMNCAH performance and poverty levels.....	77
Figure 12: Trends in neonatal mortality per 1,000 live births, by urban-rural residence	77
Figure 13 Stillbirths per 1,000 health facility births, mainland overall, top 2 and bottom 2 regions, DHIS	78
Figure 14 Average RMNCAH coverage index for BRN regions and for the other 18 regions, DHIS data	78
Figure 15 RMNCAH performance and categories of resources inputs (HRH, infrastructure)	79
Figure 16 HSSP V themes.....	91

Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
AMO	Assistant Medical Officer
ANC	Antenatal Care
ART	Antiretroviral Therapy
BEmOC	Basic Emergency Obstetric Care
BEmONC	Basic Emergency Obstetric and Neonatal Care
BNR	Big Results Now
CAG	Controller and Auditor General
CBO	Community Based Organisation
CDC	US Government Centre for Disease Control and Prevention
CCHP	Comprehensive Council Health Plan
CEmOC	Comprehensive Emergency Obstetric Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CFR	Case Fatality Rate
CFS	Consolidated Fund Service
CHF	Community Health Fund
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CLTS	Community Led Total Sanitation
CMO	Chief Medical Officer
CMR	Child Mortality Rate
CPD	Continuing Professional Development
CPR	Couple years Protection Rate
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
CYP	Couple Years of Protection
DANIDA	Danish International Development Agency
DAP	Director of Administration and Personnel
D-by-D	Decentralisation by Devolution
DC	District Council
DED	District Executive Director
DHIS	District Health Information System
DHIS 2	District Health Information Software 2
DHFF	Direct Health Facility Financing
DHS	Demographic and Health Surveys
DMO	District Medical Officer
DOT	Directly Observed Therapy
DP	Development Partner
DPP	Director of Health Policy and Planning
DPS	Director of Preventive Services
eGov	Electronic Governance
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
eMTCT	Elimination of Mother To Child Transmission
EOP	Emergency Operational Plan
EPI	Expanded Programme on Immunization
FBO	Faith-Based Organization
FGM/C	Female Genital Mutilation or Circumcision
FY	Financial Year
GBS	General Budget Support
GBV	Gender Based Violence

GDP	Gross Domestic Product
GF	Global Fund
GNP	Gross National Product
GOT	Government of Tanzania
GOTHOMIS	Government of Tanzania Hospital Management Information System
HBF	Health Basket Fund
HF	Health Facility
HFGC	Health Facility Governing Committee
HFS	Health Financing Strategy
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human immuno-deficiency virus/Acquired Immuno-deficiency Syndrome
HMIS	Health Management Information Systems
HMT	Hospital Management Team
HR	Human Resources
HRD	Human Resources Development
HRH	Human Resource for Health
HRHIS	Human Resources for Health Information System (MOHSW)
HRHSP	Human Resource for Health Strategic Plan
HRIS	Human resources Information System (PMO-RALG)
HRM	Human Resources Management
HSDG	Health Sector Development Grant
HSR	Health Systems Research
HSSP IV	Health Sector Strategic Plan IV (2015 – 2020)
HSSP	Health Sector Strategic Plan
ICD	International Classification of Diseases
I-CHF	Improved Community Health Fund
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IHI	Ifakara Health Institute
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IMTC	Inter Ministerial Technical Committee
IPC	Infection Prevention and Control
IPT	Intermittent Presumptive Treatment
ISC	Inter-Ministerial Steering Committee
ITN	Insecticide Treated Nets
JAHSR	Joint Annual Health Sector Review
JICA	Japan International Cooperation Agency
LGA	Local Government Authority
LGDG	Local Government Development Grant
LMIS	Logistics Management Information System
LMU	Logistics Management Unit
MAT	Medical Association of Tanzania
MC	Municipal Council
M&E	Monitoring and Evaluation
MDA	Mass Drug Administration
MDA	Ministries, Departments, Agencies
MDGs	Millennium Development Goal(s)
MDR	Multi-Drug Resistant
MESI	M&E Strengthening Initiative
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MMR	Maternal Mortality Ratio
MNCH	Maternal ,Newborn and Child Health
MO	Medical Officer
MOCS&T	Ministry of Communication, Science and Technology

MOEVT	Ministry of Education and Vocational Training
MOFEA	Ministry of Finance and Economic Affairs
MOHSCDGECC	Ministry of Health Community Development Gender Elderly and Children
MPEE	Ministry of Planning and Economic Empowerment
MRCC	Medical Research Coordinating Committee
MSD	Medical Stores Department
MTC	Medicines Therapeutics Committee
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
MTSP	Medium Term Strategic Plan
MTUHA	Mfumo wa Takwimu wa Uendeshaji wa Huduma za Afya
MUCHS	Muhimbili University College of Health Sciences
MUHAS	Muhimbili University of Health and Allied Sciences
NACP	National AIDS Control Programme
NACTE	National Accreditation Council for Technical Education
NAO	National Audit Office
NBS	National Bureau of Statistics
NCD	Non Communicable diseases
NEHP	National Essential Health Package
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research
NM	Nurse Midwife
NMCP	National Malaria Control Programme
NMP	National Medicines Policy
NPPP	National Public Procurement Policy
NSGRP	National Programme for Economic Growth and Poverty Reduction (MKUKUTA)
NTD	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Programme
OOP	Out of Pocket (expenses)
OPD	Outpatient department
OPRAS	Open Performance Review and Assessment System
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PHA	Public Health Act
PHC	Primary Health Care
PHDR	Poverty and Human Development Report
PHSDP	Primary Health Services Development Plan [MMAM]
PLHIV	Persons Living with HIV/AIDS
PLWD	People Living With Disabilities
PO-RALG	President's Office – Regional Administration & Local Government
PMTCT	Prevention of Mother to Child Transmission
PO-PSM	President's Office – Public Service Management
POW	Programme of Work
PSRP	Public Service Reforms Programme
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality Improvement Team
RAS	Regional Administrative Secretary
RBF	Results Based Financing
RHHSB	Regional Hospital Health Services Board
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RMNCAH	Reproductive, Maternal Neonatal Child and Adolescent Health
RRH	Regional Referral Hospital

SARA	Service Availability and Readiness Assessment
SAVVY	Sample Vital registration with Verbal Autopsy
SC	Steering Committee
SDG	Sustainable development Goals
SLA	Service Level Agreement
SNHI	Single National Health Insurance
SO	Strategic Objective
SOP	Standard Operating Procedures
STEPS	WHO STEPwise approach to Surveillance for Chronic Diseases
STI	Sexually Transmitted Infections
SUN	Scaling Up Nutrition
SWAp	Sector-Wide Approach
SWOC	Strengths, Weaknesses, Opportunities, and Challenges
TA	Technical Assistance
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzanian Social Action Fund
TB	Tuberculosis
TB/L	Tuberculosis and Leprosy
TBS	Tanzania Bureau of Standards
TC	Technical Committee SWAp
TC	Town Council
TDHS	Tanzania Demographic and Health Survey
TDS	Tanzania Disability Survey
TFDA	Tanzania Food and Drug Authority
TFNC	Tanzania Food and Nutrition Centre
TG	Treatment Guidelines
THIS	Tanzania HIV/AIDS Indicator Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TIKA	Tiba Kwa Kadi (CHF in urban areas)
TJHR	Tanzania Journal of Health Research
TMIS	Malaria Indicator Surveys
TOR	Terms of Reference
TPEHI	Tanzania Package of Essential Health Interventions
TPHA	Tanzania Public Health Association
TPRI	Tropical Pesticides and Research Institute
TQIF	Tanzania Quality Improvement Framework
TSH	Tanzanian Shilling
TT	Tetanus toxoid
TWG	Technical Working Group
TZS	Tanzania shillings
UHC	Universal Health Coverage
UNAIDS	United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
U5MR	Under-five Mortality Ratio
USAID	United States Agency for International Development
USD	United States Dollar
UTI	Urinary Tract Infection
WASH	Water, Sanitation and Hygiene
WB	World Bank
WDC	Ward Development Committee
WFP	World Food Programme
WHO	World Health Organization
WHO/AFRO	World Health Organization - Africa
ZHRC	Zonal Health Resource Centre

Executive summary

Mid Term Review Objectives and Process

Objectives of the Mid Term Review (MTR)

The primary objective of the MTR is to analyse, document progress, challenges, and lessons learned from the first three years of HSSP IV implementation (July 2015 – December 2018). The MTR assesses the overall performance by taking stock of quantitative and qualitative achievements as related to HSSP IV Strategic Directions and the cross cutting issues in the health sector. The MTR identifies best practices identified on the review process.

Recommendations from the HSSP IV MTR suggest improvements to the final period of HSSP IV implementation and inform the design and formulation the National Health Policy, the health policy implementation strategy and the formulation of the HSSP V.

Health Service Delivery

Performance Indicators

The Mid Term Review analysed the indicators of Health Sector Strategic Plan IV (HSSP IV). The full explanation of this findings and – for some indicators – regional disaggregation can be found in the analytical report, that is part of this MTR.

Key points of the statistical analysis

The statistical assessment of progress during 2015-2018 shows many positive developments in terms of expanding program coverage for family planning with modern methods, antenatal, delivery and postnatal care, PMTCT and HIV treatment. Also, the quality of care appears to have improved considerably according to the star rating assessment in all regions.

Yet, many of the HSSP IV targets will not be met. Neonatal and child mortality need to decline faster. Adolescent childbearing remains persistently high. Fertility and unmet need for family planning are still high in spite of positive trends. The coverage of malaria and TB interventions needs to increase. Access to improved drinking water source and sanitary facilities is improving but still far from targets, especially in the rural population. The health system strength has only improved piecemeal during HSSP IV, most prominently access to essential medicines and health information systems. Major gaps in health workforce in almost all regions, and service access in some regions. There is some evidence of the increasing burden of non-communicable diseases.

For almost all indicators there are persistent inequalities between urban and rural populations, the poorest and richest households and between regions, and there is only limited evidence of reductions.

Quality systems

Strategic Direction: *The primary focus will be on quality in order to improve outcomes of health care and social welfare services and to enhance trust of the population and other stakeholders in the sector. A series of measures will make quality of health care visible, more acceptable to users, and safer for both clients and health workers. Transparency and value for money will attract investments in the sector.*

Key findings: Quality is improving in many areas, and step-by-step a culture of focus on quality is emerging. Quality Improvement Teams have a positive impact. However, many of the initiatives are not yet reaching peripheral institutions, and parallel initiatives in the area of QI are noticed. The star rating programme has been very successful in improving health facilities in essential areas, but further improvements are needed to achieve the set targets. Certification and accreditation are within reach, and necessary for a Single National Health Insurance. The Client Charter is in place, but needs further improvement to achieve compassionate care in health facilities.

Package of Interventions by Levels of Care

Community Health

Strategic Direction: Revitalising Community Based Health Care, increasingly supported by professional Community Health Workers, will ensure that essential health promotion, health protection and prevention activities are addressed in partnership with communities, with a high rate of return on investments. The Community-based health programme aims to reduce the pressure on facility-based care through enhancing healthy living at households, in schools and work places.

Key findings: Community health activities as extension of health facility services are increasing, but often having more a preventive or curative focus, than a health promotion focus. Information is provided, but not reaching all communities. Traditional beliefs that hamper health continue to exist, and affect maternal and reproductive health. The Community Based Health Programme has not taken off, and around the role, functions, incentive packages many different practices continue to exist.

Intensified Health Communication

Strategic Direction: Integrated prevention and promotion services are needed, that aim at empowerment of communities and address determinants of health.

Key findings: Community empowerment to solve water, sanitation or nutrition issues are often taking place with little involvement of the health workers. Health workers do not have the time or the competencies to address social determinants of health.

Council Health Services

Strategic Direction: Council Health Services will constitute the backbone of the health services. These services will provide the National Essential Health Care Intervention Package (NEHCIP-Tz) while guaranteeing quality (3-star rating) and transparency (social accountability). Increased trust will sensitise the population to enrol in the Single National Health Insurance and take part in management of Council Health Services.

Key findings: Council health services are improving and star rating has increased, but not yet reaching the target. On the one hand, availability of medicines had a positive impact, but on the other hand shortage of staff make it impossible to provide all essential health services. Direct Health Facility Financing has had a very stimulating impact on initiating improvements at health facility level, and social accountability is improving through collaboration with Health Facility Governing Committees.

PPP at local level is not developing, and Service Level Agreements are not actively maintained. Excluding Faith-based health facilities from DHFF has had a negative effect.

Regional Referral Level

Strategic Direction: Regional Referral Hospitals (RRH) will serve as centres of medical excellence and referral in the Regions, and as the hubs for technical innovation to be disseminated to lower levels.

Key findings: Services in Regional Referral Hospitals are improving, quality systems and procedures are better implemented. Shortage of staff is an issue, especially for complicated referrals. Electronic medical records are being introduced and other e-health applications. Management is being strengthened, but most RRHs do not have a Regional Hospital Health Services Board.

Zonal and National Level, including International referral

Strategic Direction: Expansion of the number of Zonal and National Hospitals will enable referral of complicated cases countrywide, and will reduce the necessity for international referral.

Key findings: Hospitals are improving and adding new activities to their services. The MTR could not find information on the impact on international referrals.

Health Service Provision by type of Service

Nutrition Services

Strategic Direction: The health sector in collaboration with partners will accelerate nutrition interventions, with emphasis on pregnancy stage and the two first years of life (1000 days).

Key findings: The National Multisectoral Nutrition Action Plan is being rolled out, and leading to gradual reduction in malnutrition and stunting. However, at grassroot level, health workers are hardly involved in the community activities.

Reproductive, Maternal, Newborn, Child & Adolescent Health

Strategic Direction: The health system will be strengthened to provide quality services which will contribute to achieving the goal of ending preventable maternal, newborn and child deaths and ensure universal access to sexual and reproductive and adolescent health services.

Key findings Reproductive Maternal Neonatal Health: Service provision figures for antenatal, delivery, post-partum check-up and also for reproductive health services are increasing. However, some quality indicators are not improving in these fields. This could indicate more, but not better services. CEmONC services in most health centres are not yet what was planned in HSSP IV, especially with regard to theatre and blood transfusion practices. Impact on maternal and neonatal mortality could not be included in this report due to lack of recent reliable data. The MTR found still many traditional beliefs in communities which hamper better use of available services.

Key findings Child Health: Services like IMCI, vaccinations, nutrition monitoring are provided everywhere and have an impact in child mortality. Urban-rural differences still exist.

Key findings Adolescent Health: Adolescent health services are improving, but still far from reaching the targets. There is little improvement in reduction of teenage pregnancies, HIV incidence among adolescent girls, or gender-based violence.

Key findings Regional differences: There are remarkable differences between regions in performance in RMNCAH, that are not clearly correlating with numbers of staff and numbers of health facilities. Also socio-economic factors cannot fully account for the differences. Other factors like leadership, support by NGOs, PPP, etc. play a role. Regional priority setting and implementation should replace country wide actions.

Communicable Diseases

Strategic Direction: The health system will maintain the high level of performance of Disease Control Programmes; reduce morbidity and mortality caused by infectious diseases while increasing efficiency through improved integration of activities.

Findings: In the area of curative services most disease control services are doing well with increased testing, improved adherence, improved cure rates, etc. However, in prevention and screening the programmes perform much less. Targets in HSP IV of use of bed nets, case detection rate for TB, or incidence of HIV will not be met. At grassroot level there is integration in the work of health facilities, but at higher levels, logistics, planning, monitoring and evaluation is mainly separate. Development Partners contribute to this separate approaches.

Many programmes to reduce neglected tropical diseases perform well with support from NGOs.

Non Communicable Diseases (NCDs)

Strategic Direction: The country will focus on community-based prevention, health promotion, screening and early treatment as well as rehabilitation. Activities will be integrated in health services and not as new vertical programme.

Key findings: Non-communicable diseases are increasing and becoming dominant in morbidity and mortality in Tanzania. A strategic plan has been formulated to reduce NCDs. Yet, the MTR could not find much results, with low levels of knowledge among health workers, no activities in facilities, and no human and financial resources to even start implementation at a larger scale. There is no sense of urgency that NCDs are an important threat to Tanzania.

Health Care Support Systems

Human Resources for Health (HRH)

Strategic Direction: Adequate staffing of health facilities and social welfare institutions at all levels is the most critical success factor in achieving quality health and social welfare services. Equitable staff distribution, retention and maintaining high performance standards for employed professionals will be at the heart of quality improvement in health and social welfare services. Human Resources production will follow HSSP IV priorities.

Key findings: HRH planning is still an administrative activity, rather than a strategic activity. There is no workload-based planning and the information is not sufficiently analysed. The MTR analysis gives food for thoughts on moving to a more needs-based planning.

HRH distribution was seriously affected by government measures in the last years, and has led to a shortage of around 50% of staff. This affects quality of work. There is still a serious inequity in staff distribution between regions, but also within regions and councils. Performance is not directly correlated to numbers of staff; other factors play a role, like infrastructure, leadership, support from NGOs. Performance management systems are not really working, neither at individual nor at facility level.

HRH production has increased considerably; not all newly-trained health workers can be absorbed in the system. However, not all training programmes deliver high quality education. Curricula are not always up to date, and infrastructure of training institutions is sometimes insufficient. Continuing professional development is increasing, but is still too much fragmented. Development of a centre for continuing education, and accreditation of modules, will help streamlining CPD.

Essential Medicines and Health Products

Strategic Direction: Essential medicines and health products will be quality assured, right priced, efficiently delivered through MSD and complemented by decentralised procurement engaging the private sector. National stewardship and regulatory oversight will be coupled with custodianship from local government and mechanisms for public accountability. The appropriate use of medicines will improve through quality assurance measures

Key findings: There is a dramatic improvement of availability of essential (tracer) medicines leading to better treatment of patients. The improvement has been achieved through increase in funding for medicines (government, HBF, insurance schemes), better performance of MSD with among others direct delivery to health facilities, framework contracts with suppliers. The bottom-up quantification is helping to get correct quantities of medicines and supplies. The prime vendor arrangements enable local procurement of medicines from reliable sources, when medicines are out-of-stock in MSD. However, a next step is needed to make all essential medicines available, which will require considerable new investments.

Rational prescription of medicines is promoted with treatment guidelines, but needs further follow-up to reduce wastage of medicines.

Standardisation of lab equipment, with bulk procurement and maintenance contracts, is a major step forward that should be an example for other types of equipment.

Research & Development is still in an infancy, but increased production of generic medicines is a first step in that direction.

Infrastructure, Transport and Equipment

Strategic Direction: The health and social welfare sector will engage in balanced and sustainable infrastructure development with emphasis on geographic prioritisation, quality and maintenance, to provide equitable access to quality services for the population. The LGAs will link infrastructure development to HRHSW planning and equipping of health facilities. Newly constructed and refurbished facilities will meet standards for future accreditation.

Key findings: *There has been a considerable increase in construction and rehabilitation of facilities, leading to an increase in per capita density of facilities. Still more facilities are under construction. However, the construction does not go hand in hand with staff placement, and not with allocation of medicines and financial resources. Without providing the complete package, new health facilities cannot function properly, and contribute little to service improvement. There is still considerable inequity of distribution of facilities over the country. There is no clear correlation between density of health infrastructure and performance of health services. This asks for more needs-based planning, instead of standards for number of facilities in every ward or Council.*
Next to buildings, equipment, water and sanitation, and transport are areas of concern, where health facilities are limited in performing essential services.

Monitoring and Evaluation Systems in Health Sector

Strategic Direction: *M&E Systems will be focusing on data-for-decision making, utilising web-based data collection and analysis, linking information systems, providing stakeholders access to data. Under the BRN there will be quarterly feedback on performance to service providers and managers for immediate action.*

Key findings: *HMIS has improved a lot in the last years, to a level that it can now be considered as reliable, and can be used for analysis and decision-making. Other statistics like causes of death in health facilities, are less advanced. Vital statistics are still not in place in Tanzania.*

Automation is slowly progressing, but has not yet reached primary health facility level. There are still many parallel systems, often automated, and health workers complain about extra workload. Attempts to rationalise and streamline health information systems have not been effective so far. Demands from funding agencies are a constraint in rationalisation. Next to HMIS there are other systems, like notifiable diseases surveillance, sentinel surveillance, demographic surveys, which are important for understanding epidemiological trends. Some of those are not optimal, which can for example hamper disease outbreak control.

The culture of using data for decision-making is still very weak. Most strategic plans have abundant indicators, but managers generally are not making follow-ups. For HSSP IV similar experiences were found. The analytical report of the MTR is the first comprehensive overview of health sector performance, since 2015.

Information and Communication Technology and e-Health

Strategic Direction: *The health sector will embrace the rapid development of ICT for improving administrative processes, patient/client recording and communication. The MOHSW will stimulate the development and guide interoperability of systems.*

Key findings: *There are more than 180 apps, developed in parallel, sometimes with similar objectives. There are three major areas: information and administration, individual patient records, and education/capacity building. Health workers experience this mushrooming of ICT in health as a burden. There are two major platforms: Muungano Gateway and Health Information Mediator. The National Digital Health Strategy gives guidance in further development of ICT in health, especially interoperability of systems. This is very much needed. Besides investments in infrastructure and content, more attention is required for sustainability and capacity building. The wealth of data that will become available, should be used for better management of health services by integrating ICT in day-to-day management.*

Health Financing

Strategic Direction: Cost-effective, quality health services should be available to all residents without financial barriers at the time of need. The goal of Tanzania's health financing strategy is to enable equitable access to affordable and cost-effective quality health care and financial protection in case of ill health, according to a nationally defined standard minimum benefit package.

Key findings: The health financing strategy is still in its infancy, and fragmented financing of health services still continues. The focus now is on the Single National Health Insurance, that hopefully will be approved before the end of this HHSP period. In the mean time more people are enrolled in existing health insurance schemes. Improved Community Health Fund is a viable option for improving accessibility to health services. Only 32% of the population has some type of health insurance.

The resource envelope for health is growing, but only in nominal terms, not in per capita and not as percentage of government budget or GNP. The growth in financing is just enough to keep up with population growth. Budget execution is between 60% and 80%, but delays in disbursement create serious problems for Councils and facilities. External support from Development Partners is slowly diminishing, although it is difficult to get a complete picture due to off-budget support.

Financial management is improving and Direct Health Facility Financing is a major success in enabling health facilities to finance their own priorities. Health Facility Governing Committees play a role in budgeting and monitoring of expenditure, increasing community accountability.

Governance and Management of Implementation HSSP IV

Strategic Direction: In line with the BRN approach the health sector will strengthen Leadership, Accountability and Partnership to ensure that all involved parties can make their contributions to improving the health system.

Governance will be inclusive, i.e. empowering communities, involving partners, being gender sensitive.

Key findings: Governance in the health sector is in line with the overall policies and strategies in the country, and programmes, e.g. with regard to financial management, e-government, decentralisation are followed.

HSSP IV has not served as leading strategy in the health sector; most MDAs have followed their own strategies. There was no implementation plan for HSSP IV and the monitoring plan was not followed.

At **national level coordination** is weak, leading to inefficiencies, duplications and gaps (like not addressing health financing or the NCD epidemic). Programmes are not yet integrated.

SWAp is at a low, often focusing on day-to-day issues, lacking a focus on strategies, and long-term development. Some TWGs are dysfunctional, and there are too many. Decentralisation is identified as issue, but not yet elaborated.

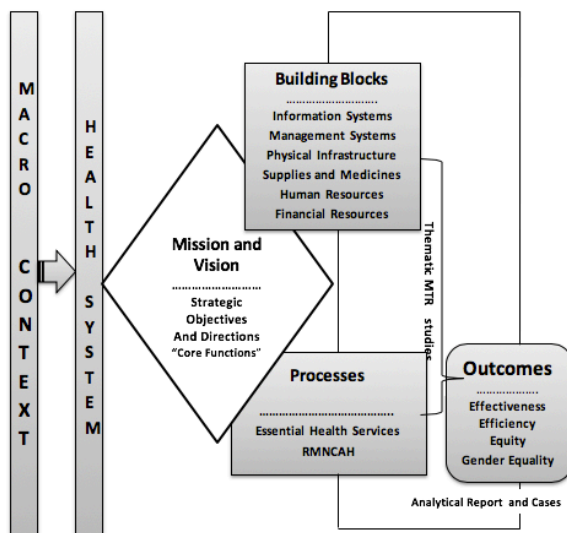
D-by-D in general is successful, e.g. with functioning DHFF and HFGCs. CCHPs are well-established. Supervision, mentoring, on-the-job training are happening but restricted by financial resources.

PPP is good in terms of information exchange, but most collaboration is not progressing; e.g. FBO institutions do not get DHFF, and very late reimbursements for costs made. Only in the pharmaceutical sector there are new initiatives.

Performance management is not functioning well, neither at facility level, nor at individual level.

Intersectoral collaboration is moving well at national and regional level to bring Health in All Policies forward, but at grassroot level there is little collaboration with other sectors. In general, the focus is very much on what the health sector needs from others than on win-win situations.

Conclusions



Measuring HSSP IV against the input – processes – outcome framework, a positive picture emerges. Starting with the **outcomes**: quite a number of indicators that could be measured in recent years, show improvement, but not all health areas in the same way, and not all regions in the same way. This asks for more decentralised, smart targeting of interventions. With regard to equity and gender, still considerable steps have to be made to achieve the HSSP IV goals set.

Processes are running better, especially at facility and Council level. Procedures are well-established and automation can

help smoothening planning, reporting and accounting. Harmonisation of ICT systems is badly needed. Quality systems are slowly becoming integrated in work processes and start changing the culture. Community health is improving, but needs a boost empowering communities to engage in their own health issues.

With regard to the **building blocks** a mixed picture can be seen. While in infrastructure, equipment, medicines and supplies, major achievements have been noted, concerns with regard to human resources have increased in the last years. Not only numbers of health workers are insufficient, but also competencies are inadequate to cope with all (quickly changing) demands of the services. Financial resources remain insufficient, and innovative alternatives for government funding and donor funding have not yet been sufficiently developed. A SNHI has to highest priority, replacing an inadequate waiver and exemption system.

Mission and vision are clear but the strategic objectives as defined in HSSP IV, are not commonly shared among stakeholders. There are too many autonomous strategies, sometimes going against HSSP IV. In the MOHCDGEC there is not yet a culture of achieving a common goal, and harmonisation is an urgent challenge. Here a big task remains for leadership of the involved MDAs. SWAp requires revitalisation and adaptation to developments in Tanzania.

The **socio-economic developments** in Tanzania are favourable for the health sector, with reduction of absolute poverty, improvement of infrastructure, etc. Also the policy environment of D-by-D, performance management, PPP and investment, help in strengthening service delivery. Urbanisation, industrialisation, environmental threats and global warming, on the other hand, need to be taken better into account.

Recommendations MTR HSSP IV

Governance

D-by-D Capacity building of local HFGCs and CHMBs is important to take D-by-D one step further and really empower the beneficiaries of health services. The Terms of Reference for HFGCs, VHCs and WDCs have to be clarified and collaboration has to be strengthened to play a role in community empowerment.

National coordination There should be one health sector strategic plan, accompanied by an implementation plan at national level. MOHCGGEC headquarters needs a matrix structure, and more integration between curative and preventive services. More leadership is needed to focus disease control programmes on achieving goals, especially in prevention and screening, where they are lagging behind.

Health in all policies Intersectoral collaboration to address the social determinants of health should continue, but more as effort to create win-win for all sectors. Focus on social determinants of health should reach the grassroot level, and change working culture in peripheral health facilities, to become more outward looking.

PPP Increasing urbanisation requires better arrangements with private providers for access to quality services for the poor. Service Level Agreements with FBO institutions require a quality improvement to increase transparency, and guarantee financial support of services provided.

SWAp The MTR recommends to revitalise the SWAp and make it relevant again as mechanism for joint action to strengthen the health sector. The focus at national level should be more on monitoring strategic directions than on control of implementation. It is important to see how SWAp can catch up with the decentralisation of government.

Health financing

Health Take the SNHI forward, and follow the necessary legal procedures of adoption of the legislation. In the meantime, strengthen improved CHF, expand it to more regions and improve acceptability by the community. Payment of matching funds is necessary.

Health Financing Strategy The Health Financing Strategy should be put back on the agenda, and innovative types of funding for health services need to be elaborated and implemented.

Financial management Timely disbursement of government funding, health basket funding, result-based financing, insurance reimbursements is absolutely necessary.

Service delivery and RMNCAH

Quality Further development of star rating system and certification for accreditation is very important as incentive for maintaining a quality focus (and needed for a viable and reliable insurance system).

Equity A system of frequent analysis of poor performing health facilities and vulnerable populations, can help Councils to quickly address needs, where they are identified.

Gender Gender issues need an approach that affects all levels of the system, from policies and strategies, to training, equipment, organisation of services. For the next HSSP a gender implementation plan should accompany the strategic plan.

RMNCAH RMNCAH needs a fully functioning health system, with good infrastructure, equipment, capable workforce, etc. Gender based violence needs more attention. Similarly, adolescent health needs more support, especially in providing required services.

Community health Health education and health promotion should be strengthened and health literacy improved. The health sector has to work closely with the community

development branch and others. Emphasis on prevention in PHC facilities is needed to address upcoming NCDs. This should also become part of training.

Emergency and Outbreak Preparedness Ensure that the systems reach grassroot level, through capacity building and through provision of resources (information materials, consumables).

Commodities and medical supplies

Medicines Quantification and procurement requires further harmonisation of systems, to increase efficiency. Parallel systems need to be brought under one umbrella. Integration of logistics supply management systems is absolutely necessary.

Equipment Standardisation of all types of equipment is the way forward for better functioning of diagnostic services as well as surgical and dental services. Maintenance contracts are helping to do preventive maintenance and keep services running.

Infrastructure and transport

A strategic location of new infrastructure is very important, to make more impact. While building, the full package of equipment, human resources, allocation for purchasing medicines, HBF, etc. should be put in place as well.

Human Resources

Human resources planning Human resources planning should become smart, needs-based with effective information systems.

Human resources management New types of employment should be introduced, with different types of contracts. Further increase of productivity will be possible with smart personnel management. Performance management has to be strengthened, and payment of dues, career development belong to this approach as well.

Human resources development The present training system in the health sector needs a complete overhaul. The training programmes need scientific support, better guidance and more qualified teachers. Infrastructure should be adequate for training. Competency focused education needs more practice. Continuing professional development should become quality assured, accredited and part of reregistration of professionals. Mentoring and on-the-job training need to be institutionalised, and be part of CPD as well.

M&E and ICT

HMIS Interoperability and rationalisation of information systems should be put high on the agenda. The workload for health workers in peripheral health facilities should be reduced. DHIS2 has to be strengthened, be the core of information systems, and automation should be taken to grassroot level.

ICT A clear digital health strategy has been formulated to move integration, harmonisation and interoperability forward. This strategy should get full support from the leadership, and from DPs. Apps to be used in the health sector should be licenced to ensure interoperability and user-friendliness.

Capacity building is very important, both in using the systems, as in using the data generated for management. Adequate ICT staffing at all levels is required to keep systems going.

1 Introduction

This report summarises the findings, assessment and recommendations of the Mid Term Review (MTR) of the Fourth Health Sector Strategic Plan (HSSP IV) for the period 2015–2020 in Tanzania, which is implemented under leadership of the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) and the President’s Office for Regional Administration and Local Government (PO-RALG). This MTR covers the period July 2015 to December 2018.

In addition to this main report, there is the Analytical Report, with information on all relevant indicators in HSSP IV. There are eight technical reports, on Service Delivery and Infrastructure, Reproductive Maternal Neonatal and Child Adolescent Health (RMNCAH) with two sub-reports, Community Health, Human Resources for Health (HRH), Monitoring and Evaluation (M&E), Health Commodities, Health Care Financing and Governance. Furthermore, there are two special study reports, on Gender and on Equity. There are eight Field Trip Reports of the MTR and a quantitative analysis report of those field trips. The inception report of this MTR provides details on the Terms of Reference and the methodology applied.

This main report focuses on key issues and recommendations. Inevitably, not all important points from the technical reports and special studies can be incorporated in this main report. As the other reports are an integral part of the MTR, we recommend further reading for details of findings and recommendations in those documents.

Within this report, Chapter 2 describes the MTR methodology. Service delivery is discussed in Chapter 3, support services in Chapter 4, financing in Chapter 5. Chapter 6 presents Governance. Chapter 7 analysis of strategic objectives, Chapter 8 analysis and conclusions and Chapter 9 recommendations. Where necessary, this main report refers to the other publications in the context of the MTR for detailed information.

1.1 MTR Objectives and Process

Objectives of the MTR

The primary objective of the MTR is to analyse, document progress, challenges, and lessons learned from the first three years of HSSP IV implementation (July 2015 – December 2018). The MTR assesses the overall performance by taking stock of quantitative and qualitative achievements as related to HSSP IV Strategic Directions and the cross cutting issues in the health sector. The MTR identifies best practices identified on the review process.

Recommendations from the HSSP IV MTR suggest improvements to the final period of HSSP IV implementation and inform the design and formulation the National Health Policy, the health policy implementation strategy and the formulation of the HSSP V. The full Terms of Reference are reflected in the MTR inception report.

Approach in the MTR

Conceptual Framework

The conceptual framework for measuring the health system performance is adapted and refined for the HSSP IV MTR from the work by Handler, Issel and Turnock, 2001¹, which links structure, processes, output, and outcome. As shown in Figure 1, this model has four

¹ Handler A, Issel M and Turnock B, A Conceptual Framework to Measure Performance of the Public Health System, Am J Public Health. 2001 August; 91(8): 1235–1239.

components: mission (strategic directions), structural capacity (building blocks), processes (service delivery), and outcomes. These health system components are affected by the fifth component, the macro context. Although each component is displayed separately, the health system is assumed to be an open system with a relationship that leads to interaction among the components. Likewise, numerous feedback loops are assumed to exist between components.

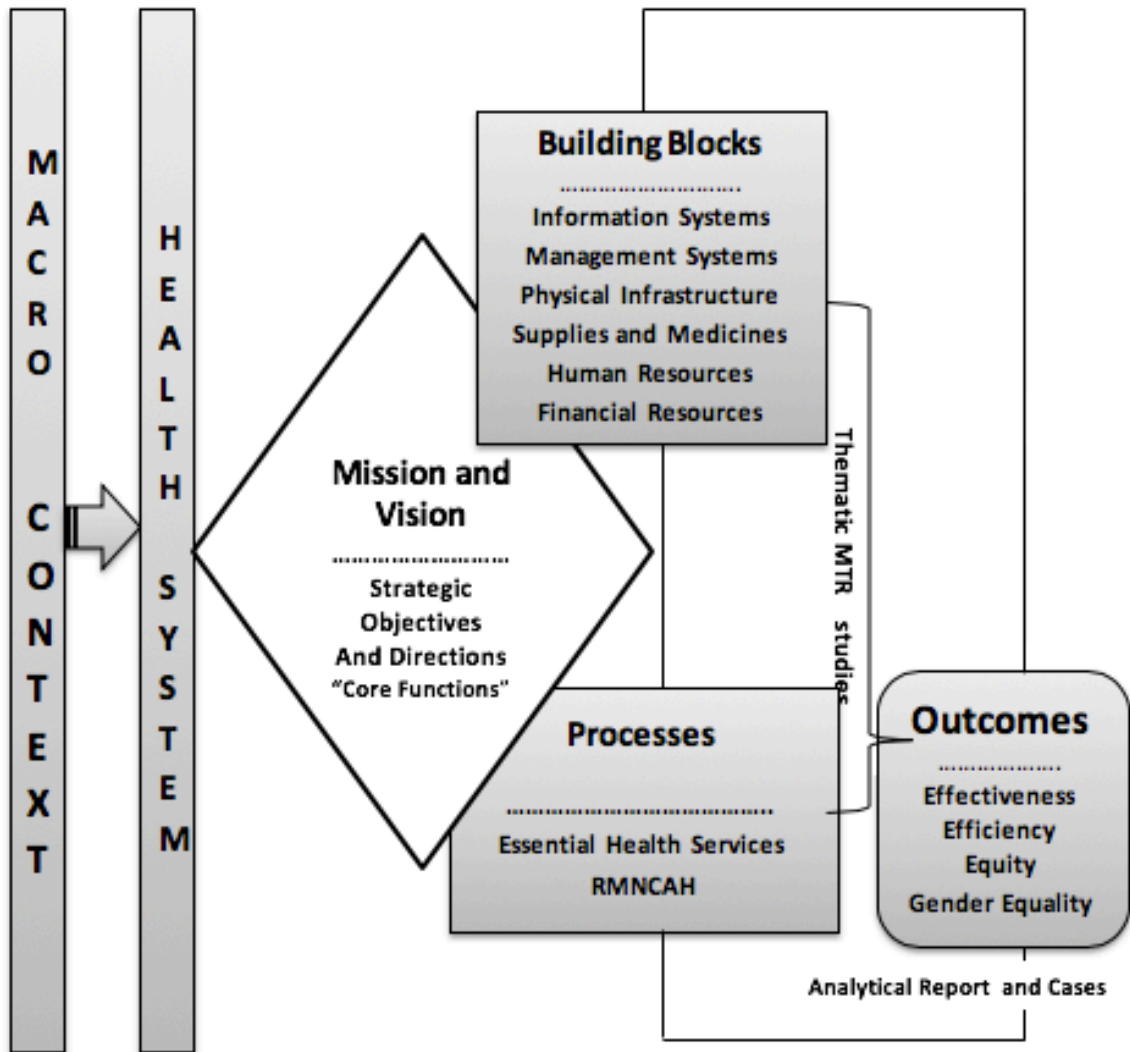


Figure 1 HSSP IV MTR conceptual framework

The figure shows that the thematic reports mainly focus on building blocks and on processes, while the analytical report, the gender and equity reports provide more information on the outcomes, especially at community level.

WHO strategies for integrated people-centred health services²

WHO recommends five interwoven strategies that need to be implemented in order to achieve the vision that all people have equal access to quality health services that are co-produced in a way that meets their life course needs. Health authorities are encouraged to

² <https://www.who.int/servicedeliverysafety/areas/people-centred-care/strategies/en/>

select those policies and interventions that best fit their national, sub-national or local needs and to customize them to match their priorities, capabilities and resources.

1. Engaging and empowering people and communities;
2. Strengthening governance and accountability;
3. Reorienting the model of care;
4. Coordinating services within and across sectors;
5. Creating an enabling environment.

The WHO model is relevant and to a large extent consistent with the strategic objectives of HSSP IV. Therefore, it offers a good reference framework for assessment of progress of the implementation of HSSP IV.

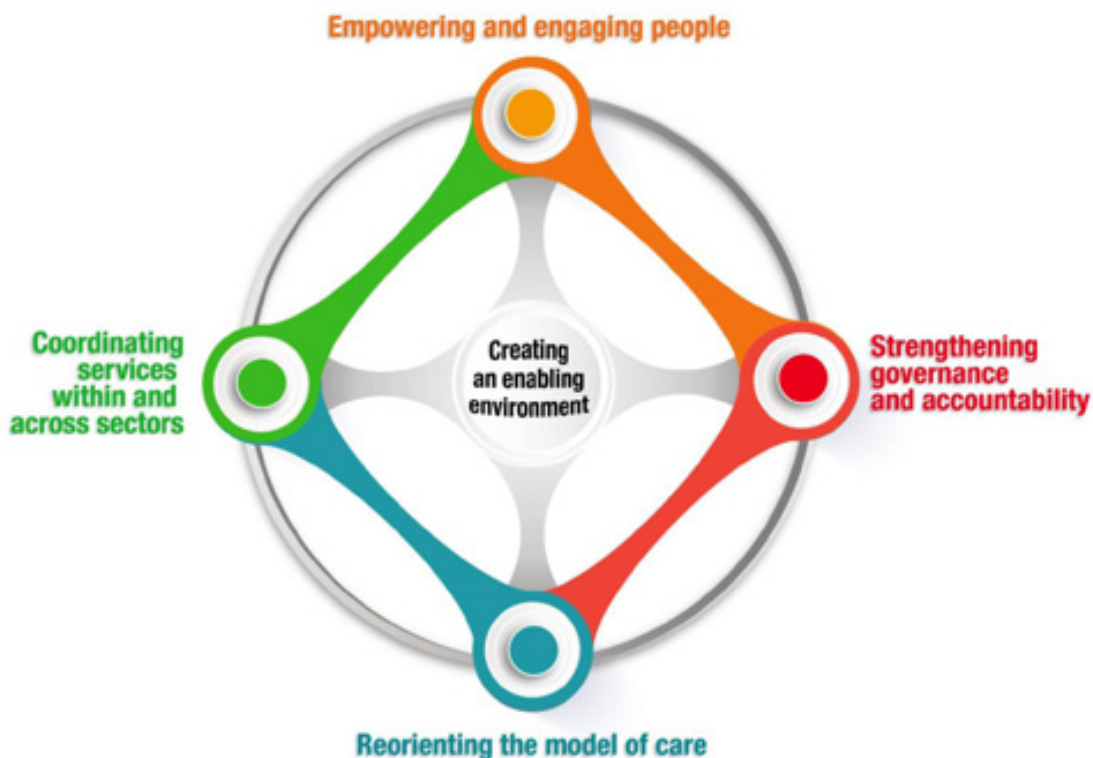


Figure 2 WHO integrated people oriented health services

MTR Process

The MTR aimed to be as much as possible locally managed and locally implemented, using capacities of universities, institutions and consultancy firms in Tanzania. The MTR also aimed at optimal participation and consultation, through involvement of experts from the health sector in the technical support team, and through consultation and validation rounds, before formulating conclusions and recommendations.

MTR Team

The MTR team consisted of one international consultant, and nine national consultants. The analytical team had one international consultant and five local consultants. In addition, two Tanzanian consultants were engaged for special studies. A core team of experts from MOHCDGEC and Development Partners worked side by side with the MTR team to give direct to the process.

Technical Support Team

There was a Technical Support Team (TST) of in total 18 people from Ministries, Departments and Agencies, that worked with the Mid-Term Review Team. The role of the TST members

was to facilitate the information process between consultants and stakeholders in the review, to participate in the field visits and to provide inputs for conclusions and recommendations.

MTR governance

The overall guidance was provided by the Steering Committee chaired by the Permanent Secretary of MOHCDGEC and the Deputy Permanent Secretary Health of PO-RALG. Day-to-day governance was provided by a Task Force consisting of representatives from the Ministries and Development Partners Group (DPG-Health). The core team was directly guiding the consultants.

MTR time frame

The MTR was conducted in a phased approach, as shown in the figure below.

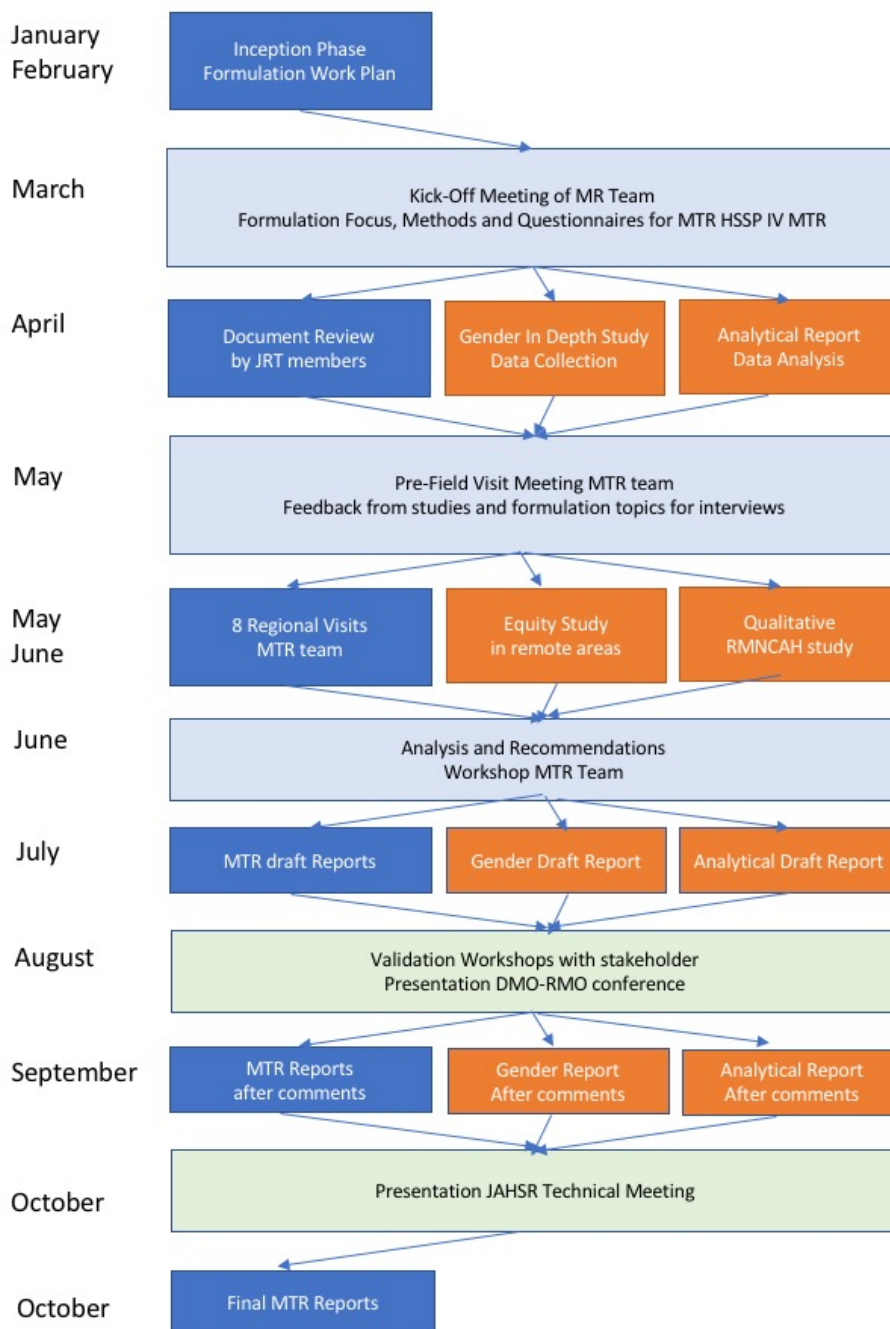


Figure 3 Time frame MTR HSSP IV

After the inception phase and kick-off meeting in March 2019, the MTR team performed desk studies and other consultants did special studies into gender and data analysis in April. Also a small study into use of Information and Communication Technology (ICT) in maternal health was done. Before the field visits, the results of this work was shared in a workshop in May, and topics for the field visits were identified. The questionnaires were completed, and training in use of software was done. The field visits were performed in May and June in eight regions (one per zone) in Dar-es-Salaam, Lindi, Katavi, Mbeya, Dodoma, Kigoma, Geita and Tanga. In each region the team visited three councils, and in each council three health facilities and their communities. In total 56 health facilities were visited. In each region the Regional Referral Hospital (RRH) and at least one training institution was visited. During the field visit a qualitative study into RMNCAH was performed in eight regions, and a qualitative study into equity in four remote Councils in four regions.

<i>Region</i>	<i>Council</i>	<i>Council</i>	<i>Council</i>
1. Dar es Salaam	Ilala,	Temeke	Ubungo
2. Dodoma	Dodoma Town	Chemba	Bahi
3. Geita Region	Geita Town	Bukombe	Chato
4. Katavi	Mpanda Town	Nsimbo	Mlele
5. Kigoma	Kigoma Town	Kakonko	Buhigwe
6. Lindi Region	Lindi Town	Lindi Rural	Kilwa
7. Mbeya Region	Mbeya Town	Rungwe	Ileje
8. Tanga	Tanga Town	Korogwe	Lushoto

Table 1 Regions visited during MTR HSSP IV

After returning from the field visits in June, consultants shared their findings and first conclusions. Recommendations for thematic reports were formulated.

In July consultants produced draft thematic reports, and the team leader summarised the reports in six papers for consultation of stakeholder. In August six consultative workshops took place and draft conclusions were shared in the DMO-RMO meeting. Feedback was obtained from those consultants.

In September pre-final reports were disseminated for comments, and in October the findings and recommendations were presented in the Joint Annual Health Sector Review Technical Meeting (JAHSRTM). Thereafter the report was finalised.

2 Government Policies and Strategies

2.1 General Policy Framework

In Tanzania a coherent system of government policies, legislation, strategies and programmes is emerging, giving direction to development. Consistency between general and sectoral policies is increasing. Policy implementation pace has encountered variations in application and enforcement.

Tanzania Development Vision 2025

Tanzania Development Vision 2025 (Vision 2025) is a document providing direction and philosophy for long-term development. By 2025, Tanzania wants to achieve a high quality of livelihood for its citizens, peace, stability and unity, good governance, a well-educated and learning society and a competitive economy capable of producing sustainable growth and shared benefits by 2025.

The Vision 2025 document identifies health as one of the priority sectors contributing to a higher-quality livelihood for all Tanzanians. This will be attained through strategies, which will ensure realisation of the following health service goals:

- Access to quality primary health care for all;
- Access to quality reproductive health services for all individuals of appropriate ages;
- Reduction in infant and maternal mortality rates by three-quarters of levels in 1998;
- Universal access to clean and safe water and sanitation;
- Life expectancy comparable to the level attained by typical middle-income countries;
- Food self-sufficiency and food security; and
- Gender equality and empowerment of women in all health parameters.

Five Years' Development Plan 2016/17 – 2020/21

The theme of Five Years' Development Plan II 2016/17 – 2020/21 “Nurturing Industrialization for Economic Transformation and Human Development” incorporates growth and transformation and poverty reduction. FYDP II outlines new interventions to enable Tanzania industrialise in a way that will transform its economy and its society. FYDP II also implements aspects of Tanzania’s Development Vision (TDV) 2025 which aspires to have Tanzania transformed into a middle income and semi industrialized Nation by 2025.

Key interventions proposed for the health sector:

- Strengthening health systems (primary and referral);
- Equipping district, regional and referral hospitals with modern equipment;
- Training health staff (short and long courses);
- Management of Non-Communicable Diseases (NCDs);
- Improving working environment for health personnel (commensurate remuneration, housing in close proximity to work premise);
- Speed up comprehensive health care, focusing on proactive preventive medicines and timely and effective control of epidemic diseases.

During implementation of FYDP II, emphasis will be on strengthening of health service delivery system with service delivery geared towards improving the health of mothers and children; addressing commonly prevalent illnesses such as malaria and HIV and AIDS and Non-communicable diseases (NCDs) which are major causes of deaths as well as addressing the human resource crisis which constrains provision of adequate health care. Indicators and targets for the development of the health sector over the Plan period and beyond are indicated in Table 4.16.

2.2 Health Sector Policy and Strategy Framework

National Health Policy

The MOHSW revised the 1990 National Health Policy in 2003 and 2007. On-going socio-economic changes, new government directives, emerging and re-emerging diseases and advances in science and technology necessitated the policy update. The policy outlines achievements and challenges facing the health sector.

The Government aims to improve the health of all Tanzanians, especially those at risk, and to increase the life expectancy, by providing health services that meet the needs of the population.

In summary, specifically the Government aims to:

1. Reduce morbidity and mortality in order to increase the life expectancy of all Tanzanians by providing quality health care as needed for specific age categories;
2. Ensure that basic health services are available and accessible for all people;
3. Prevent and control communicable diseases, especially AIDS, Malaria and Tuberculosis, and non-communicable diseases resulting from mismanagement of chemicals, poor nutrition, environmental and working conditions.
4. Sensitise the citizens about preventable diseases and improvement of health;
5. Create awareness on the part of the individual citizen to his/her responsibility on his/her health and health of the family;
6. Build partnership between public sector, private sector (including traditional and alternative medicine providers), religious institutions, civil society and community in provision of health services;
7. Plan, train, and increase the number of competent health staff for all levels of health care;
8. Identify needs for health services in communities, construct and maintain health infrastructure and medical equipment; and
9. Review, evaluate and produce health policy, guidelines, laws and standards for provision of health services.

At present the national health policy is under reformulation.

MMAM

The Primary Health Care Services Development Programme (MMAM) 2007–2017 aimed to accelerate the provision of primary health care services for all.

The main areas are strengthening the health systems, rehabilitation, human resource development, the referral system, increasing health sector financing and improving the provision of medicines, health care waste management, sanitation, equipment and supplies. The MMAM ended in 2017 and was not replaced by a new programme. However, it was relevant during a part of the HSSP IV implementation.

Big Results Now Key Result Area in Healthcare (BRN)

In 2014, the National Key Result Area in health care was introduced and four broad outcomes were identified for health in the period from 2015/16 to 2017/18:

1. **Human Resources for Health (HRH)** aims to attain 100% balanced distribution of skilled health workers at primary level in identified thirteen underserved regions by 2017/18.
2. **Health Commodities targets** to ensure 100% stock availability of essential medicines in all primary health facilities in the country.
3. **Health facility performance management improvement** aims to attain 80% of primary health facilities to be at 3-stars and above by 2017/18 in twelve identified priority regions.
4. **Reproductive Maternal Neonatal Adolescent and Child Health (RMNCAH)** services targets to achieve 20% reduction in maternal and neonatal mortality rates in five identified priority regions by 2017/18.

The Big Results Now approach was important for the start of HSSP IV. Later it got integrated on health strategies, and progress was monitored as part of HSSP IV.

HSSP IV

The **mission** of the health and social welfare sector is derived from the Vision 2025 and is *“the provision of basic health and social welfare services that are of good quality, equitable, accessible, affordable, sustainable and gender sensitive”*.

The **vision** of the health and social welfare sector is *“to have a healthy society with improved social wellbeing that will contribute effectively to individual and national development.”*

The overall objective of HSSP IV is to **reach all households with essential health and social welfare services**, meeting as much as possible expectations of the population and objective quality standards, applying evidence-based, efficient channels of service delivery.

In order to achieve the overall objective, five specific objectives have been formulated:

- **Strategic Objective 1:** The health and social services sector will achieve objectively measurable **quality improvement** of primary health care services, delivering a package of essential services in communities and health facilities.
- **Strategic Objective 2:** The health and social welfare sector will improve **equitable access** to services in the country by focusing on geographic areas with higher disease burdens and by focusing on vulnerable groups in the population with higher risks.
- **Strategic Objective 3:** The health and social welfare sector will achieve active **community partnership** through intensified interactions with the population for improvement of health and social wellbeing.
- **Strategic Objective 4:** The health and social welfare sector will achieve a higher rate of return on investment by applying **modern management methods and innovative partnerships**.
- **Strategic Objective 5:** For improving **social determinants of health and welfare**, the health and social welfare sector will achieve close collaboration with other sectors, and advocate for inclusion of health promoting and health protecting measures in other sectors’ policies and strategies.

For service delivery and for health services support systems strategic directions are formulated, that will serve as the reference for the assessment, and that will be shown in the sections below.

3 Service Delivery

3.1 Performance Indicators

The indicators below are key indicators for service delivery in HSSP IV. The traffic light colour of each indicator shows achievement vis-à-vis the target in HSSP IV. The full explanation of this findings and – for some indicators – regional disaggregation can be found in the analytical report, that is part of this MTR.

Key points of the statistical analysis

The statistical assessment of progress during 2015-2018 shows many positive developments in terms of expanding program coverage for family planning with modern methods, antenatal, delivery and postnatal care, PMTCT and HIV treatment. Also, the quality of care appears to have improved considerably according to the star rating assessment in all regions.

Yet, many of the HSSP IV targets will not be met. Neonatal and child mortality need to decline faster. Adolescent childbearing remains persistently high. Fertility and unmet need for family planning are still high in spite of positive trends. The coverage of malaria and TB interventions needs to increase. Access to improved drinking water source and sanitary facilities is improving but still far from targets, especially in the rural population. The health system strength has only improved piecemeal during HSSP IV, most prominently access to essential medicines and health information systems. Major gaps in health workforce in almost all regions, and service access in some regions. There is some evidence of the increasing burden of non-communicable diseases.

For almost all indicators there are persistent inequalities between urban and rural populations, the poorest and richest households and between regions, and there is only limited evidence of reductions.

Indicator	Baseline (Year)	Target 2020	Achievement	Comments
General Impact indicators				
Under-five mortality per 1,000 live births	81 (TDHS 2010 for 2006-10)	54	67 (TDHS 2015/6 for 2011-15)	Major progress in the past decade but MDG target not met; inequalities are modest
Infant mortality rate per 1,000 live births	51 (TDHS 2010 for 2006-10)	-	43 (TDHS 2015/6 for 2011-15)	Good progress in last decade, especially in the post neonatal period
Neonatal mortality per 1,000 live births	26 (TDHS 2010 for 2006-10)	19	25 (TDHS 2015/6 for 2011-15)	Little progress, neonatal deaths are now 37% of under-5 mortality
Life expectancy at birth (years)	60/64 (M/F) (Census 2012)	59/62	62/66 (WHO estimates 2016)	Targets met, due to improvements in child and adult mortality
RMNCAH indicators				
Total fertility rate among women 15-49 years	5.2 (TDHS 2015/16 and Census 2012)	5.0 (one Plan II)	4.9 (TMIS 2017)	Target achieved; TFR refers to 3 year-period before survey

Indicator	Baseline (Year)	Target 2020	Achievement	Comments
Contraceptive prevalence rate with modern methods (among married women 15-49))	32% (TDHS 2015/16)	45%	No new survey data	CYP increasing in 2018 according to DHIS, most prominently implants which is the leading method
Teenagers who have begun childbearing (under 20)	21.0% (TDHS 2015/16)		20.8% (TMIS 2017)	No change in adolescent fertility, higher than 10 years ago
Maternal mortality per 100,000 live births	556 (TDHS 2015-16)	192		No progress in the past decade; no new population-based data
Maternal deaths per 1000 deliveries in health facilities		-		Recent data from DHIS not available
ANC: first visit before 12 weeks of pregnancy	24% (TDHS 2015/16) 13% (DHIS 2015)	60%	27% (DHIS 2018)	Modest increase but still well-off target
ANC at least 4 visits among pregnant women	51% (TDHS 2015/16); 37% (DHIS 2015)	80%	62% (TMIS 2017) 61% (DHIS 2018)	Steady increase from 2014- 2017 followed by major increase in 2017-2018.
IPT 2 (intermittent preventive therapy)	35% (TDHS 2015/16); 54% (DHIS, 2015)	90%	81% (DHIS 2018) 56% (TMIS 2017)	Major increase, target may be met if the increase continues
Institutional delivery rate	63% (TDHS 2015/16) 65% (DHIS 2015)	80%	77% (DHIS 2018)	Steep increase between 2017 to 2018 DHIS. Target of 2020 may be met
Skilled Birth Attendants use during childbirth	64% (TDHS 2015-16)	80%		Parallel increase to institutional deliveries
Emergency Obstetric Services: facilities that can provide EmONC (%)	25% of dispensaries and HC (2015 EmONC assessment)	BEMOC – 70% of all HC and dispensaries; CEMOC - all hospitals	BEMOC – 20% of dispensaries and 39% of HC; CEMOC - 81% of hospitals, 17% of HCs (SARA, 2017)	Targets for 2020 not likely to be met at current level of increase
Postnatal care within 48 hours (women)	34% (TDHS 2015/16) 42% (DHIS 2015)	80%	66% (DHIS, 2018)	Rapid increase in PNC use; 2020 target within reach
Postnatal care within 48 hours (Newborns)	43% (TDHS 2015/16)	80%	65% (DHIS, 2018)	Rapid increase in PNC use; 2020 target within reach
C- Section Rate	6 % (TDHS 2015/16) 6.3% (DHIS, 2015)	5-15%	8.0% (DHIS, 2018)	2020 goal has been met, but many women still lack CS access
Emergency Obstetrics Services: facilities that can provide EMOc (%)	25% (2015 EMOC survey)	70%	15% Health centre; 81% Hospitals (2017 SARA)	Achieved in hospitals but not in health centres
DPT3/pentavalent coverage in children under 1 (%)	88% (TDHS 2015/16)	90% (survey and DHIS2)	91% (DHIS 2018)	High coverage, remains near target
Measles vaccination in children under 1 (%)	78% (TDHS 2015/16)	90% (survey), 90% DHIS2	100% (DHIS 2018)	Above target and increasing to reach nearly all children.

Indicator	Baseline (Year)	Target 2020	Achievement	Comments
Percent of all malaria cases that are lab confirmed	64% (2014 HMIS)	95% (NMCP)	99% (DHIS 2018)	Target achieved
Children with febrile illness who received a diagnostic test for malaria	25% (THMIS, 2012) 36% (TDHS 2015/16)	80%	43.4% (TMIS 2017)	Progress, but still far from 2020 target
Mothers who received 2 doses of IPT for malaria during last pregnancy (%)	35% (TDHS 2015) 55% DHIS2, 2015)	80%	56% (TMIS 2017) 80% (DHSI2, 2018)	Increase during 2012-2017 and 2018 suggests target reached
pregnant women 15-49 years of age, children under 5 sleeping under an ITN the previous night (%)	72% under-5, 75% pregnant women (THMIS 2012); 54% under-5, 54% PW (TDHS 2015/16)	80% for both populations	55% (children) 51% PW (TMIS 2017)	Decline since peak in 2011/12, and far from target
Infectious diseases indicators				
HIV prevalence among 15-24 years	15-19: 1.0% 20-24: 3.2% (THMIS 2012)	0.8% and 2.4% by 2017 (NACP)	0.6% and 2.4% (THIS 2016/17, 15-24 yrs)	Targets achieved
HIV positive women receiving ART for PMTCT	65% (NACP, 2012)	90% by 2017 (NACP)	99% (2018)	Target achieved
ART Coverage among eligible persons living with HIV infection (under 5, 5+, by sex)	65% (adults) 25% children	95% (adults) 80% (children)	75% of all people living with HIV (NACP, 2018) 47% of children living with HIV (2018)	Eligibility criteria changed during HSSP IV, now based on all people living with HIV
TB case detection rate (and TB notification rate)	36% (2014) (notification rate: 128 per 100,000 (2015))	72% case detection rate	50% (NTP 2018); (notification rate 140/100,000 (NTP 2018))	Progress but target still well-off;
TB treatment success rate (among smear positive cases)	90% (2013)	>90%	90% (2018)	No changes
Leprosy: disability grade 2 at leprosy diagnosis	13% (2013)	7%	13.1% (NTP 2018)	No progress
Children among newly detected cases	5% (2013)	<2%	3.8% (NTP 2018)	Progress towards target
Water and Sanitation Indicators				
% Population improved, not shared source of water	55% (TDHS 2011/12) 56% (Census 2012)	60% (TMIS 2017)	70%	Improvement since 2016, but short of target; rural access only 49%
% Population using an improved sanitation facility (not shared)	14% (TMIS 2011/12); 14% (Census 2012)	24% (TMIS 2017)	30%	Improvement
Non-Communicable Diseases Indicators				
Obesity and overweight among adults (25-64 years)	Obesity: 2.5% (M) 15.0% (F) (STEPS 2012, 25-64 yrs)			

Indicator	Baseline (Year)	Target 2020	Achievement	Comments
Obesity and overweight among adults (25-64 years)	Obesity: 6.1%, women (TDHS 2010); overweight or obese: 21.3%	No increase in obesity	10.0% (F, 15-49, TDHS 2015/16); overweight or obese 28.1% (F, 15-49, TDHS 2015/16)	Obesity has increased strongly
Raised blood pressure among adults	25.4% (M), 26.5% (F) (STEPS 2012)	Reduced by 25%	NA	
Raised blood glucose among adults 25-64 years	8.0% (M); 10.0% (F) (STEPS 2012)	Reduced by 10%	NA	
Cervical cancer screening among women 30-49 years with VIA	11% (HMIS 2014)			
Health systems indicators				
CCHP annual plans approved at first assessment (%)	20% (2014-15)	50%	90.2% (2018)	Target met and exceeded
CCHP implementation reports approved at first assessment (%)	41% (2013/14)	75%	No data	
General government expenditure on health as % of total government expenditure	9.1% (PER 2014); 10.3% excluding debt relief etc.	10.00%	10.0% in 2017/18; 8.9% in 2018/19	Achievement excludes debt relief etc.
Insurance coverage/enrollment in CHF/THIKA/NHIF/NSSF-CHIB/ CHIF	19% (NSSF, 2013)	50%	9.0% of women and 9.5% of men health insurance (TDHS 21015/16); includes 4.5% through community-based insurance	Enrolment target not met; coverage still very low
Medical Officer/ Assistant Medical Officer per 10,000	MO=0.4 (2011); AMO 0.4; total 0.8	NA	MO=0.61 / 1,000 population; AMO 0.27; total 0.88/1,000 (2018)	Increased density medical doctors
Nurse midwives per 10,000	4.0 (2011); 5.0 (2014)	7	6.2 (2018)	Increased yet below the target
Number of outpatient visits per capita	0.92 (DHIS 2015)		1.06 (DHIS 2017)	Gradual increase to 2017; 2018 not show due to data issue
Health facilities without any stock-out of 10 tracer medicines including 1 vaccine	86.6% (DHIS 2014)		95.9% (DHIS2, 2018)	Availability is good and improved over time
Facilities with 3-star rating or higher (%)	2% (Star rating assessment 2015/16)	50%	19% (Star rating assessment 2017/18)	Major progress in overall rating but still far from target
Completeness of reporting in DHIS	90% (2014)	95%	95% (2018)	Increased over time, target met

Table 2 Key performance indicators HSSP IV (source MTR analytical report 2019)

3.2 Quality systems

Strategic Direction: *The primary focus will be on quality in order to improve outcomes of health care and social welfare services and to enhance trust of the population and other stakeholders in the sector. A series of measures will make quality of health care visible, more acceptable to users, and safer for both clients and health workers. Transparency and value for money will attract investments in the sector.*

Key findings: *Quality is improving in many areas, and step-by-step a culture of focus on quality is emerging. Quality Improvement Teams have a positive impact. However, many of the initiatives are not yet reaching peripheral institutions, and parallel initiatives in the area of QI are noticed. The star rating programme has been very successful in improving health facilities in essential areas, but further improvements are needed to achieve the set targets. Certification and accreditation are within reach, and necessary for a Single National Health Insurance. The Client Charter is in place, but needs further improvement to achieve compassionate care in health facilities.*

Quality Improvement

The Tanzania Quality Improvement Framework (TQIF) in Health Care (2011–2016) is a comprehensive national reference document for Tanzania’s health sector. In 2018 a Community Quality Improvement Framework complemented the TQIF.

The MTR found advance in the introduction of Quality Improvement (QI) in health facilities, especially in Regional Referral Hospitals and First Line Hospitals. Guidelines, Standard Operating Procedures (SOPs), Formularies, etc. are often present and used. However, in peripheral facilities (health centres and dispensaries), these guidelines are not available as required and not always adhered to. Guidelines are in many cases only available in electronic form and the MTR found that many lower-level staff cannot understand them. Quality Improvement Teams (QIT) are operational in most Councils and give guidance to health facility staff in quality issues.

Nevertheless, there is room for improvement. More coherence in QI initiatives at national level can enhance reach and effectiveness. Committed leadership, as well as advocacy and follow-up through mentoring and supervision appears to be an approach that bears success, and should become standard countrywide. A new QI framework is under development addressing these issues. However, full collaboration from departments and programmes is needed to enable this update and make it operational throughout the country.

Certification towards Accreditation

The star-rating has given a major boost to introduction of a quality culture. Primary Health Care (PHC) facilities started with a very challenging low level of baseline ratings in 2015. Only 2% met three stars or more and 34% scored zero. One and a half years after the initial assessments marked improvements were recorded with 19% of facilities assessed scoring 3 stars and above; only 4% were at zero stars’ status. Facilities that scored 1 star at baseline were 51%: two years down the line facilities rated 1 star and above were 94%, quite a remarkable increase. Improvement was achieved through tackling urgent issues, that were relatively easy to address (low hanging fruits). Reaching the final required levels will take much more efforts.

At regional level in RRHs the External Hospital Performance Assessment is most prominent element of QI initiatives. In hospital the 5S Kaizen management approach is often applied.

The private hospitals act is now under revision. At this moment only private hospitals are being accredited, but in future all public and private hospitals and health facilities will be subject to the same accreditation system. This will contribute to creating a level playing field

for public and private service providers. Accreditation will be a necessary step in creating a credible national health insurance, that the population can trust.

Best practice Availability of quality data has enabled a CHMT to conduct BRN star rating assessment in addition to the assessment that was done through the central government. In doing so health facilities' star rates considerably increased over time compared with the 2016 baseline assessment.

Clients' Charter

Health facilities visited during the MTR featured the placement of signage and public display of telephone numbers of key officers of the facility, as well as having suggestion boxes at key points. These constitute concrete examples evidencing implementation of the Clients' Charter beyond simply displaying it. Complaints handling mechanisms are supported by capture of complaints in earmarked registers. Community voice is registered in operating routines of health facilities through various channels (suggestion boxes, telephone calls or sms, WhatsApp, or direct face to face encounters). In the community interviews the MTR found that complaints are rarely made, even if there is dissatisfaction with the services provided. However, respectful communication and privacy and confidentiality are less well implemented, than required according to the Client Charter. The message on rights and obligations contained in the Clients' Charter has not yet been applied more practically as a tool for dialogue amongst providers and between providers and beneficiaries.

The health sector is not gender sensitive, at best gender blind. There is little attention for specific needs of women and girls (beyond maternal health). Gender-based violence is addressed in more and more places, but not yet country-wide. Few facilities have kits for examination of gender-based violence.

Best practice: Some CHMTs train in leadership in order to guide health workers through coaching, mentoring and support. As quality is very much related to work culture, living by example by CHMT members, stimulates health workers to follow this approach.

Best practice: Nyamagana Council in Mwanza, attracted more women to give birth at the health facilities by putting the Client Charter into practice. Birth companion is allowed and mitigates disrespect and abuse of women in labour.

3.3 Package of Interventions by Levels of Care

3.3.1 National Essential Health Care Intervention Package

At this moment the National Essential Health Care Intervention Package Tanzania (NEHCIP-TZ) (2013) is in place. In principle, it offers good guidance for planning and provision of services, including essential medicines, laboratory tests, etc. At his moment, it does not include new innovations in service provision (e.g. CEmONC at health centre level). It can only partially be implemented due to resource constraints. A Minimum Benefit Package (MBP) for the Single National Health Insurance has been conceptualised awaiting high level decision to put it into practice. For equitable access to services the MBP should at least cover the NEHCIP-TZ), which is updated regularly to keep track of the new developments in healthcare delivery strategies.

3.3.2 Community Health

Strategic Direction: *Revitalising Community Based Health Care, increasingly supported by professional Community Health Workers, will ensure that essential health promotion, health protection and prevention activities are addressed in partnership with communities, with a high rate of return on investments. The Community-based health programme aims to reduce the pressure on facility-based care through enhancing healthy living at households, in schools and work places.*

Key findings: *Community health activities as extension of health facility services are increasing, but often having more a preventive or curative focus, than a health promotion focus. Information is provided, but not reaching all communities. Traditional beliefs that hamper health continue to exist, and affect maternal and reproductive health. The Community Based Health Programme has not taken off, and around the role, functions, incentive packages many different practices continue to exist.*

During the period the health sector formulated a comprehensive approach to Community Based Health through the National Community Based Health Care Programme (CBHP) and the National Costed CBHP Strategic Plan (2015-2020).

Formalisation and integration of CHWs and their training

In HSSP IV the Community Health Programme was presented as the game changer in health, including a cadre called Community Health Worker (CHW), who would get a formal training and an official remuneration. A Scheme of Service for the CHWs was developed, but dropped off before its application. Different payment schedules are implemented, sometimes with different plans from different organisations and programmes. Old (shorter) training programmes and voluntary CHWs continue to exist, next to the new cadre. The process of coming to one professional type of remunerated CHW is still ongoing and there are still debates about the best way forward.

The MTR showed positive effects of the work of CHWs, e.g. in disease control programmes, health education, nutrition and sanitation. However, the penetration of the CBHP is very unequal in the country, with very few CHWs in remote rural areas, and very little support from NGOs.

Health action in schools

The National School Health Programme is performing well in most areas visited during the MTR. The programme addresses issues around nutrition, hygiene and lifestyles. It offers an opportunity of reaching adolescents and youths in school to address sensitive issues in this target group such as sexual and reproductive health, gender in health, Gender Based Violence (GBV), etc. There is good inter-ministerial coordination among PO-RALG, Ministry of Education and Vocational Training, and MOHCDGEC. A national School Health Policy guideline and strategy are in place.

Intensified Health Communication

Strategic Direction: *Integrated prevention and promotion services are needed, that aim at empowerment of communities and address determinants of health.*

Key findings: *Community empowerment to solve water, sanitation or nutrition issues are often taking place with little involvement of the health workers. Health workers do not have the time or the competencies to address social determinants of health.*

Extension and outreach services, especially vaccination programmes and disease control programmes are operational; often as special programmes. Activities for control of Neglected Tropical Diseases (NTDs) are implemented in various regions. National guidelines for health promotion are in place, including relevant information materials. A health communication resources centre has been established with an Audio-Visual studio, printing unit, social media accounts, and a Health Promotion Digital Platform, engaging social and mass media to reach the public with educative and correctional messages more efficiently (e.g. the CHWs SOS WhatsApp).

Health promotion and awareness raising is taking place in communities, but in many places visited during the MTR, it is still not resulting in behavioural change, especially not in gender related issues. Health seeking behaviour has not changed. This affects effective reproductive and maternal health, as well as family planning. Health literacy remains low in many places, resulting in inadequate health seeking behaviour.

Community empowerment in self-help groups, or in community-led sanitation, water, or nutrition, is very much dependent on local initiatives (NGOs, CBOs) and partner funding. These initiatives are not equitably spread over the country. In general, at grassroot level the interaction between health and community development remains weak. In the interviews 60% of health facilities indicated that they did not have any joint programme with other sectors, like water, education, agriculture.

During the MTR field visits only 60% of the communities indicated that there was a water and sanitation programme in their village, and only 55% mentioned a nutrition programme. In most of the remote and hard to reach areas there are less ongoing activities intending to improve community health.

Best practice: *NGOs work with vulnerable groups (e.g. elderly, vulnerable children) on home gardening and small economic activities that have a direct economic benefit and health benefit as well.*

3.3.3 Council Health Services

Strategic Direction: *Council Health Services will constitute the backbone of the health services. These services will provide the National Essential Health Care Intervention Package (NEHCIP-Tz) while guaranteeing quality (3-star rating) and transparency (social accountability). Increased trust will sensitise the population to enrol in the Single National Health Insurance and take part in management of Council Health Services.*

Key findings: *Council health services are improving and star rating has increased, but not yet reaching the target. On the one hand, availability of medicines had a positive impact, but on the other hand shortage of staff make it impossible to provide all essential health services. Direct Health Facility Financing has had a very stimulating impact on initiating improvements at health facility level, and social accountability is improving through collaboration with Health Facility Governing Committees.*

PPP at local level is not developing, and Service Level Agreements are not actively maintained. Excluding Faith-based health facilities from DHFF has had a negative effect.

Integrated and evidence-based health planning and decision making at LGAs

Bottom-up planning, starting in health facilities with Health Facility Governing Committees (HFGCs) and functional Council Health Services Boards, resulting in Comprehensive Council Health Plans (CCHPs) is functioning well. National guidelines are clear and well-used. The quality and relevance of plans is clearly improving. The Health Management Information System (HMIS) is reaching a level of quality, allowing it to be used for local planning and priority setting. However, further capacity building of HFGCs is needed to strengthen their position.

Further integration of planning systems of social services (health, community development, social protection) at village and ward level is needed. Local HFGCs, VHCs, WDCs, village authorities could work better together.

Decentralisation of financial management to the facility level

The Direct Health Facility Funding (DHFF) has been one of the major successes of HSSP IV. It allows health facilities to allocate Health Basket Funding (HBF) to local priorities (within certain limitations). The Health Facility Governing Committees (HFGCs) are generally closely involved in the budgeting and expenditure process, working together with the health facility staff. Not only has the money been very well spent, e.g. to address issues revealed in the start-up process, but it also has been accounted for very well. The MTR visits made clear that it is highly motivating for health facility staff, to be empowered to make decisions on health services. However, private not-for-profit facilities are not benefiting from this financing mechanism.

Partnership with Private Providers

The private sector is working closely with the Government from the grass root level up to the national level, with Christian Social Services Commission (CSSC) and the Association of Private Hospitals in Tanzania (APHTA). The secondary and tertiary level institutions (both public and private not for profit) are monitored and directly supported by the MOHCDGEC, while primary level health facilities are monitored and supported by the LGAs.

In general, the Service Level Agreements are used as instruments for collaboration between faith-based institutions and CHMTs. Often the general templates are used, and no specific arrangements are made, based on local analysis. Sometimes discussions exist on the package of services offered, exemptions for clients or construction of government facilities near faith-based institutions. The monitoring and evaluation is often very minimal, and no key performance indicators are in place. After introduction of the DHFF, support to FBO facilities has come to a halt in most councils.

A longstanding agreement that certain FBO hospital should become referral hospital at regional level, was never implemented, although service level agreements were ready for signing.

The introduction of the single national health insurance, with reimbursement based on services provided, and a single accreditation system for health facilities, will create a level playing field for public and private providers, and maybe unwanted competition.

3.3.4 Regional Referral Level

Strategic Direction: *Regional Referral Hospitals (RRH) will serve as centres of medical excellence and referral in the Regions, and as the hubs for technical innovation to be disseminated to lower levels.*

Key findings: Services in Regional Referral Hospitals are improving, quality systems and procedures are better implemented. Shortage of staff is an issue, especially for complicated referrals. Electronic medical records are being introduced and other e-health applications. Management is being strengthened, but most RRHs do not have a Regional Hospital Health Services Board.

Electronic medical records and e-health expansion

In many RRHs electronic medical records are being introduced, especially GoT-HoMIS. Some use it only in specific wards, or only in the Out-Patient Department (OPD). The experiences are still limited to draw conclusions (see below automation). Other electronic applications, e.g. for consultation of colleagues, telemedicine, etc. are gradually introduced. It is still to be evaluated how much this is improving the quality of services.

SOPs, clinical audits and mentoring

As mentioned under quality improvement, there is a markedly improvement of quality instruments in RRHs. There are clinical guidelines, formularies, etc. of in electronic formats, and therapeutic committees are in place in most RRHs visited during the MTR. In general, clinical audits are performed.

There is still a shortage of staff, and the number of medical specialists is not sufficient in most RRHs. There is in several hospitals a high turn-over of staff, leading to problems with continuity of care.

Leadership, planning and resource management capacity

Management capacity is improving, with Quality Improvement Teams (QITs), Work Improvement Teams (WITs) in place in most RRHs. Resource management is improving, with income from insurance schemes becoming more and more important sources to guarantee continuity of operations. RRHs do not receive health basket funding. Most RRHs do not have a Regional Hospital Health Services Board, reducing community accountability.

It is too early to evaluate the impact of the decision to move the RRHs under the direct responsibility of MOHCDGEC. Some respondents fear unstable relations between the Regional Administrative Secretariat (RAS) and the hospitals, and longer lines for approval of plans and budgets, leading to reduction of efficiency.

3.3.5 Zonal and National Level, including International referral

Strategic Direction: Expansion of the number of Zonal and National Hospitals will enable referral of complicated cases countrywide, and will reduce the necessity for international referral.

Key findings: Hospitals are improving and adding new activities to their services. The MTR could not find information on the impact on international referrals.

Muhimbili National Hospital and Mloganzila Hospital, the Zonal Referral Hospitals and the Specialised Hospitals (MOI, JKCI, ORCI, Kibong'oto) and also the Benjamin Mkapa Hospital in Dodoma have been handling referral patients according to the range of available expertise. The quality of services focused in these high level institutions requires to be reviewed or studied in depth, considering the complexity of their internal processes and operational realities.

Also at this level further steps need to be taken to come to service level agreements with hospitals like Bugando Medical Centre, KCMC and Haydom Hospital.

3.4 Health Service Provision by type of Service

3.4.1 Nutrition Services

Strategic Direction: *The health sector in collaboration with partners will accelerate nutrition interventions, with emphasis on pregnancy stage and the two first years of life (1000 days).*

Key findings: *The National Multisectoral Nutrition Action Plan is being rolled out, and leading to gradual reduction in malnutrition and stunting. However, at grassroot level, health workers are hardly involved in the community activities.*

The Tanzania Food and Nutrition Commission and nutrition stakeholders revised of the Food and Nutrition Policy of 1992, developed its implementation strategy (2015/2016 – 2025/26). A National Multisectoral Nutrition Action Plan-NMNAP (2015 – 2020) was developed. The NMNAP was rolled out for implementation countrywide and across key sectors.

Stunting and malnutrition in Tanzania are gradually decreasing, probably due to social and economic development in the country. But the difference between urban and rural population and between the rich and the poor remain high.

Growth monitoring and mothers counselling on key nutrition interventions including provision of supplements (Vit A, iron, folate, zinc), exclusive breastfeeding, supplementary feeding, screening of diseases and early treatment of illness, constitute routine measures at RMNCAH clinics. Mass distribution of Vit A is no longer taking place, leading to a drop in this indicator.

The MTR field visits revealed that the NMNAP was being addressed in terms of putting in place Regional Action Plans consequently followed by Council plans, all of which are multisectoral. However, regional and Council intersectoral committees do not follow up regularly, due to lack of funding. There is a critical implementation gap noticeable at Ward and village level. The health workers are mainly focusing their own activities in clinics rather than joining hands with other sectors. Their knowledge about promotion of good nutrition is also limited.

3.4.2 Reproductive, Maternal, Newborn, Child & Adolescent Health

Strategic Direction: *The health system will be strengthened to provide quality services which will contribute to achieving the goal of ending preventable maternal, newborn and child deaths and ensure universal access to sexual and reproductive and adolescent health services.*

Key findings Reproductive Maternal Neonatal Health: *Service provision figures for antenatal, delivery, post-partum check-up and also for reproductive health services are increasing. However, some quality indicators are not improving in these fields. This could indicate more, but not better services. CEmONC services in most health centres are not yet what was planned in HSSP IV, especially with regard to theatre and blood transfusion practices. Impact on maternal and neonatal mortality could not be included in this report due to lack of recent reliable data. The MTR found still many traditional beliefs in communities which hamper better use of available services.*

Key findings Child Health: *Services like IMCI, vaccinations, nutrition monitoring are provided everywhere and have an impact in child mortality. Urban-rural differences still exist.*

Key findings Adolescent Health: *Adolescent health services are improving, but still far from reaching the targets. There is little improvement in reduction of teenage pregnancies, HIV incidence among adolescent girls, or gender-based violence.*

Key findings Regional differences: There are remarkable differences between regions in performance in RMNCAH, that are not clearly correlating with numbers of staff and numbers of health facilities. Also socio-economic factors cannot fully account for the differences. Other factors like leadership, support by NGOs, PPP, etc. play a role. Regional priority setting and implementation should replace country wide actions.

Overall performance

The analytical report of the MTR shows a composite indicator that can be considered as representation of overall performance in RMNCAH.

Progress in RMNCAH coverage by region, as shown in the composite indicator, is based on an index of 11 indicators, including ANC early visit, ANC4 visits, institutional delivery, IPT2, and child immunisations (penta3 and measles), using DHIS2 data over the period 2015 - 2018. The figure shows that all regions made progress in performance, but some more than others. The differences between regions still remain big. The yellow bars are regions which received extra inputs under the Big Results Now programme. While three regions managed to reach the top league for performance, other BRN regions improved, but are still underperforming. Staffing and infrastructure issues are probably debet to this, as elaborated in the analytical report.

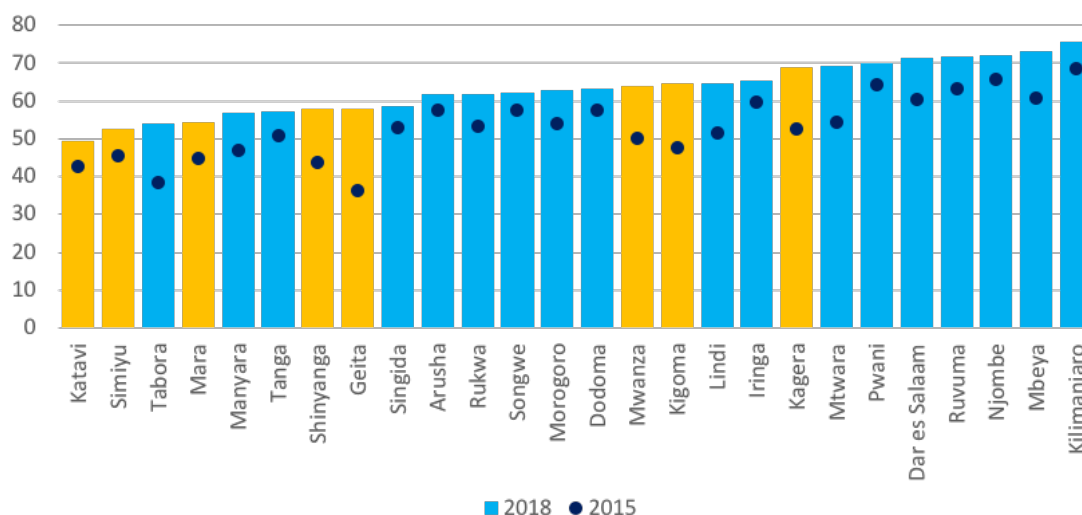


Figure 4 Composite indicator RMNCAH performance in Tanzania 2015 – 2018

Maternal and Newborn Care

This MTR cannot draw conclusions on the trend in maternal mortality in the period 2015-2018, as no survey was conducted. The health facility reporting of maternal deaths has not yet achieved complete reporting of all maternal deaths, and therefore cannot replace surveys. Antenatal care coverage improved during HSSP IV, including an increase of women making at least 4 visits (59%) and first trimester visits (but still low at 26%), as well as testing rates for syphilis and anaemia and IPT2 coverage, especially in 2018. However, targets set for quality, like always measuring blood pressure during ANC visits, or always testing Hb, are not met. Risk identification during ANC is not yet optimal. Prevention of mother-to-child transmission of HIV is generally well-integrated in ANC, though difficult to implement in peripheral dispensaries. Male involvement in maternal health is not yet as required, while for example husbands make decisions on early ANC visits.

Institutional delivery care increased rapidly to 78%, especially in 2018, although major regional differences persisted, accompanied by increase in C-section rates to 8.0% and in

postnatal care attendance (within 24 hours) to 65%. The MTR found the use of partograms during delivery is around 50%.

The availability of emergency obstetric care facilities had improved in hospitals, but not in health centres, by 2017. The increase was mainly in 2017-18. Problems are still in adequate human resources (e.g. anaesthetists) and equipment (e.g. blood bank).

Newborn data from DHIS for 2015-2018 indicate a decline of stillbirth rates (from 16 to 12/1,000 births), intrapartum stillbirth rates (from 6.4 to 5.0/1,000), low birthweight (5.5 to 5.0% among health facility births) but no changes in newborn care such as neonatal resuscitation (declined from 12.0% to 9.5% of health facility neonates) or Kangaroo mother care (54% and 56% of all babies weighing 2500 grams or less). Fresh stillbirths are still over 50% of all stillbirths. The coverage of interventions for maternal and newborn care for adolescent mothers is about the same as for older mothers.

A steady increase in all PNC indicators was noted between 2014 and 2018, with mothers coming more frequent, and earlier.

Overall, progress is being made in maternal and neonatal care. However, the indicators on quantity are improving more than indicators on quality. It is very heart-warming to see institutional delivery increase so much, but when partograms are not used and fresh stillbirths still occur a lot, the targets set are not achieved. Issues of limited human resources and other resources constitute the main barrier for achieving optimal results. Important is to stress again the differences between regions, and within regions. For achieving the targets of the Sustainable Development Goals (SDGs), the weakest performing Councils must catch their performance.

Best practice: WhatsApp groups where health professionals could consult each other, have been very successful. Advice on how to deal with alarm signs or complications helped health workers to provide better care. Referrals could be organised in a better way.

Best practice: Uturu village has active community partnership and community committees that perform local sensitisation of populations concerning risk factors and LGAs that put in place measures to increase institutional deliveries.

Child Health

Under-5 mortality and infant mortality in Tanzania continued its decline, although there is no recent data to show effects of HSSP IV. The gaps between urban and rural children and between the poorest and richest children are increasing. Neonatal mortality is also declining but at a slightly slower pace and is becoming more prominent, as nearly half of the under-5 mortality occurs in the first month of life. Surprisingly, neonatal mortality appears particularly high in urban populations.

Respiratory tract infections and diarrhoeal diseases are main diagnoses, while malaria is reducing. Better diagnosis and treatment, through use of Integrated Management of Childhood Illnesses (IMCI), better availability of medicines, contribute to reduction of mortality. Frequent supervision and guidance is important in ensuring that standard operating procedures like IMCI are followed.

One of the most successful programmes is the vaccination programme, where Tanzania belongs to the best performing countries in the world with coverages far over 90%. The vaccination programme, combined with better nutrition and better hygiene are the main drivers behind the improved health of infants and children.

Best practice: Breast feeding within one hour after delivery has increased from 60% to 75% in the last five years, because midwives were sensitised to instruct mothers on

importance of early breastfeeding. Increase in number of institutional deliveries did also contribute.

Adolescent Health

Still one in five women under 20 years delivers a child. Teenage pregnancy has even increased in the last years. Rural adolescent girls have considerably higher adolescent birth rates compared to those in urban settings, 24% and 15% respectively. As a result, many girls do not complete secondary school and drop out of education. Once pregnant, young women make use of available maternal health services in the same way like other women do.

Vulnerability of young women for HIV infection (nearly three time as high as young men) remains an area of concern, as little progress is made in reducing new infections

Slowly, health facilities are offering more adolescent-friendly services, e.g. on Saturday mornings. In the MTR 60% of facilities indicated they could offer some type of special services for adolescents. Knowledge of staff, but also cultural barriers among staff (paternalism) and adolescents (shame) play a role. Lack of privacy is a major obstacle for adolescents to seek help. School health programmes offer little information specifically for this age group.

Best practice: *some facilities sensitise schools to incorporate health issues for adolescents in the curriculum and disseminate information about availability of adolescent clinics (mostly on Saturdays).*

Family Planning

Total fertility rate remains high in Tanzania with a slow decline from 5.2 in 2015/6 to 4.9 children per woman in 2017. Rural fertility is just below 6 children per woman and urban fertility around 3.5. There were very large fertility differences between the regions, ranging from 2.8 children in Dar es Salaam to 7.6 in Simiyu region. Modern contraceptive prevalence rate (CPR) among married women increases, especially due to use of more long-term methods. Just over half of the family planning needs are covered.

The slow increase in use of family planning is largely dependent on gender issues, where men in general oppose family planning, and are not willing to be educated in health facilities. On the side of service provision, the bottleneck is lack of privacy in facilities, but also lack of skills of staff, e.g. in applying implants.

Best practice: *Some facilities are addressing health workers' attitudes towards contraceptive use (also among non-married people). Having an open professional attitude helps to reduce barriers for women to ask for contraceptive advice.*

Violence against Women and Children

Generally, the MTR found that prevention of and response to violence against women, adolescents and children is at the rudimentary stage. Gender-based violence (GBV) and violence against children (VAC) incidences were remarkably under-reported.

The main barriers to provision of GBV and VAC services included few skilled healthcare providers and lack of GBV kits in most of the health facilities visited in the surveyed regions, weak linkages among the key sectors i.e. health facility, police, civil societies, legal authorities. Many victims do not report or delayed for reasons related to male dominance, low knowledge and fear of the consequences that may follow. More than 60% of women in Tanzania consider GBV and VAC still a part of the culture.

Field visits indicated that services for sexual violence were sub-optimally provided at dispensaries and health centres because of lack of investigations and expertise. In hospitals the situation is slight better.

Best practice: *in some Councils local committees perform door to door sensitisation about GBV, at the same time when mass media campaigns are being conducted. This has a cumulative effect on behavioural change.*

3.4.3 Communicable Diseases

Strategic Direction: *The health system will maintain the high level of performance of Disease Control Programmes; reduce morbidity and mortality caused by infectious diseases while increasing efficiency through improved integration of activities.*

Findings: *In the area of curative services most disease control services are doing well with increased testing, improved adherence, improved cure rates, etc. However, in prevention and screening the programmes perform much less. Targets in HSP IV of use of bed nets, case detection rate for TB, or incidence of HIV will not be met. At grassroot level there is integration in the work of health facilities, but at higher levels, logistics, planning, monitoring and evaluation is mainly separate. Development Partners contribute to this separate approaches.*

Many programmes to reduce neglected tropical diseases perform well with support from NGOs.

Malaria

Health facility data indicate a significant decline in malaria incidence, prevalence and mortality. Malaria diagnostic practices in health facilities improved greatly and 99% of reported cases are now lab-confirmed.

The coverage of the key preventive interventions of ITN use IPT2 were still far from the targets. The percent of under-fives and pregnant mothers sleeping under treated mosquito nets even dropped to just over 50% by 2017, while IPT2 increased to just 50%, and both are still well-off the 80% targets. It looks like efforts in malaria prevention a less successful. Experiences from neighbouring countries show that malaria can bounce back, when prevention is neglected. There is no reason for complacency, as the disease is not yet fully under control.

HIV/AIDS

The HIV/AIDS problem in Tanzania still constitutes a big challenge. The national prevalence rate at 2016/17 was 4.7% compared to the 2012 levels of 5.1%. HIV prevalence is gradually declining among young people, indicating reduced HIV incidence, but young women aged 15-24 still have a considerably higher prevalence than young men (2.2% and 0.7% respectively). PMTCT interventions are almost universally accessible, utilisation rates are high and PMTCT coverage rates were over 90% during HSSP IV, reaching the target, resulting in a decline in HIV positive infants.

There has been an increase in access (facilities providing Anti-Retroviral Treatment (ART) services), utilisation (increase of number of clients accessing HIV care) and coverage of ART for people living with HIV. ART coverage increased in all regions, even though late initiation of ART and loss to follow up are still major challenges.

Several indicators show increasing programme outputs, such as proportion of persons who know their HIV status and male circumcision rates. The regional differences are important to

note, especially because there is a shift. Regions that had a very low prevalence in the past, now show a higher prevalence (like Tanga and Dodoma), and regions with a higher prevalence show now lower figures (like Dar es Salaam and Njombe). Constant vigilance is needed to monitor the trends and respond adequately.

Tuberculosis and Leprosy

The tuberculosis (TB) case detection rates in 2018 were well below target (50%). The TB notification rates declined until 2015 but increased since from 128 to 140. This is not necessarily due to an increase in TB cases but could be due to improvements in case detection. In the western parts of the country case detection is generally lower. Among the population knowledge about TB and stigmatisation still play a role in low case detection.

TB treatment success rates are as high as 90% and the target has been achieved. The Direct Observed Therapy treatment programme and outreach services assist follow up of defaulters using Community Health Workers.

Neglected Tropical Diseases

Neglected tropical diseases program data indicate progress in the battle against several NTDs such as trachoma and filariasis, as well as high coverage for preventive mass drug treatment efforts to control schistosomiasis and soil-transmitted helminths. For most programmes over 80% of vulnerable populations are reached. The programmes often use CHWs or other community based cadres for mass treatment.

Integration of programmes

The HIV/AIDS programme and TB programme are well integrated at facility level, not least because of frequent co-infections and need to monitor patients under both programmes. The malaria programme is using the same grassroot facilities for services. At a higher level there is less integration with separate committees, separate information systems, separate logistical systems, and separate mechanisms for intersectoral collaboration. A barrier to integration is separate funding mechanisms by some Development Partners, which have specific demands with regard to handling logistics and reporting.

3.4.4 Non Communicable Diseases (NCDs)

Strategic Direction: *The country will focus on community-based prevention, health promotion, screening and early treatment as well as rehabilitation. Activities will be integrated in health services and not as new vertical programme.*

Key findings: *Non-communicable diseases are increasing and becoming dominant in morbidity and mortality in Tanzania. A strategic plan has been formulated to reduce NCDs. Yet, the MTR could not find much results, with low levels of knowledge among health workers, no activities in facilities, and no human and financial resources to even start implementation at a larger scale. There is no sense of urgency that NCDs are an important threat to Tanzania.*

Prevention and control

NCDs are an increasing problem in the country and there is not a single sign that a start is being made to get these diseases under control. Nearly half of the hospital deaths are now due to NCDs and in all facilities an increased disease burden is being reported.

Obesity is not only a risk factor for diabetes and cardio-vascular diseases, but also for various types of cancer. There is a dramatic increase in obesity (and overweight) in Tanzania, as shown by survey data from women 15-49 years where obesity prevalence increased from 6% to 10% in just 5 years. Obesity and overweight are increasing everywhere in mainland Tanzania, but by 2015/16 obesity was three times higher among urban women than rural women (18% and 6% respectively), and more than 10 times higher among the wealthiest women compared to the poorest quintile women (21% and 2% respectively).

The last STEPS survey into NCDs was conducted in 2012, and no recent data are available on trends in prevalence of NCDs and risk factors. Besides lifestyle factors, environmental factors like air pollution are important for lung diseases, etc.

The MTR field visits found a low level of knowledge, with only 30% of health workers having training in this area. Less than half of the facilities can offer treatment for diabetes, hypertension or cancer. Often medicines for treatment of NCDs are not available in lower level health facilities. Besides individual counselling, there were no health promotion activities found in the communities. This is left completely to NGOs with very limited funding.

There is a strategic plan for NCD control, but at national level here is a very small section in the MOHCDGEC, that does not have resources. There are no Development Partners who show interest in the topic, apart from international NGOs. Some local NGOs are active in lifestyle issues and health promotion. A booklet for general public education on NCDs has been produced by the Tanzania Non-Communicable Disease Alliance (TANCDA) and currently been utilised as resource material as well as distributed at events that address NCDs.

Tanzania is party of the WHO Framework Convention on Tobacco Control and has put in place measures for tobacco control, but smoking is not reducing in the population. Measures to control sweetened beverages, or salt and sugar in food products are not in place.

A new national NCD control programme will be launched in November. However, it is not clear which resources will be made available to make the programme effective.

Cancer

The only national cancer screening programme is for cervical cancer screening. Most RRHs have facilities for screening of cervical cancer, and sometimes first line hospitals, when there is support from NGOs in this area. It is estimated that only 12% of the target population is reached with screening. Of course, the HPV vaccination is an important instrument in reduction of cervical cancer.

There are local programmes for breast cancer screening in collaboration with NGOs. They may reach around 5% of the target population. In general, women only detect breast cancer late, and can only get treatment in a specialised hospital. The MOHCDGEC is in the process of developing national guidelines for breast cancer screening and treatment. For scaling up, specialists, like pathologists, equipment, like mammographs, etc. are needed.

3.5 Emergency Preparedness and Response

The country has made major steps in improving emergency preparedness and response. The National Action Plan for Health Security 2017 -2021 is the most important document that addresses different types of emergencies, like epidemics, chemical, nuclear disasters. It also spells out intersectoral and technical collaboration, with coordination by MOHCDGEC.

There are also specific response plans, especially focussing on Ebola.

There is an information centre in the MOHCDGEC where all information comes in, and is disseminated to all stakeholders. It serves as info centre in case of disasters, with videoconference facilities etc.

The national intersectoral committee meets regularly and keeps each other updated. There is now a national taskforce for Ebola and Dengue to enhance preparedness.

At regional level there are committees as well under the RAS, but they function not all very well. Not all RHMTs have a fully skilled emergency coordinator (sometimes only knowledge in infectious diseases). Strengthening regional teams is needed.

There are limited resources available in all regions (especially for Ebola), but high risk regions have more resources. In case of real disasters the resources need to be mobilised and sent to area. In some areas there is Cholera for which resources are available. Zonal laboratories can analyse samples to detect epidemics like Ebola, Marburg, etc.

In the MTR the teams found that most RRHs are reasonably informed about emergencies, but have limited stocks. However in lower-level facilities knowledge is much less, with less than half of the staff trained, and no stocks or equipment in place. In dispensaries there is less awareness; 25% of the lower-level facilities was not reporting notifiable diseases. 40% did not have guidelines on emergency management in the facility.

Road Disaster Management is under development. A pre-hospital component, capacity building, community providers (1st aiders), emergency ambulances at accident prone areas/locations, rescue vans, orientation of surrounding communities, VHF radios linked vehicles and health facilities are reported to be in place in selected areas. Health facilities in accident prone areas will have restructuring for organised Emergency Medicine Departments (EMDs).

Best practice: *The MOHCDGEC and partners are now experimenting with high way patrol for medical emergencies, to gain experience in intersectoral collaboration for road safety.*

4 Health Care Support Systems

4.1 Human Resources for Health (HRH)

Strategic Direction: Adequate staffing of health facilities and social welfare institutions at all levels is the most critical success factor in achieving quality health and social welfare services. Equitable staff distribution, retention and maintaining high performance standards for employed professionals will be at the heart of quality improvement in health and social welfare services. Human Resources production will follow HSSP IV priorities.

Key findings: HRH planning is still an administrative activity, rather than a strategic activity. There is no workload-based planning and the information is not sufficiently analysed. The MTR analysis gives food for thoughts on moving to a more needs-based planning.

HRH distribution was seriously affected by government measures in the last years, and has led to a shortage of around 50% of staff. This affects quality of work. There is still a serious inequity in staff distribution between regions, but also within regions and councils. Performance is not directly correlated to numbers of staff; other factors play a role, like infrastructure, leadership, support from NGOs. Performance management systems are not really working, neither at individual nor at facility level.

HRH production has increased considerably; not all newly-trained health workers can be absorbed in the system. However, not all training programmes deliver high quality education. Curricula are not always up to date, and infrastructure of training institutions is sometimes insufficient. Continuing professional development is increasing, but is still too much fragmented. Development of a centre for continuing education, and accreditation of modules, will help streamlining CPD.

4.1.1 HRH planning and management

Efforts to ensure planning skills is enabled at all levels were noted. At Council level Health Secretaries are the ones working on HRH planning. However, HRH planning is more focusing on budgeting for personnel emoluments than on “getting the right people in the right place”. At peripheral levels there is much dependency on central level to plan and distribute, rather than proactively looking for solutions locally. PPP forums at Council level do not function well, and therefore HRH needs of FBO facilities are not incorporated in the personnel needs of Councils.

At this moment, a rather static establishment (health workers per type of facility) is guiding for planning, and is behind reality, as staff needs due to construction of new facilities is not foreseen ahead, and workload of health workers is not a factor in planning. Another major shortcoming is that policy and strategy changes are only incorporated in the planning after the changes are put in operation. For example, the Direct Health Facility Funding required accounting assistants, who were not planned, and were recruited on local contracts. The new CEmONC approach with surgical procedures at health centre level, does not go hand in hand with planning of new anaesthetists, lab technicians. Now only 30% of health centres can provide CEmONC. HRH planning should be part of strategic planning, and not an administrative function.

A functional information system is indispensable for planning. Efforts to integrate HRHIS to DHIS2 are ongoing to ensure that HRH data is routinely available. But in the MTR it has been

a challenge to find information on HRH availability. There is lack of capacity in the ministry to analyse data and use them for planning.

4.1.2 Distribution of staff

The aim of HSSP IV period was that 90% of the public primary health facilities in Tanzania will have qualified staff according to minimum norms while there is a sufficient number in the country for private providers to employ staff according to accreditation standards. In at least 150 public health facilities in selected regions the private sector will contribute to HRH through PPP arrangements. The MTR found in the field visit that only 15% of facilities is staffed according to the minimum numbers and MTR consultants did not see any PPP initiative.

HSSP IV was guided by the strategic options set during the BRN lab: prioritised allocation of employment permits to regions with critical shortage, strengthened production and recruitment plan, as well as conversion of permits to recruit critical cadres which are in critical shortage. This would have made the targets which were set in 2015 achievable.

However, an employment freeze for 2015-2016 was followed by removal of ghost workers and those with fake certificates from the payroll. In 2017, permits for recruiting 3,152 workers were issued to replace those who were taken out of the systems. With these permits 334 health facilities without trained staff were served. Partners facilitated attraction of qualified staff in hard-to-reach areas, e.g. by providing settle-in package. Some partners hired and seconded staff to facilities. In the MTR interviews, 50% of councils reported that staff did not turn up after posting. Employment focused on middle level cadre in primary facilities in the regions with high burden of maternal mortality. Currently, all government health facilities have at least one trained staff, as was confirmed during the field visit of the MTR. However, some FBO facilities, dependent on seconded government staff, have been closed, because they were not considered in the posting of staff. Permit absorption increased for two consecutive years but only reached 100% in 2018.

Facility Levels	HRH Required	HRH Available	Shortage	Percent Available	Shortage Percent
Dispensary	99,060	30,625	68,435	30.92%	69.08%
Health Centre	32,487	17,954	14,533	55.27%	44.73%
District Hospital	21,600	17,443	4,157	80.75%	19.25%
Other Hospital	26,400	11,243	15,157	42.59%	57.41%
Regional Hospital	14,226	11,373	2,853	79.95%	20.05%
National, Zonal, Specialized and Referral Hospital	14,509	10,349	4,160	71.33%	28.67%
Health Training Inst.	1,321	697	624	52.76%	47.24%
Grand Total	209,603	99,684	109,919	47.60%	52.40%

Table 3 Human resources per type of facility (source MOHCDGEC 2019)

The table shows that overall there is a shortage of 52% of health staff in relation to the establishment. The shortage is more serious at the peripheral level of dispensaries and health centres, despite the approach of hiring staff for underserved areas.

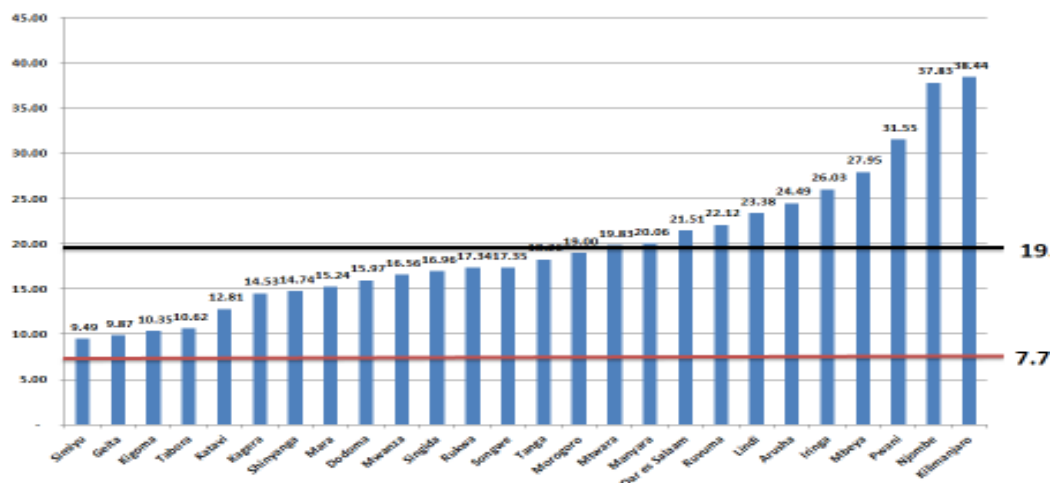


Figure 5 Human resources (all cadres) per 10,000 population per region (source analytical report MTR)

There is overall increase in HRH but the density per 10,000 population remains more or less the same over the past decade. This means that increase of health workers is just keeping up with the population growth. Figure 5 shows that huge regional disparities exist, with in the highest density region four time more staff than in the lowest density region.

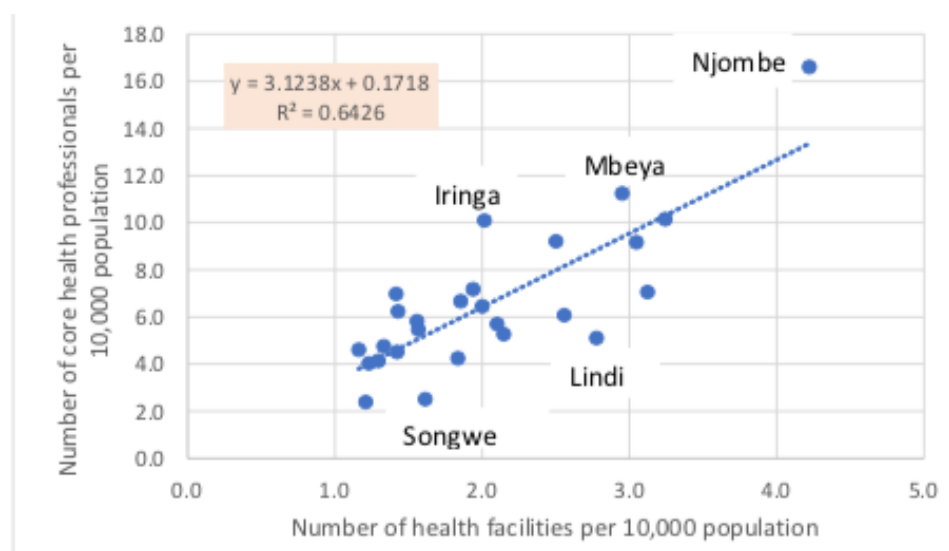


Figure 6 health workers - health facility density (source analytical report MTR)

Figure 6 shows that the differences in health staff per region cannot be explained by differences in density of health facilities per region. A linear relation would be the blue dotted line in the figure. Some regions have a very low health facility density and on top of that fewer staff than expected.

The current progress indicates that the pace at which HRH shortage is reduced is unacceptably slow. The gap is expected to widen following construction of new facilities and HRH attrition which is estimated to be 3% per year. Following the current economic situation, it is less expected that there will be a dramatic increase in hiring staff to abridge the current 52% gap.

Best practice: Councils provide short induction courses, mentoring and on-the-job training for health workers who are newly recruited, to bridge the gap between training in school and demands in practice.

4.1.3 Performance management

Performance management would be a core element of the HRH strategy, both at collective level, through Results Based Financing and performance component of Health Basket Funding, and at individual level through OPRAS. The MTR found that the OPRAS is not functioning as it was supposed to be. It has become more of a bureaucratic exercise than a management tool. New methods of performance appraisal are being experimented now.

Despite huge shortage of staff, compared to the establishment (around 52%), productivity has increased: the output of health services is considerably higher than 5 years ago as indicated in service delivery statistics in the previous section.

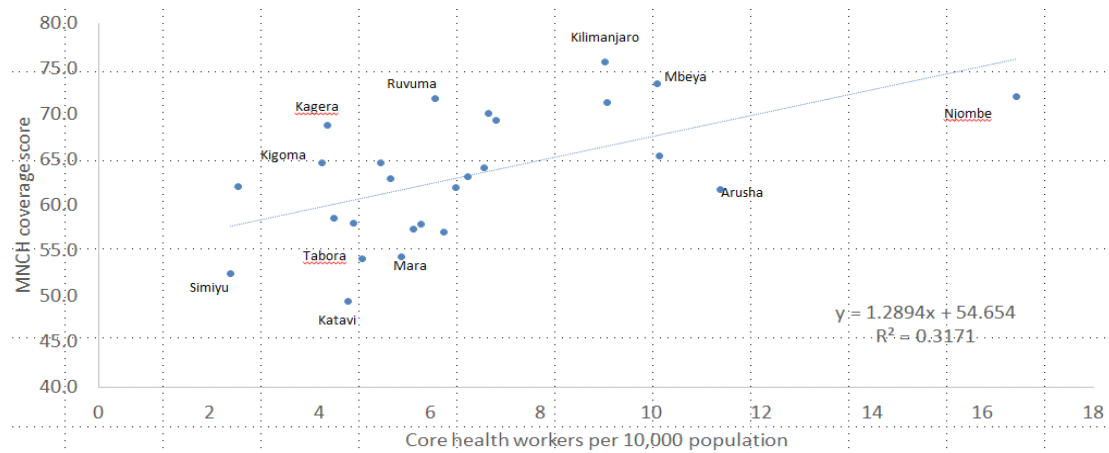


Figure 7 RMNCAH performance per health workers density (source analytical report MTR)

Figure 7 gives the composite RMNCAH indicator (see figure 4) in relation to health workers density. These findings suggest that, there is no linear relation between production of services and numbers of staff. For example, Kagera and Katavi have the same density of health workers, but the performance indicator of Kagera is one and a half time that of Katavi. Of course, other inputs play an important role in productivity, like availability of medicines, road infrastructure, population density, NGOs supporting health services.

The analysis shows that simplistic calculations of establishment are outdated. Productivity in the health sector overall has increased considerably. Regional differences are huge and require further analysis. Performance management is very important as way forward for management of HRH, but is extremely context sensitive.

Recently a Workload Indicators of Staffing Need (WISN) was conducted to inform HRH planning based on work load indicators. Final data are not yet available. A previous study by SIKIKA (2018) following a similar WISN methodology showed huge variations between Councils and even within Councils. In the majority of health facilities the workload is high. There are challenges in redistributing staff based on workload analysis. Transfer of health workers within and between Councils is difficult and expensive.

At the same time, retention is an important issue. Most Councils indicate that they provide support to newly posted staff, to settle in and to get acquainted to the job. Most of these incentive schemes are not formal, more ad-hoc. Councils sometimes provide other incentives to keep staff. Career development is an important issue for most staff. In almost all councils visited during the MTR, staff entitlements such as leave payment claims have not been paid for several years and it has been very difficult to pay on call or extra duty due to financial constraints. Performance management, whereby the employer does not stick to legal obligations, is bound to fail.

The present situation asks for a complete paradigm shift in HRH management. The plan in HSSP IV to bring in new Public Private Partnerships in HRH management in health services,

and experiment with sourcing-in or sourcing-out, with franchising, etc. never took off. The MTR made clear that sticking to a centralised top-down civil service approach is not a solution that will improve quality and equity in health.

Best practice CHMT conducts quarterly meeting with in-charges of facilities and gives out prizes for best-performing health facilities, including prizes for facilities that have improved much since last quarter.

4.1.4 Information and research

As mentioned above, the information systems for HRH are not functioning and not analysed properly. Nevertheless, there is a wealth of information that can be used for better planning and management. There are still considerable efficiency gains to be made. In a sector where labour constitutes the highest percentage of expenditure, information technology can be used better to raise cost-effectiveness.

The MTR team identified dozens of recent scientific publications with regard to HRH in Tanzania. Often these publications concern knowledge, attitudes and practices in relation to specific topics like RMNCAH or HIV. These scientific publications have a remarkably low impact on HRH management and development in the country. Lessons are not drawn to improve quality of HRH. This is a missed opportunity.

4.1.5 HRH development

Pre-service training

While 10 years ago the production of newly trained staff was the major issues, at this moment it is the other way around. Production is progressing well exceeding the absorption capacity. This achievement is attributed to government support to training institutions, both public and private, focusing attention on the production of middle level cadre.

Since 2015-2018, more than 10,000 middle level cadres were produced and only about 1,500 were recruited by government institutions. Probably, not all excess trained staff was absorbed by the private sector. Unemployed workers are sometimes volunteering; others have turned to other sectors for employment.

While output from training institutions is increasing, there are doubts about the quality of the training programmes. It has been noted in the MTR that many programmes use old curriculum systems. For example, out of existing 19 programmes only 4 programmes have been approved and their curricula are validated, 8 programmes have outdated curricula and 7 programmes don't have proper curricula to support competency-based training.

The MTR found that many health workers, also newly trained ones, do not have the necessary competencies, e.g. for certain medical procedures, that are common in practice. Thus, increased production of cadres whose training is outdated, is somehow a lost investment. The MTR noted that RHMTs hardly maintain contacts with training schools, while they could give feedback on training needs from the field.

Training institutions under MOHCDGEC are constrained in almost all aspects. This MTR noted a huge difference between the status of infrastructure in public and private training institutions. The private institutions were found to have good structures and ensured that the minimum standard requirements are met. This is done to ensure they get registered and continue in business. The situation was found different in some government institutions where students leave in dilapidated dormitories with poor water supply and have ill-equipped skill labs. Availability of teaching staff is another big challenge. It was noted that the shortage of teaching staff is 62% and 68% for support staff.

The ministry is considering drastic reorganisation of the training institutions and professionalise curriculum development and support to training institutions. More clustering of institutions could create better teaching environment. At the same time, it is important that hospitals can create an environment conducive for training, and that resources are allocated to those institutions of learning, to help developing a new generation of health workers.

Continuing Professional Development (CPD)

There are many different initiatives for CPD, often linked to disease control programmes or RMNCAH programmes. Many of those CPD activities take place in collaboration with partners. 58% of staff interviewed during the MTR field visit indicated to have participated in some type of CPD in the last year. However, lack of coordination and lack of overview make it difficult to reach all staff. The MTR found that the quality control and follow-up of CPD is limited. Some health workers still do not know how to implement what was learned, or do not have the equipment needed to practice it. Some CPD activities are not integrated in QI strategies, and are stand-alone activities. There is limited effectiveness and efficiency in this approach. Further, through partners support, CHMTs and RHMTs reported to have been trained in leadership and management.

Mentoring and on-the-job training of young professionals is coming up as a method to get staff that is better prepared for the job, especially because pre-service training is not adequate at the moment. Training programmes are under development for mentors.

Professional councils raise importance of CPD in licensing of the professionals. The Nursing Council is proactively promoting accredited CPD, that counts for re-registration as professional. That would on the one hand improve quality control and on the other hand would ensure that all health workers are reached. CPD should also be linked to career development, (para)medical professions are dynamic due to many innovations.

MOHCDGEC has opened a centre for distance learning in Morogoro, offering e-learning modules. But next to the programmes offered through this channel, there are also training modules offered by programmes and NGOs. There is no good overview, and no quality control on distance learning, so accreditation would be an improvement.

Best practice:

Some Councils provide high frequency, low dose refresher courses, linked to supportive supervision or mentoring. This approach keeps reminding health workers of standard operational procedures, without taking them away from work.

4.1.6 Nursing and Midwifery Services

Nursing is now a department because 60% of health staff is belongs to the nursing profession. The department has a strategic plan 2016 – 2021. It aims at improving quality of nursing through improvement of training, continuing professional development. It aims at improving (ethical) standards and adherence to those standards. There is much work done in improving training of nurses, especially during the clinical instruction period. Professional standards (also in relation to compassionate care) are developed, and training is offered. But due to limited funds, not all nurses in the periphery can be reached.

Career development and job satisfaction are important in retention of staff, and more work will be done for nurses in this direction, especially because OPRAS is not functioning as required.

Best practice: A module on compassionate care for nurses has been developed, to refocus them on the essence of nursing, where many CPD courses are very technical, introducing new working methods. This module was developed in response to complaints about rude behaviour of nurses and midwives, working under stress.

4.2 Essential Medicines and Health Products

Strategic Direction: Essential medicines and health products will be quality assured, right priced, efficiently delivered through MSD and complemented by decentralised procurement engaging the private sector. National stewardship and regulatory oversight will be coupled with custodianship from local government and mechanisms for public accountability. The appropriate use of medicines will improve through quality assurance measures

Key findings: There is a dramatic improvement of availability of essential (tracer) medicines leading to better treatment of patients. The improvement has been achieved through increase in funding for medicines (government, HBF, insurance schemes), better performance of MSD with among others direct delivery to health facilities, framework contracts with suppliers. The bottom-up quantification is helping to get correct quantities of medicines and supplies. The prime vendor arrangements enable local procurement of medicines from reliable sources, when medicines are out-of-stock in MSD. However, a next step is needed to make all essential medicines available, which will require considerable new investments.

Rational prescription of medicines is promoted with treatment guidelines, but needs further follow-up to reduce wastage of medicines.

Standardisation of lab equipment, with bulk procurement and maintenance contracts, is a major step forward that should be an example for other types of equipment.

Research & Development is still in an infancy, but increased production of generic medicines is a first step in that direction.

While in the MTR of HSSP III non-availability of medicines was a major issue, leading to poor performance of the health system, this MTR of HSSP IV shows a dramatic improvement. According to the HMIS there is a 95% availability of 10 tracer medicines in health facilities. Applying the new standard of 30 tracer medicines, the MTR found 75% availability of those medicines in health facilities. Although stockouts still occur, improvement of availability of medicines belongs to one of the key successes of HSSP IV.

Increasing the budget for medicines and related medical supplies from 31 TSH billion during FY 2015/2016 to 270 billion TSH during FY 2017/2018 is a positive indicator that the Government prioritises health commodities and that a huge portion of the budget is channelled to ensuring health commodity availability. However, budget realisation is still lower than the budget committed. Likewise, 73% of the funds from the Global Fund in the current grant are allocated to procurement and distribution of health commodities (Global Fund Audit, 2018). One third of the Health Basket Fund is earmarked for procurement of medicines. Income from NHIF and CHF is becoming more and more important as source of funding for procurement of medicines and supplies. PEPFAR and PMI also invest much of their funding in commodities and supplies.

4.2.1 Stewardship from the national level

During this Mid Term Review of the HSSP IV, there have been remarkable improvements in improving governance, ownership and accountability in relation to supply chain of health commodities.

The Logistics Management Unit has transitioned to Logistics Management Section (LMS). The management of supply chain activities is fully integrated into the government structures.

The transition has been supported with the development of LMS charter and Standard Operating Procedures. Standardised National Supply Chain Key Performance Indicators are now in place for transparent monitoring and accountability. The Health Commodities and Health Technologies Technical Working Group (HCHT TWG) has been formed and can offer a good avenue for provision of guidance and decision making for improving availability of health commodities. For better coordination of supply chain activities, a detailed roles and responsibility framework was developed and signed. The framework helps to avoid duplication of activities so as to instil efficiency and accountability.

However, while overseeing quantification and procurement of medicines and supplies is now well managed, there are still a lot of parallel structures and procedures, for disease control programmes and for different types of equipment, that hamper efficient and transparent stewardship. There is evidence that this approach is leading to inefficiencies and wastage. Further harmonisation is highly needed.

The emphasis in the past years has been on the most needed medicines. For functioning according to standards primary health care facilities need 135 types of medicines, and hospitals 312. There is still a long way to go to make those medicines available throughout.

4.2.2 Planning, Quantification, Costing, Procurement and Monitoring Supply Chain

National level

Bottom-up quantification of medicines and procurement by health facilities has been introduced during this HSSP IV period. Bottom up quantification was focused on essential medicines primarily. Recently, disease control programme commodities have been included. There are different structures set to oversee the process from health facility level to PORALG and MOHCDGEC. Overall, there is existence of National Quantification Team to oversee the whole process. Evidence-informed selection and rational use of medicines and health technologies taking place in public and private sector health facilities and the community. Product selection is based on an updated National Essential Medicine List (NEMLIT) and informs which products (type, dosage and form) need to be procured and other supply chain decisions. As a best practice, the NEMLIT is aligned with National Standard Treatment Guidelines (NSTG), and other national approved service delivery guidelines. Unfortunately, the MTR found that the NEMLIT and NSTG are only available in a minority of health facilities, although they are published electronically. This affects rational medicine prescription in practice.

MSD has become much more effective in the last years. MSD is now dealing directly with 150 manufacturers, cutting out the middlemen. It has now framework contracts with suppliers, which allowed shortening of the procurement period from nine to six months. All medicines distributed through MSD to public health facilities are checked for quality by Tanzania Medicines and Drugs Authority (that also checks imports and local produced medicines).

It has improved warehousing, and has introduced direct health facility delivery, with a big fleet of vehicles (donated by Global Fund), which has cut out all delays caused by intermediate handlers. MSD has now its own app where health facilities can check on available stocks, price list, their customer statements and order status. For the MTR it was surprising to see that programmes are not yet fully integrated in the system, e.g. vaccines distribution via CHMTs to

facilities, and stock keeping of certain medicines in CHMT stores. In the MTR most expired medicines found were those distributed through disease control programmes.

Automated systems are in place for quantification such as (quantmed, quantb and PipeLine® software), monitoring and reporting on the supply chain data. Several MIS systems report on health commodities data (e-LMIS, DHIS2, GOTHOMIS, VIMS,e9). The integration FFARs and e-LMIS permits visibility of other sources of funds which may be used for procurement of health commodities at MSD. Further refinement and interoperability of systems is needed to increase efficiency.

Facility level

As mentioned in the previous section bottom-up quantification and decentralised procurement have become the standard in Tanzania. There are still peripheral institutions that do not have access to automated systems, and that work with paper systems up to CHMT level. The decentralisation of responsibilities did not go hand-in-hand with increase of pharmaceutical personnel. There is a critical shortage of pharmacy assistants and pharmacy technicians. The responsibilities of management of pharmaceuticals are now mostly with clinical staff, that has no time and no specific knowledge with regard to procurement, storage and dispensing. Here is room for improvement by increasing pharmaceutical staff.

In strengthening health commodity systems, the IMPACT approach (Information Mobilised For Performance Analysis And Continuous Transformation) was introduced in 2018 in Tanzania mainland that has empowered RHMTs and CHMTs in using supply chain data for decision making. The teams have been very instrumental in building capacities of RHMT, CHMT and consequently health facility staff in improving health commodity availability and will play a big role in bottom up quantification. Establishment of national level and health facility level IMPACT teams is underway.

During this MTR, 97.8% of the visited health facilities pointed out that members of the HFGCs are involved in approving the procurement of health commodities such as medicines. The visited councils have functional Council Health Service Boards (CHSBs) that play a critical role in looking for various sources of funds for health commodities procurement.

The Prime Vendor Model has been rolled out in all 26 regions in Tanzania mainland to complement Medical Stores Department (MSD) in provision of health commodities in case of unavailability at MSD and upon MSD approval.

Despite all the mentioned initiatives to improve health commodities availability, especially at the service delivery points, there is a challenge of delays in timely availability of these commodities, attributed to a number of factors including late release of out of stock notification by MSD. The latter was mentioned by many facilities during the MTR field visit. On the other hand, sometimes late orders fulfilment, or late delivery by Prime Vendors could be causing problems as well.

Finally, the topic of rational medicines use and tackling antimicrobial resistance is an area which needs further development , and collaboration among various stakeholders including MOHCDGEC including disease control programmes, PO-RALG ,TMDA, Implementing partners, health care personnel, to mention a few.

Best practice: *Five Regional Referral Hospitals have formularies, adding value because they provide information on medicines approved for prescription, indicate medicines that are interchangeable and contraindicated, hence provide proper guidance to prescribers. More importantly, they provide key information on composition, description, selection, prescribing, dispensing and administration of medicines.*

Best practice: in some Councils there are WhatsApp groups where responsible staff in pharmacies exchange information on medicines and supplies; facilities help each other out when one has a temporary out-of-stock problem, to guarantee continuity of care.

4.2.3 Research and Production

In 2018 MOHCDGEC in consultation with other ministries has developed guidelines for Investment opportunities for the production of local pharmaceuticals. This aligns very well to the 5-year Development Plan 2016/17-2020/21 that aims at nurturing industrialisation for economic transformation and human development.

There are 13 licensed pharmaceutical manufacturing industries; four of which have acquired Good Manufacturing Practice status. Now 15% of medicines used in Tanzania mainland has been produced domestically. Increased domestic capacity is envisioned to result in reduced lead times and inventories by both MSD and private pharmaceutical wholesalers. For bulk pharmaceutical products such as large parenteral and syrups, transport costs will be reduced. During this MTR period, it has been uncovered that there are new eight Pharmaceutical Industries in various stages of construction. The local pharmaceutical industry focuses mainly on generic medicines production and does not prioritise R&D. There is some donor support for R&D, but for becoming a player on the international market, industries must do much more. Also, pharmacy departments in universities should do more in R&D and work with local industries.

Price regulations

As per NPAP (2015-2020), there is no regulation of pharmaceutical prices in the private sector. Medicines tend to be unaffordable for most but especially for the rural poor. Medicines price surveys using standardised WHO methodologies indicate great variability in prices for the same medicine across locations, as well as consistent differences according to facility ownership. However, health commodities price control guidelines are available in draft form under PSU.

4.3 Infrastructure, Transport and Equipment

Strategic Direction: The health and social welfare sector will engage in balanced and sustainable infrastructure development with emphasis on geographic prioritisation, quality and maintenance, to provide equitable access to quality services for the population. The LGAs will link infrastructure development to HRHSW planning and equipping of health facilities. Newly constructed and refurbished facilities will meet standards for future accreditation.

Key findings: There has been a considerable increase in construction and rehabilitation of facilities, leading to an increase in per capita density of facilities. Still more facilities are under construction. However, the construction does not go hand in hand staff placement, and not with allocation of medicines and financial resources. Without providing the complete package, new health facilities cannot function properly, and contribute little to service improvement. There is still considerable inequity of distribution of facilities over the country. There is no clear correlation between density of health infrastructure and performance of health services. This asks for more needs-based planning, instead of standards for number of facilities in every ward or Council.

Next to buildings, equipment, water and sanitation, and transport are areas of concern, where health facilities are limited in performing essential services.

4.3.1 Infrastructure

Following the MMAM targets all 12,545 villages should have a dispensary, for all 4,220 wards should have a health centre and for each council to have a hospital. By 2018, 53% of villages had dispensaries (38% public and 15% private or faith-based organization), and 16% of wards had health centres (12% public and 4% private/FBO). There were 70 Councils with hospitals out of 184 councils (38%). Between 2015 and 2018, 304 health centres were rehabilitated (or constructed). In addition, the construction of 67 district hospitals started in January 2019. According to the DHIS there were 11,251 health facilities, which translates into 2.1 facilities per 10,000 population for the mainland. The majority of these facilities were dispensaries (61%) (Table 2). One in six facilities was private-for-profit (17.4%) and about 1 in 11 were owned by a faith-based organization (8.9%).

	Number	Percent	Density per 100,000
Hospitals	295	2.6	0.6
Health centres	796	7.1	1.5
Dispensaries	6,874	61.1	13.1
FBO	1,002	8.9	1.9
Private	1,961	17.4	3.7
Other	323	2.9	0.6
Mainland	11,251	100.0	21.4
Population 2018	52,619,314		

Table 4 Number, percentage distribution and density per 100,000 population, 2018 (source MTR analytical report)

There were however marked regional differences in the distribution of health facilities with considerably higher densities in southern/eastern regions than in northern/eastern regions (Figure 7.7). Njombe region had by far the highest facility density (4.2 facilities per 10,000 population), including the highest density of hospitals as well as health centres. There were four other regions with densities exceeding 3.0 facilities per 10,000 population: Iringa, Pwani, Kilimanjaro and Arusha (all in the range of 3.0-3.2 facilities per 10,000). The five regions with the lowest densities were Geita, Simiyu, Kigoma, Kagera and Tabora (1.2-1.3).

Changing disease patterns, more need for privacy and more (small surgery) services at primary health care level, ask for a critical review of the design of facilities.

4.3.2 Maintenance of equipment

MSD has placed big orders for purchase of laboratory equipment, one for hospital equipment and one for health centre equipment, in combination with procurement of consumables and maintenance contracts for all new equipment in primary health care facilities and hospitals. This is a major step forward. Standardisation will reduce wastage of consumables, and will improve continuity of use of the equipment, as breakdowns will be solved much quicker. It is important to draw lessons from the lab equipment programme, and if successful adopt a similar approach in purchase and maintenance of imaging equipment, theatre equipment, dental equipment, etc.

4.3.3 Transport and Ambulance Services

The MTR field visit found that 80% of hospitals (including RRHs) and 80% of the health centres has an ambulance. Only 20% of hospitals and 33% of health centres has another utility vehicle

which means that in many places ambulances are not always available for patient transport. Even if maternal health care is exempted, patients often have to buy the fuel for the ambulance in case of referral. Referral was expressed as one of the major issues in community interviews concerning RMNCAH.

4.4 Monitoring and Evaluation Systems in Health Sector

Strategic Direction: *M&E Systems will be focusing on data-for-decision making, utilising web-based data collection and analysis, linking information systems, providing stakeholders access to data. Under the BRN there will be quarterly feedback on performance to service providers and managers for immediate action.*

Key findings: *HMIS has improved a lot in the last years, to a level that it can now be considered as reliable, and can be used for analysis and decision-making. Other statistics like causes of death in health facilities, are less advanced. Vital statistics are still not in place in Tanzania.*

Automation is slowly progressing, but has not yet reached primary health facility level. There are still many parallel systems, often automated, and health workers complain about extra workload. Attempts to rationalise and streamline health information systems have not been effective so far. Demands from funding agencies are a constraint in rationalisation. Next to HMIS there are other systems, like notifiable diseases surveillance, sentinel surveillance, demographic surveys, which are important for understanding epidemiological trends. Some of those are not optimal, which can for example hamper disease outbreak control.

The culture of using data for decision-making is still very weak. Most strategic plans have abundant indicators, but managers generally are not making follow-ups. For HSSP IV similar experiences were found. The analytical report of the MTR is the first comprehensive overview of health sector performance, since 2015.

4.4.1 HMIS

According to the analytic report, the quality of the reported data has generally improved at all levels. Completeness of reporting for seven forms (family planning, antenatal care, delivery care, postnatal care, child, OPD and IPD) increased to 98% by 2018. Very few regions or councils have reporting rates below 90%. Also, the annual verification of reported data in the context of the Health Basket Fund and RBF showed good correspondence between facility registers and DHIS. The data quality has reached a stage, where HMIS can be used for evidence-based planning, as well as for accounting for activities. The use of scorecards at local and national levels increased rapidly, made possible by DHIS2. Further work is needed to improve their accuracy and utility for health action. There is also a need to continue automation down to the health facility level, which will reduce errors and enables analysis at grassroot level.

However, registration of morbidity and cause of death in health facilities is still quite poor, not least because diagnostic competencies of health staff are limited. Maternal mortality trends in health facilities cannot be monitored, because of inconsistent reporting by facilities which may also be related with fear of sanctions. Maternal (and perinatal) death surveillance and response urgently needs to tackle this.

HSSP IV provided guidance for the improvement of the HMIS by trimming down the data collection tools (registers) through prioritisation of data elements and expanding the use of electronic tools, improving the quality of data, age aggregate in routine data and coordination for collaborative/joint assessment of facilities. Contrary to the intentions, the MTR found that there has been further proliferation and fragmentation of information systems. There are now

dozens of partially overlapping information systems initiated by MOHCGGEC, PO-RALG, disease control programmes, MSD, etc. It has reached a level, where health workers complained in interviews during the MTR visits, that these information systems are increasing their workload. Introduction of automation in data collection in the health sector is technology-driven: “information that can be collected, should be collected”. It has created more fragmentation than integration and simplification. It has added more administrative duties for health workers instead of streamlining work processes. Automated information systems can be seen as one of the major issues to be solved in the health sector in the coming time.

Best practice: Quarterly meetings organised by CHMT that involve facilities where each coordinator presents the performance pertaining to their respective portfolios. Score cards display the performance and alert health facilities to improve in areas that have been poorly scored

4.4.2 Other Data Systems

Several data systems have been developed since implementation of HSSP IV 2015-2019. The review by CBC (2018) have shown that there are about 169 data systems of which 149 (82) capture specifically health data or issues and 29 (18%) capture issues or data beyond health. Some of these systems are programme or project based; some are tied to disease control programmes, or government systems of PO-RALG or MOHCDGEC.

Data systems cover nearly all building blocks of the health system: service delivery, medicines and supplies (quantification, supply chain monitoring), human resources (planning, deployment), finances (budgeting and accounting), infrastructure, health facility and council health planning. Each of these systems has valuable elements which are important for management, e.g. planning for CCHP, accounting for DHFF, procurement of medicines by MSD, surveillance of epidemics control. But much could be gained if the systems would be more integrated and geared to needs of health staff.

GoTHoMIS should be mentioned here separately, as new – locally developed – system for capturing electronic medical records. Around 500 health facilities are using the system now, sometimes only in wards or OPDs and more experiences are gained with the system. Improvements are made constantly. Other modules can be attached to the system, like medicines stock management, billing. Further expansion needs careful guided implementation, given experiences in other countries, where too big and to expanded systems tend to crash.

Surveys remain the most important source of information for population and community data, like the Tanzania Demographic Health Survey (TDHS), HIV/AIDS and Malaria Indicator Survey, Population and Housing Census. The recent reports have shown that- HIV/AIDS and Malaria Indicator Survey have been split. Malaria indicators have been integrated into Tanzania Demographic and Health Surveys. The TDHS 2015/16 was of high quality and provides baseline data for many HSSP IV indicators. A regular high-quality survey system, with at least a DHS once every 5 years, is the backbone of trend analysis of the population’s health. Preparations for the next DHS are in full swing.

The sample registration system run by Ifakara Health Institute (SAVVY) was very successful in producing vital statistics for this national sample of 23 districts, but unfortunately was stopped. It will be important to re-establish a sample registration system, which can help the strengthening of the civil registration and vital statistics system. In the end vital registration is needed for sustainable population information.

Integrated disease surveillance is in place, support by an eDRS. Though the system is still improving, data obtained are not yet reliable, partly caused by instable software. Only 70% of CHMT checked the data provided by facilities, in the MTR field visits. Further strengthening is in preparation, but a ministerial level better harmonisation is needed between departments.

HSSP IV aimed at introducing community health information systems. Most of the existing data systems are health facility focused and do not adequately capture community level data (e.g., data on births and deaths that take place outside health facilities), leading to incomplete data on maternal and infant mortality and burden of disease. This situation is contributed by lack of standardised tool and guideline for collection of community level data.

4.4.3 Operational Research

Research institutes in Tanzania, like National Institute for Medical Research (NIMR) and Ifakara Health Institute (IHI) a thriving with extensive research programmes, activities in centres and satellite institutions. Also in universities there is medical and health research taking place. Relations with ministries are good. Research Institutes like NIMR and IHI produce policy briefs. However, the MTR could not find evidence that research has changed policy decisions and that there is regular interaction between departments, programmes and researchers. This MTR collected via database searches dozens of scientific articles concerning the health system in Tanzania, that are covering all areas of service delivery and support systems. This information is not available and not used in ministries. For example with regard to HRH, there are various publications that show that the present strategies for HRH development and management need adjustment, which was not taken on board.

Further strengthening of relations between research institutes and government, also at lower levels, can enhance evidence-based planning and innovation.

4.4.4 Use of Data and Knowledge Management

In facilities, CHMTs and RHMTs the culture of data analysis and use of data-for-decision making is slowly improving. In the MTR review 70% of dispensaries, 60% of health centres, 65% of hospitals, 95% of CHMTs and 100% of RHMTs indicated to do at least a quarterly analysis of key indicators. They also used scorecards and other tools. 90% of CHMTs apply data-driven feedback in the supervisory visits. Some respondents mentioned that information was actually used to redirect priorities, e.g. outreach, dependent on available opportunities to be flexible. The MTR did not find similar levels of use of information at national level. In fact information is quite segmented, and not shared. The efforts the MTR analytical team had to put in getting data is a proof that information does not really play a role in management at top level. Only in the annual performance reviews information is brought together.

A Tanzania National Health Data Portal was developed to share aggregated data from DHIS2. This is a good initiative, but clearly a website that need maintenance and updates. It is still incomplete as regards available information.

HSSP IV had a monitoring plan, to keep track of all indicators in the strategy. This was never implemented. Some indicators were monitored by departments or programmes, by PO-RALG or MOHCDGEC. But overall, the progress of HSSP IV was only monitored through the analytical report of the MTR.

In general, there is a tendency to formulate many indicators in strategic plans; some of which cannot even be monitored routine wise. The MTR found that 25% of indicators in One Plan II could not be analysed, because of lack of data. The tendency to increase indicators also has

an impact on grassroots health workers who have to collect data, through yet another form and other reporting system. And knowing that the information is not even analysed, or used for planning, is frustrating health workers. This should give reason for simplifying monitoring systems. Initial steps for rationalising monitoring of strategic plans have to be taken: the bottlenecks have been identified, but solutions have not yet been formulated.

Best Practice CHMT scores marks for quality of data submitted for each Health facility. Plans are that the highest scoring Health facility should be rewarded, as budgeted in 2019/20. This is expected to motivate other health facilities to submit quality data timely, and also foster the practice of data analysis and use at HF level.

Best practice CHMT: Quarterly analysis to identify top 10 diseases which help in decision making for planning and budget. What diseases to insist on during health education activities

4.5 Information and Communication Technology and e-Health

Strategic Direction: The health sector will embrace the rapid development of ICT for improving administrative processes, patient/client recording and communication. The MOHSW will stimulate the development and guide interoperability of systems.

Key findings: There are more than 180 apps, developed in parallel, sometimes with similar objectives. There are three major areas: information and administration, individual patient records, and education/capacity building. Health workers experience this mushrooming of ICT in health as a burden. There are two major platforms: Muungano Gateway and Health Information Mediator. The National Digital Health Strategy gives guidance in further development of ICT in health, especially interoperability of systems. This is very much needed. Besides investments in infrastructure and content, more attention is required for sustainability and capacity building. The wealth of data that will become available, should be used for better management of health services by integrating ICT in day-to-day management.

Like in all countries in the world, ICT will have a major impact on health service delivery in the coming decades. Information systems, starting from electronic medical records, to data aggregation on service utilisation etc., are already in place and under development. Systems for management of logistics, finances and accountability are also in place. Telemedicine, remote interprofessional consultation, sharing images, etc. will change the practice of health professionals at all levels. Apps directly to be used by citizens for health, and apps for e-learning will change the way information comes to users and professionals of health services. It is therefore of strategic importance that top level management in the health sector gets engaged in development of ICT in the health sector.

Technical infrastructure

As mentioned above, there are too many apps, with partly overlapping functions, and with poor interoperability. ICT development is still highly compartmentalised and technology driven. There are two major platforms Muungano gateway under PO-RALG and Health Information Mediator (HIM) under MOHCDGEC. Interoperability between the systems is still problematic.

Recently a National Digital Health Strategy has been formulated that outlines the strategy for further technical development. The strategy also provides guidance on a governance

structure, investment policy, etc.. A technical team with representatives from MOHCDGEC, PO-RALG, other ministries and universities is working on the implementation. There is a clear vision and strategy on further development of the technology, and the MTR can only recommend to follow this strategy.

At this moment there is quite some funding available for development of ICT, and start of new systems. However, there is insufficient funding to attract competent ICT personnel (also at lower levels in the health system), procurement and replacement of equipment, servers, etc. The development is very much dependent on external funding. In the National Digital Health Strategy the long-term sustainability needs to be strengthened.

Content of ICT in health

While the vision on technology is quite clear, the vision on content is less developed. How do ICT systems (e.g. telemedicine, interprofessional consultation) fit in the health systems? What is needed to make work in health facilities easier and improve quality (e.g. clinical guidelines, formularies)? How does it affect day-to-day practice (work procedures)? How do we need to teach our students to be prepared for an ICT supported work environment? One lesson learned from ICT development in Western countries, is that technology-driven development always ends in complicated, overloaded systems, that confuse health workers, rather than supporting them.

It is up to top level management in MOHCDGEC and PO-RALG to clearly define a strategy with regard to contents of systems, to set priorities and certainly to define boundaries. In future health apps should need licenses, and should be linked to platforms that are interoperable. For e-learning an initiative has been taken to bring everything under one umbrella. This has to be reinforced and linked to CPD programmes.

Capacity building for ICT

Use of information systems

Many health workers use ICT in day-to-day practice, but have limited ICT competencies. At this moment capacity building happens in a haphazard way. Introduction of ICT applications requires training, supportive supervision, help desk etc. each Council should have an ICT expert in function.

Using ICT for decision-making

Dashboards, scorecards, etc. visualising data are meant as instruments for better use of data for decision-making. In practice it appears to be difficult. Information is not used, or not shared. Work in the analytical report of this MTR has shown, that many managers are not conversant with data analysis and evidence-based decision making. It is a matter of training (imparting knowledge on the importance of data use and skills) and changing culture through institutionalisation of accountability mechanism.

5 Health Financing

Strategic Direction: *Cost-effective, quality health services should be available to all residents without financial barriers at the time of need. The goal of Tanzania's health financing strategy is to enable equitable access to affordable and cost-effective quality health care and financial protection in case of ill health, according to a nationally defined standard minimum benefit package.*

Key findings: *The health financing strategy is still in its infancy, and fragmented financing of health services still continues. The focus now is on the Single National Health Insurance, that hopefully will be approved before the end of this HHSP period. In the mean time more people are enrolled in existing health insurance schemes. Improved Community Health Fund is a viable option for improving accessibility to health services. Only 32% of the population has some type of health insurance.*

The resource envelope for health is growing, but only in nominal terms, not in per capita and not as percentage of government budget or GNP. The growth in financing is just enough to keep up with population growth. Budget execution is between 60% and 80%, but delays in disbursement create serious problems for Councils and facilities. External support from Development Partners is slowly diminishing, although it is difficult to get a complete picture due to off-budget support.

Financial management is improving and Direct Health Facility Financing is a major success in enabling health facilities to finance their own priorities. Health Facility Governing Committees play a role in budgeting and monitoring of expenditure, increasing community accountability.

Increasingly new mechanisms of resource mobilisation will contribute to financing health and social welfare services. The Single National Health Insurance (SNHI) will be operational countrywide in 2020. Levies and special taxes will contribute to closing the resource gap.

5.1 Health Financing Strategy 2015-2025

The health financing objectives in HSP IV were ambitious, aiming at reforming the health financing in Tanzania. It was anticipated that development and approval of a comprehensive Health Sector Financing Strategy (HFS) would serve to address the fragmented health financing architecture, the standard minimum benefit package of primary and secondary health care, the dependency on external funding, expansion and consolidation of health insurance, the role of user fees, exemptions and waivers, output-based financing, public funding to non-government providers, and other issues. To date, the HFS is still in a draft form not yet approved entirely. After the inter-ministerial steering committee discussion of the HFS, options for the consolidation of risk pools, revenue collection, purchasing, and benefits packages, a consensus emerged that the HFS should be focused on a single national health insurance (SNHI). Other proposed health financing reforms as per HFS are still waiting for crucial decisions to be made at a political level. However, the MTR team note that some of the thinking and logic of HFS are being adapted in implementation in the health sector. For example, the strategic purchasing concept has been applied through the Direct Health Facility Financing approach.

5.2 Single National Health Insurance

The fragmented health insurance architecture still exists in Tanzania. Efforts to harmonise the fragmentation through the Introduction of Mandatory Single National Health Insurance (SNHI) are progressing very slowly. The harmonisation will help maximise the size of their risk pools and increase the confidence of potential subscribers in the systems, which may encourage people to enrol. However, an Actuarial study of the proposed Single National Health Insurance Scheme in Tanzania show indicated that there is a risk that contribution income (premiums) on its own may not be sufficient to maintain the solvency of the SNHI scheme. As such, it is important to ensure critical design elements are carefully reconsidered before implementation.

A draft bill is in preparation, and has been submitted to Cabinet Secretariat. Private healthcare providers mentioned to the MTR team that they have not be consulted in any stage of the preparation. The full content of the bill was not accessible for the MTR team. The bill is covering all important issues on mandatory single national health insurance design like:

- Governance: The relationships between the health insurance institutions and those who supervise and influence them (often including legislators, government agencies, contributors, and beneficiaries);
- Revenue collection: what contributions are there to collect? What mechanisms are needed? What provisions will be made for the indigent?;
- Benefits package: what will be the minimum set of services to purchase? Will there be any distinctions (tiers)? Will there be any co-payments?

Achievements in increasing health insurance coverage

While the bill for the SNHI is under preparation, steps are made to increase enrolment in any of the following schemes: NHIF, NSSF-SHIB, CHF, TIKA, CHIF. There is a slow increase in coverage of both NHIF (from 7% to 8% of the total population for years 2015/16 and 2017/18 respectively) and CHF/iCHF (18% to 25% 2015/16 and 2017/18 respectively) and SHIB (from 10% in 2015/16 to 29% in 2016/17). On average, the total health insurance coverage 32% of the population in Tanzania.

A positive development is the introduction of improved CHF, which will replace CHF and TIKA, with a better package, better geographical coverage, and better administrative procedures, allowing it to grow into a fully-fledged health insurance scheme. To-date 16 regions out of 25 regions in Tanzania mainland have implemented iCHF, and further expansion is underway.

Low Insurance coverage implies that a larger percentage of the Tanzania population is still reliant on user fees, exemptions and out of pocket payments to finance healthcare needs. Exemptions and waivers are neither effective nor efficiency in terms of revenue collection at the facility level. It is estimated that about 70% of all patients are eligible to benefit from the exemption and waiver, seriously affecting income generation in health facilities. The exemptions and waivers are not equitable in terms of targeting the poor because of the challenges in identifying real poor in the community. Children of rich parents are exempted, while poor adults are not. Thus it is recommended to review the exemption and waiver policy to match with reality, especially in consideration of the coming Mandatory Social Health Insurance.

Best practice *Accounts assistants hired through income generated in health facilities, performed active recruitment of community members for i-CHF. They also assisted in administrative work for insurance claim, and generated much more money than their own salary.*

5.3 Minimum Benefit Package (MBP)

HSSP IV aimed to make a standard minimum benefit package of primary and secondary health care services fully accessible to all Tanzanians with a focus on the poor and vulnerable groups. The services in the MBP would be fully funded within the available resources pooled for the SNHI. The HSSP IV envisioned the formulation of MBP drawing from the existing the National Essential Health Care Intervention Package (NEHCIP-Tz -2013). However, to date, due to delay in approving the HFS, the formulation of the standard MBP has remained stalled. Hence, the NEHCIP-Tz continues to serve as the basis for the financing of service delivery at various levels in the health care delivery. This package is no longer up to date, e.g. in RMNCAH services that have been updated in One Plan II.

5.4 Financing Public Health Activities

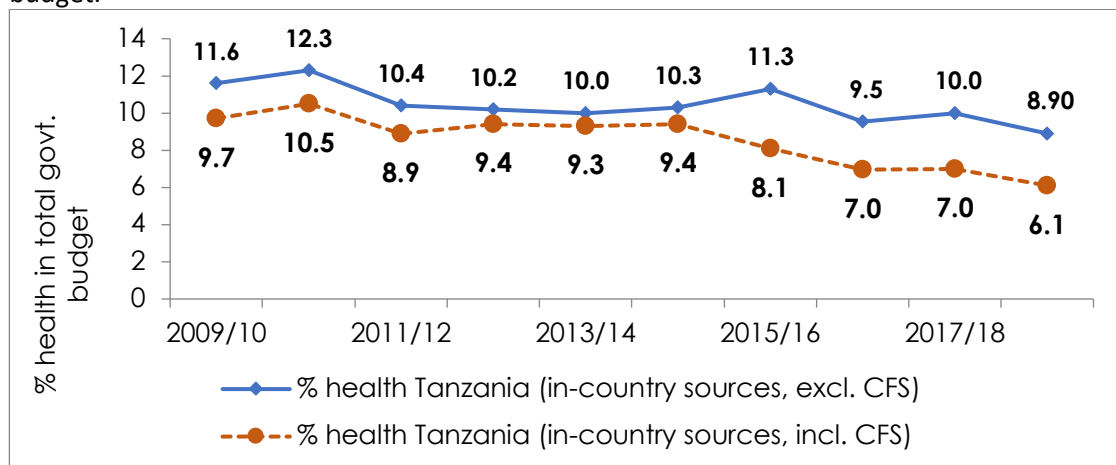
While a SNHI offers a solution for financing of curative services, reimbursing for treatment of diseases, it does not offer a financing for preventive and promotive activities, that protect health or improve health in the community. At this moment, there is a large dependency on public funding and funding from Development Partners, often through NGOs. On the long run this financing is insecure. It is important to realise that with the changing disease patterns and upcoming lifestyle related chronic NCDs, community health becomes more important. Financing strategies for prevention of NCDs need to be developed.

5.5 Resources for Health

5.5.1 Budget trends

Government budget

The Government budget for health is every year increasing in nominal value reaching 2.2 trillion TZS in 2017/2018 (including on-budget donor support). Government allocations for health are declining as a share of the total government budget if CFS is included in the calculations. If CFS is not included in calculations of the national budget, for more than a decade the health sector share is around 10 percent of the national budget and never reached the 15% Abuja commitment. In 2018/19 the health budget was below 9% of the government budget.



Source: MOFP, 2008-2017; MOFP, 2017; MOFP, 2018. Note: Values are inclusive of on-budget external support

Figure 8 Health share of the government budget

In other sectors the same picture is seen in the last years, of constant percentages of government budget for education, water, agriculture. Only the budget for roads and transport is increasing a lot due to infrastructure projects.

Per Capita Expenditure

The total health expenditure (THE) per capita has remained around US\$35 since 2008, applying the WHO standard methodology. This figure includes all sources, including the private provision of health and out-of-pocket payments. The WHO estimated health financing requirements for essential services is US\$44 per capita and US\$ 86 per capita to reach the Universal Health Coverage (UHC) target in SDGs.

Out-of-pocket spending to pay for services, pharmaceuticals, and other health care costs makes up a large share of spending—estimated at 40% of total current health spending. This is associated with barriers to access and higher prevalence of impoverishing and catastrophic health expenditures.

Composition of the health budget

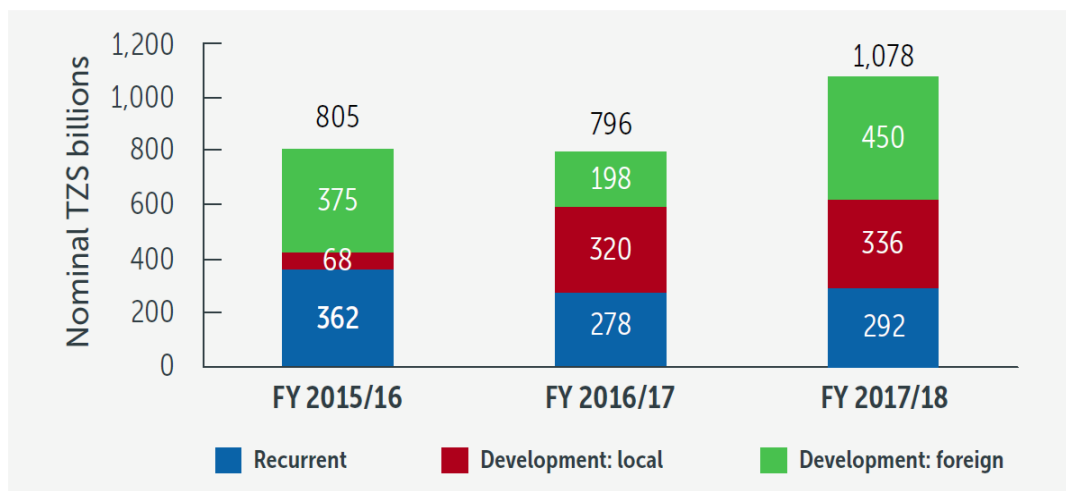
Domestic vs Foreign

The composition of health sector budget (Domestic vs Foreign) shows an increase in domestic contribution. The domestic contribution for FY 2018/19 is TZS 1736.1 billion, which is equal to 85% of the total budget. The increase in domestic financing is partly because health insurance schemes are incorporated in the calculation.

The current analysis has not factored in the off-budget support from Development Partners. This is because the required data were not made available for this exercise. Hence, this analysis presents a partial picture of the composition of the health sectors budget.

Recurrent vs Development

Budget increases to the health sector have been for development rather than recurrent spending in line with the government priorities. The increases in foreign-funded development spending are due to large on-budget transfers from the Global Fund and the Health Sector Basket Fund. Increase in local development budget is because improving the pharmaceutical supplies, as well as health service infrastructures and equipment.



Source: MOFP, 2015-2017., Lee and Tarimo (2018)

Figure 9 Compositions of Health Sector Budget (Recurrent vs Development)

Budget execution

The overall total budget execution in the health sector was 61% in 2015/16 but picked up to 77% in 2016/17 and 83% for 2017/18. The government cash budget system causes this difference between budget and actual disbursement. Personnel Expenditure funds are mostly released on time (every month). However, the releases for Other Costs is usually late and irregular, with some Councils waiting for six months between releases. FBO health facilities have to wait very long before dues are paid. Part of the Other Cost budgets are “ringfenced”, which means prioritised when disbursements are made by MoFP. The direct implications of lower budget execution are either the planned activities are not implemented on time or even not implemented at all, as often happens in the case of non-ringfenced votes.

5.5.2 Innovative financing

Result based Financing (RBF)

RBF corresponds to a paradigm shift that puts a strong focus on purchasing results rather than providing inputs to health facilities. RBF was launched in April 2015 as a pilot project in Kishapu district, Shinyanga region. The government scaled up RBF to eight regions (Shinyanga, Mwanza, Pwani, Tabora, Simiyu, Geita, Kigoma and Kagera) and as of April 30, 2018, 1,713 facilities in eight regions were implementing RBF. The programme is co-financed by the IDA, the USAID, the Global Financing Facility (GFF) and the Power of Nutrition. RBF has contributed to progress in improving the quality of care provided at various levels, as evidenced by RBF quality scores. Also, RBF start-up funds and incentive payments have significantly improved availability of supplies at the facility level and have facilitated minor infrastructure upgrade. Moreover, coverage of essential services in RBF health facilities also increased 2-5-fold.

However, RBF faces both financial and institutional sustainability issues. There have been consistent delays in payments to health facilities beyond the target of 28 days after verification since the beginning of RBF. Part of the reason for delays was insufficient cash at the MOFP to advance payment to health facilities before receiving funds from the WB. Also, through an interview, it was revealed the release of fund from the holding account at MOFP had been a challenge for the program progress. Non-release of fund from MoFP has impeded the implementation of the programme as planned.

Health Basket Fund

The Health Basket Fund (HBF) is a useful tool for coordinating sector-wide donor support. It is referred to as the most reliable source of health funding, particularly at the local government level. The funds offer the LGAs assured opportunities for implementing service delivery.

Currently, The Health Basket Fund is disbursing fund to facilities through the Direct Health Facility Financing (DHFF) approach. The DHFF has conferred autonomy to health facilities on decision making, planning and financial management. The main challenge in HBF has been late disbursement and non-release of funds from the holding account to LGAs. FBO facilities are not considered for DHFF, although they contribute to Council health services. Also, non-release of funds has resulted in fund carryover balances which may be diverted to other uses. Further details and findings are in the Mid Term Review of the Health Basket Fund performed in parallel to this HSSP IV MTR.

5.6 Financial Management System

Harmonisation DP funding

There are many different funding modalities in the health sector, e.g. Health Basket Fund, vertical programmes with separate accounts, Global Fund, GAVI, World Bank – DFF, MSD (= virtual budgets in health facilities). Some pass from MOHCDGEC to MOFP (HBF), some do not (Global Fund). This all leads to higher transaction costs, and lower transparency. Delays in disbursement are often because of complicated standing procedures in government, certainly because all variations in channelling funding and demanding accountability.

Automated systems

HSSP IV was aligned to the fourth phase of the PFM Reform Programme (2012/13 – 2016/17). It was envisioned that procedures for management, reporting and accountability of all health revenue streams, including insurances, be formulated at all levels in the health sector. Also, decentralised forms of resources mobilisation were to be accounted for properly, without transferring these funds to the central level.

To date, several achievements and challenges have been recorded regarding revenue management reforms in the health sector. The achievements include the use of ICT in revenue management through the Government e-Payment Gateway (GePG), Epicor, Facility Financing, Accounting and Reporting System (FFARS) and Web-based PlanRep in financial planning and management. The linkage of the FFARS, Epicor and PlanRep enable the user to budget through systems such as PlanRep, distribute funds through Epicor and track expenses through FFARS.

Also, the electronic system of collecting internal revenue (cost-sharing money) is applied in all district, regional, referral and zonal hospitals. The electronic revenue collection system has helped to remove loopholes for embezzlement and misuse of fund. However, the MTR team note that the electronic revenue collection system is not used at Health Centres and Dispensaries. Revenue collection at HC and Dispensaries is still manually collected. The Facility Financial Accounting and Reporting System (FFARS) enables facilities to improve revenue management, be more autonomous and accountable and strengthens public finance management (PFM).

There is a problem of availability of trained staff. Councils have temporarily hired accounts assistants to assist health facilities in managing the automated systems. Also, there is inadequate ICT infrastructure in the rural facilities (e.g. connectivity, computers and electricity) for the efficient and effective running of the electronic revenue management system.

Planning and budgeting:

HSSP IV intended to transform the planning and budgeting process from input-based to activity-based budgeting to enable results-based budget analysis at all levels. At the central level, a new Central Budget Management System (CBMS) was developed and rolled out to streamline resource allocation and expenditure. The implementation of CBMS and the Budget act (2015) have contributed to the improvement of the budgeting process. However, the PFMRP IV evaluation noted limited progress on the adoption of result-based budgeting at ministerial level. Even the Government Grant to Councils is not linked to performance, leading to challenges in performance-based budget/expenditure monitoring.

At the council level, the HBF uses the Direct Health Facility Financing (DHFF) approach, which has shifted from input-based to output-based payment. Also, the DHFF, The DHFF programme

implements the fiscal decentralisation in the health sector while fostering health services improvement by increasing resource utilisation and prioritisation decision space at the facility level. Currently, DHFF approach is applied in disbursing cost-sharing money and HBF only. Government Grant still applies the traditional fund disbursement for other charges and Development fund.

6 Governance and Management of Implementation HSSP IV

Strategic Direction: *In line with the BRN approach the health sector will strengthen Leadership, Accountability and Partnership to ensure that all involved parties can make their contributions to improving the health system.*

Governance will be inclusive, i.e. empowering communities, involving partners, being gender sensitive.

Key findings: *Governance in the health sector is in line with the overall policies and strategies in the country, and programmes, e.g. with regard to financial management, e-government, decentralisation are followed.*

HSSP IV has not served as leading strategy in the health sector; most MDAs have followed their own strategies. There was no implementation plan for HSSP IV and the monitoring plan was not followed.

At national level coordination is weak, leading to inefficiencies, duplications and gaps (like not addressing health financing or the NCD epidemic). Programmes are not yet integrated.

SWAp is at a low, often focusing on day-to-day issues, lacking a focus on strategies, and long-term development. Some TWGs are dysfunctional, and there are too many. Decentralisation is identified as issue, but not yet elaborated.

D-by-D in general is successful, e.g. with functioning DHFF and HFGCs. CCHPs are well-established. Supervision, mentoring, on-the-job training are happening but restricted by financial resources.

PPP is good in terms of information exchange, but most collaboration is not progressing; e.g. FBO institutions do not get DHFF, and very late reimbursements for costs made. Only in the pharmaceutical sector there are new initiatives.

Performance management is not functioning well, neither at facility level, nor at individual level.

Intersectoral collaboration is moving well at national and regional level to bring Health in All Policies forward, but at grassroot level there is little collaboration with other sectors. In general, the focus is very much on what the health sector needs from others than on win-win situations.

6.1 Governance in the Tanzanian Health Sector Context

Complying with national policies

Chapter 2 outlines government policies and strategies. While the vision 2025 remains the same, the National Development Plan has become more prominent, replacing MKUKUTA. Those are well-aligned and did not create any conflicts for implementation of HSSP IV. Also other relevant policies, like Decentralisation by Devolution, Public Private Partnership Policy, Tanzania Investment Policy, etc. have not changed in the past years, and do not create breaking points for implementation of health activities. Big Results Now, that was a major driving force behind formulation of HSSP IV, has been integrated in other strategies, but has left some clear positive impacts on the health sector.

The health policy is under reformulation. A first draft shown to the MTR team did not show approaches, that would lead implementation of HSSP IV in a different direction. The MMAM has expired and not been replaced by a new strategy for strengthening primary health care.

Internationally, the MDGs that were in place until the start of HSSP IV, have been replaced by the Sustainable Development Goals, of SDG 3 (health) is the most relevant one for the health sector. Some of the targets set in the SDHS may be ambitious in the African context and also in the Tanzanian context.

Important for health are the social and economic developments in the country. Tanzania knows a stable economic growth, and is gradually moving to become a middle-income country. Tanzania is slowly transforming from an agricultural society into an industrial society, with increasing urbanisation and increasing levels of education. This has an important impact on the social determinants of health.

Health in all policies

Interaction between societal developments and health is globally getting more attention. The ideal is to have a whole-of-government approach for health, which is even one step further than Health in All Policies (HiAP) approach. In Tanzania initiatives are underway to develop this approach. The MOHCDGEC initiated a high level policy meeting of thirteen Ministries whose policies have actual or potential bearing on health, to discuss health related concerns and to explore what each of the participating ministries and other stakeholders were could do to promote health given their varying portfolios. Following the high level policy (ministerial) meeting, a high level technical committee was created composed of the relevant Permanent Secretaries to continuously review how alignment of their health related interventions was being strategized, in order to create a synergies for health promotion and protection. During the interviews it was observed that health related activities or interventions have been a concern of many sectors and stakeholders now than ever before. The MOHCDGEC and PO-RALG have been mindful in inviting other sectors to harmonize their interventions, for example the One Plan II, HIV/AIDS interventions, in multi-sectoral approach to nutrition etc. On the other hand, other sectors are not always mindful to invite representatives from the MOHCDGEC and the PO-RALG when they are developing or implementing their programmes; some of which actually or potentially bear impacts on public health.

6.2 HSSP IV Strategic Plan

The Health Sector Strategic Plan is formally the umbrella strategy, that guides specific strategies in the health sector. In reality, it plays a very modest role. Specific strategic plans have all different time frames, and do not run parallel with HSSPs. In the introduction of many recent specific plans a statement is made, that the plan is aligned with HSSP IV, and reference is made to the topic that appears in HSSP IV. However, none of the specific strategic plans follows the strategic objectives or refers to relevant strategic directions of HSSP IV. Many even go against HSSP IV, e.g. announcing own information systems, instead of aligning with DHIS2. Specific strategic plans are not assessed by the Department of Policy and Planning (DPP) to see whether they fit within the overall government strategy. The MTR team could not even get (electronic) copies of most specific strategic plans from DPP, and had to search for them in departments. Most specific strategic plans cannot be found on the MOHCDGEC website. In the specific strategic plans there is no active linking to other strategies, as if each programme or department functions completely in autonomy.

The MOHCDGEC does not have an own strategy or implementation plan on how the ministry is leading implementation of HSSP IV. And, as mentioned before, the M&E plan of HSSP IV was never implemented. Given the fragmentation, and silo approach in the MOHCDGEC this is not surprising that follow-up of the HSSP IV was not a collaborative effort of the ministry.

6.3 Specific Areas for Action on Implementation Management and Governance

6.3.1 Decentralisation by Devolution

The Government is continuing implementation of its D-by-D policy. Over the past years, structures and procedures have become much more stable. There are no disputes anymore on roles and responsibilities, reporting and accounting. For example Comprehensive Council Health Plans (CCHPs) have become robust, and evidence-based.

D-by-D is now taken into a next phase whereby health facilities and communities are empowered to manage their own affairs. Health facilities have their own management boards and governing committees to ensure accountable management of the facilities. These governing authorities have representatives from communities in the neighbourhood of the facilities. The MTR found that these bodies are functioning in more than 90% of facilities, but in in RRHs. There are sometimes questions with regard to capacities of members in comparison to health facility staff, but in general they are satisfied about the functioning, as the MTR interviewers concluded.

Bottom-up planning from facility level to council level for the CCHP has become institutionalised and in many cases effective. It is through this framework that a Direct Health Facility Financing is taking place. Facilities, including health centres and dispensaries are empowered to create their own facility level strategic plans, which are (partly) directly funded through the Health Basket Fund. Council and health facility staff identified this as one of the major successes of HSSP IV: it motivates and empowers HFGCs and health staff. It really has made a difference in for example the star rating.

Training programmes to train health facility managers and the community Management and Board representatives have been conducted in several districts in regions such as Singida, Shinyanga and Kigoma. Such programmes have aimed at health systems strengthening in areas such as Management and Leadership, Planning and Budgeting, Data Quality Assessment, Integrated Logistics and Supplies Management.

6.3.2 Social Accountability

Community empowerment and accountability to representative structures was one of the aims of HSSP IV. This has been successful as regards collaboration between HFGCs or CHMBs and facilities or hospitals. However, during community interviews in the MTR people questioned how much members of the committees share information or consult with other entities like ward Development Committee or Village Health Committee. The new management arrangements have not yet resulted in a feeling of community ownership.

As discussed above, staff in health facilities is not very much engaged in community development, nutrition or WASH activities in the communities. The health sector seems to be a bit inward-looking. Especially relations with community development could be strengthened.

Community Health Workers were found in 85% of communities interviewed. They often function as extension workers for health facilities, but not as change agents to empower communities. Creating more ownership of community health programmes can motivate communities to contribute more to sustaining the nearby health facility.

A remarkable finding was that only half of the RRHs visited during the MTR had a Hospital Management Board. Accountability to community representatives at this level is not optimal.

6.3.3 Performance Management

Performance management is part of the government approach. The Performance Management System (PMS) in Tanzania is geared at improving the efficiency and effectiveness in public service delivery, consequently ensuring value for money. The specific tools for performance management include strategic and operational planning, client service charters, service delivery surveys, self-assessment programmes, performance budgets, the introduction of Open Performance Review and Appraisal System (OPRAS) and comprehensive Monitoring and Evaluation (M&E) system.

In the health sector most of these elements are implemented, as explained in previous sections. However, they are more geared towards quality improvement and effectiveness than towards efficiency or value for money. Many of the elements are implemented and monitored in different contexts, e.g. Quality Improvement, Council health management, disease control programme M&E, and are not clearly linked. Health workers too do not link the Client Charters or CCHPs to performance management.

OPRAS has become a bureaucratic exercise, that is more an administrative obligation, than a tool in career development and rewards for excellency. Alternative systems for individual performance management are being experimented.

Results Based Finance has been introduced as a way to reward performance, but the programme is not very sustainable, as explained in a previous section. The Health Basket Fund has an element of performance rewards, but due to delays in processing payments, for health workers the link with previous performance is completely invisible. They do not feel rewarded by the HBF.

Interesting is that the analytical report of this MTR found several examples of improved productivity, increased efficiency and value for money in some regions. However, these are not coming out from regular information systems, and are not used as shiny examples, where lessons can be drawn from. There is opportunity to revisit performance management, and make it clearly part of the management system.

6.3.4 Partnerships

HSSP IV knows different types of partnerships. Partnerships with Development Partners is prominent, and discussed below under SWAp. Here we address partnerships with private health service providers, suppliers, investors.

Tanzania has a long history of working with the private sector. The Faith Based Organisations (FBOs) deliver health services in rural and urban areas of the country. The Christian Social Services Commission (CSSC) coordinates all the FBO health facilities operated under the ownership of the Christian denominations in the country. The Councils contract services from FBOs through service level agreements, which lay out the services provided and remunerations. In many places the service level agreements are implemented, but hardly monitored, as no key performance indicators are agreed. There is some dissatisfaction from both sides. First of all, after the introduction of the Direct Health Facility Funding not-for-profit private providers do not receive funding anymore (which they previously received through the CHMT). This is a serious set-back for them. Secondly, with the government investment programme in health several new health centres and hospitals are built close to FBO facilities, and can create competition, and further affect the functioning of FBO institutions. Thirdly, the exemption policy is taking a heavy toll from FBO institutions. Complying means a serious loss of income, that is not sufficiently compensated by government contributions to the institutions, which are already faced with reducing support from abroad. On the other hand, councils complain that some FBOs refuse to comply with government policies, e.g. on family planning, or adolescent health. It is time to refresh thinking about conditions for collaboration with private-not-for-profit institutions. It may be time to review, and where needed, to revise

the Service Level Agreement format, and make it more relevant and actual, including commitment with regard to mutual information sharing.

In the same vein, collaboration with private-not-for-profit training institutions is not always smoothly. They complain that they are more strictly controlled by NACTE than government institutions.

Collaboration between MOHCDGEC and the Association of Private Health Facilities in Tanzania (APHFTA) is improving. More and more private facilities join the association, and provide reports to the MOHCDGEC. APHFTA distributes guidelines and instructions among the members, and runs capacity building programmes. Private providers benefit from insurance schemes, that pay for services. A SNHI will offer more opportunities to serve a wider range of clients. The future accreditation system, that applies to public and private providers, will create a level playing field where private providers may even get an upper hand in service provision. Strategic plans in the health sector turn a blind eye to this development, as if nothing will change in landscape of service providers in the coming decades.

HSSP IV envisaged various different modalities of PPP with suppliers, like caterers, contracting in private labs, even for hiring human resources. In fact, the MTR found very few examples of such collaboration. The contracting out of laboratory equipment maintenance may be the first big change in PPP in health. Through MSD PPP is established with manufacturers of medicines, which may lead to win-win in supply of medicines in the country.

PPP with investors was also promoted in HSSP IV. However, there is not much moving in this direction. There are some private insurance schemes, that only reach very few clients in the country. No other examples could be found. It seems that the health sector never actively investigated such PPP options.

6.4 SWAp Co-ordination and Management

SWAp mechanisms

Tanzania has adopted the sector wide Approach (SWAp) to enhance coordination and collaboration in a multi-sectoral and multi-stakeholder dimension in the health services development and delivery. This year is the twentieth birthday of health SWAp in Tanzania. There have been established SWAp implementation structures which are currently more active at the national level than at lower level.

The SWAp management mechanisms are clearly outlined, e.g. in the Code of Conduct, and agreed by stakeholders e.g. in documents such as the Memorandum of Understanding (MoU) or TORs. Eleven Technical Working Groups (TWGs) are in place for each of the strategic areas, feeding into the Technical Committee-SWAp (TC-SWAp) meetings and the Joint Annual Health Sector Review (JAHSR) with a technical arm and policy arm. A SWAp meeting is held twice per year; the JAHSR is the topic of one meeting. The HBF is steered by a Basket Finance Committee with representatives from government ministries and development partners. The Development Partners Group for Health (DPG-Health) serves as bilateral and multi-lateral agencies supporting the health sector a platform of dialogue among the DPs.

The MTR found a suboptimal performance of SWAp, especially where coordination and alignment concerns. Among respondents there is a feeling that no all partners are equally committed to coordination and harmonisation, and rather use the structures to discuss their own agendas and priorities. There is relatively limited follow-up on agreements made in meetings.

SWAp partners are discussing to follow the decentralisation process in Tanzania and institutionalise the SWAp implementation arrangement at sub-national level. This would be justified, as bottom-up planning and priority setting is becoming standard in the health sector. Setting top-down priorities and formulating targets centrally, as the SWAp is doing right now, does not seem to make sense anymore. However, the modalities still have to be worked out.

Decentralisation SWAp faces challenges. Partners have to identify the actual and potential partners at the Regional and the Council level. Mechanisms of coordination and exchange between the sub-national SWAps, as well as the national SWAp have to be defined. Terms of Reference need to be issued before establishing sub-national SWAps. Roles and responsibilities in SWAp between MOHCDGEC and PO-RALG need to be redefined, when operating in the periphery.

Technical Working Groups

The HSSP IV expected that the Technical Working Groups (TWGs) would operationalise and strengthen implementation of the strategy. However, the TWGs are not working as effectively as anticipated. Respondents gave various reasons. Instead of seniors, often junior GoT officials attend, who are not capable of making commitments, leaving most issues undecided. Some DPs use the TWGs as forums to discuss and endorse their own mission-agenda, thereby alienating other DPs. The movement of the MOHCDGEC from Dar-es-Salaam to Dodoma has resulted into poor attendance at the TWG meetings. Even with the existing Terms of Reference for the TWGs meetings, they still remain mainly advisory, and without authority to ensure deliverables of such meetings. Many think that the number of TWGs is too big, contributing to the silo approach. Rethinking the TWG strategy is necessary to make them functional again, whereby the decentralisation is a topic for consideration.

7 Analysis HSSP IV strategic objectives

7.1 Quality

Strategic Objective 1: The health and social services sector will achieve objectively measurable **quality improvement** of primary health care services, delivering a package of essential services in communities and health facilities.

Advancing quality improvement

In general, there has been improvement of quality of health services in Tanzania. More people have used services (especially in maternal health) and more patients have received treatment due to better availability of medicines. Unfortunately, no recent information on mortality of life expectancy are available to show impact, but indicators related to for example malaria incidence, HIV incidence, malnutrition, contraceptive use are improving.

During the HSSP IV period many initiatives in relation to quality improvement have been implemented, of which the introduction of star rating was the most prominent. In a short period of time many facilities were able to improve the star rating. Guidelines and standard operating procedures have been developed and are available in most of the health facilities. There are quality improvement teams, IMPACT teams, and data-driven supervision visits by CHMTs and RHMTs. Certification for accreditation is under development. Step by step a culture of quality improvement and quality assurance is developed and maintained.

The expansion of the infrastructure and the renovation of health facilities is certainly contributing to quality improvement, as is the procurement of standardised laboratory equipment.

ICT is assisting in the quality improvement, with relevant apps for telemedicine, interprofessional consultation, but also with clinical guidelines and management information systems. Better financial, planning and management instruments help facilities to implement activities that have directly an impact on quality of services.

Barriers

The major barriers for further improvement of quality of services are related to human resources, both in terms of quantity and in terms of quality. There is a clear shortage of health workers, even if the establishment is considered to be too static. Often, workload is unacceptably high, services cannot be provide 24/7, and health workers are not qualified for certain functions. The training programmes in training schools for many cadres are outdated and not able to provide students with the required competencies. Continuous Professional Development is often fragmented, and not quality-assured. Health workers in some cases, cannot implement the standard procedures. Indeed, productivity has increased, but some quality indicators in RMNCAH (e.g. use of partogram, neonatal reanimation) show that there are doubts whether the quality is sufficient to achieve the SDG targets. While NCDs are the new threat to health, most health workers do not know enough about these diseases, and do not provide health education in lifestyle topics.

During the MTR complaints about rude behaviour and lack of motivation of certain staffs were uttered. Dissatisfaction is not stimulating for achieving a quality-focused culture.

While availability of tracer medicines has improved, there is still a long way to go to achieve full availability of medicines for primary health care. Too often patients have to be referred to private pharmacies for treatment.

The same for infrastructure and equipment: major achievements have been recorded, but only 30% of health centres can provide CEmONC, often because of lack of theatre equipment, blood bank, anaesthetist or lab technician.

Regional differences in quality of care

What this MTR shows clearly, are the differences between regions. The figure below shows the RMNCAH performance (the combined indicators used previously) against the health inputs score (combined indicator of available HRH and infrastructure). The figure does not give linear relations between performance and inputs. Or, in other words, many more factors play a role in good or bad performance than just number of people and buildings.

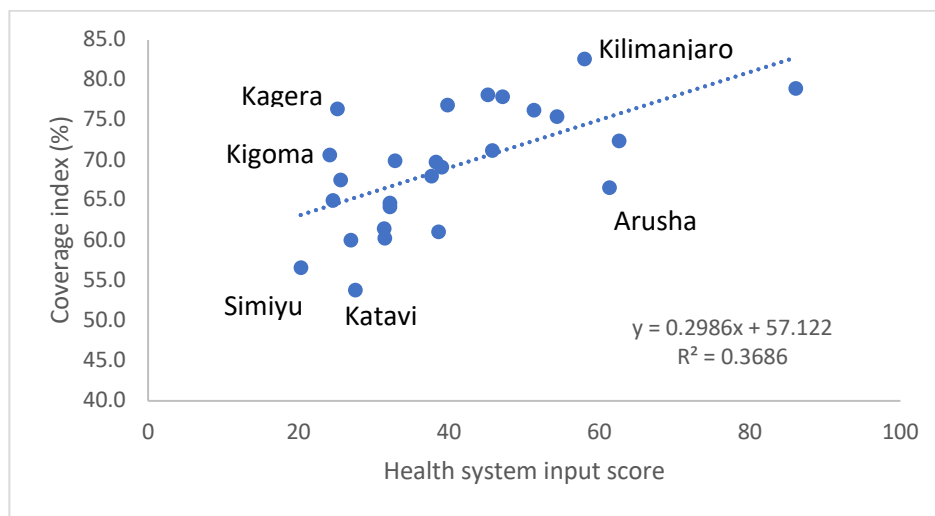


Figure 10 RMNCAH performance versus health systems inputs

Quality in general is improving, but not everywhere in the same manner. The MTR shows that for achieving quality, it is necessary to dig deeper, and look at quality of staff, leadership, collaboration with other stakeholders in the health sector, etc. This analysis has to be done per council, per region, to identify the areas where strengthening is needed. There is no “one size fits all” solution and improved information technology allows for thorough analysis.

7.2 Equity

Strategic Objective 2: The health and social welfare sector will improve **equitable access** to services in the country by focusing on geographic areas with higher disease burdens and by focusing on vulnerable groups in the population with higher risks.

Urban – Rural divide

Data on inequity

Government has made an effort to improve equitable access to health services, e.g. by construction of health facilities in underserved areas, by posting health workers to areas with facilities that did not have trained staff. The Health Basket Fund has a component of extra funding for Councils with higher rates of poverty.

Generally, the key health indicators show a small decline in inequity between rich and poor, urban and rural, but not much. The expected differences between urban and rural

populations with regard to nutrition, stunting, fertility rate, etc. were found in recent HMIS and survey data. Rural populations are generally worse off than urban populations. See the analytical report for details.

Poverty

The MTR made an effort during the field visits to interview communities in the most remote area of the most remote Council in four regions visited. The Equity Report, that is part of this set of MTR reports, gives details of the findings. In those most remote areas, the service provision is minimal, with fewer community health programmes, fewer outreach activities, less availability of medicines, less availability of laboratories, less staff. In those areas fewer NGOs are active in nutrition of WASH programmes. An important finding is that even in Councils that are performing reasonably well, there are underperforming areas. Achieving equity in health in the country may ask for very local action, and priority setting within Councils rather than zones or regions.

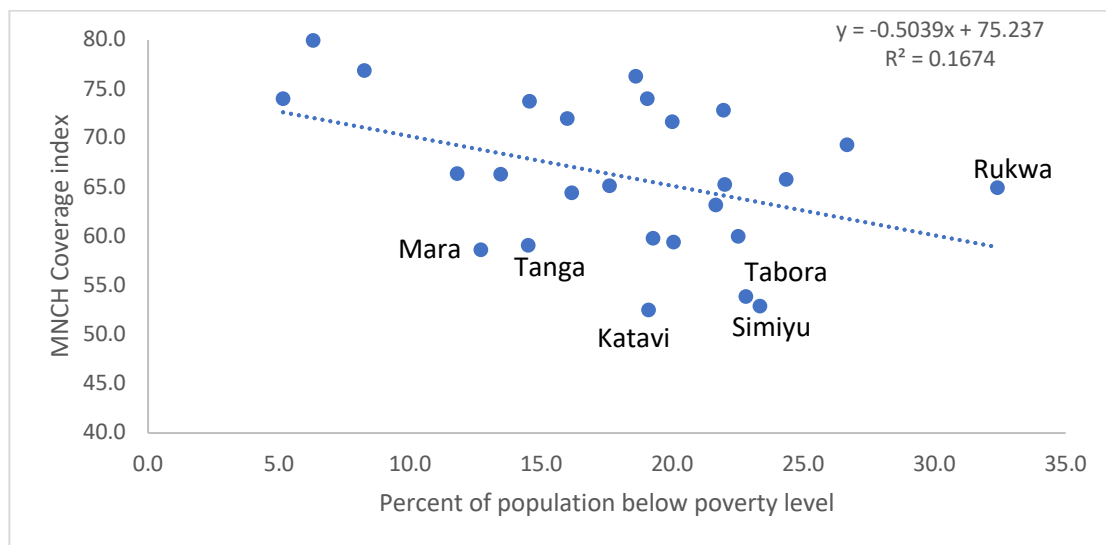


Figure 11: RMNCAH performance and poverty levels

Using the same composite indicator of RMNCAH performance related to poverty in regions, there is no direct correlation visible. Some regions with high levels of poverty are performing better than wealthier regions, e.g. Rukwa with more than twice the level of poverty in Tanga. Apparently access to health services is not a matter of financial barriers alone.

Urban access

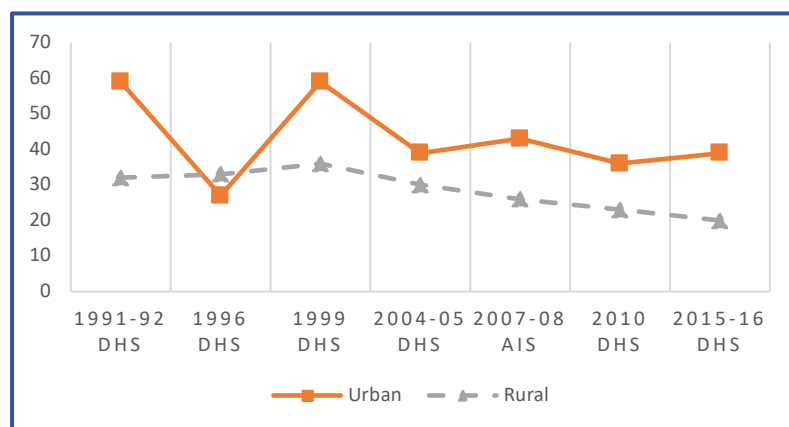


Figure 12: Trends in neonatal mortality per 1,000 live births, by urban-rural residence

Tanzania has a very unusual urban – rural mortality pattern. In most countries, urban children have better survival rates than rural children. In Tanzania mainland this is not the case. In particular, the urban neonatal mortality is elevated. Especially, Dar es Salaam region has very unfavourable survival rates.

Also the percentage of stillbirths is above average in Dar es Salaam (see figure below). The differences between the poorest and wealthiest quintiles are small. This raises questions concerning accessibility to quality maternal health services in the biggest city in the country. This needs further analysis. This statistic is warning that it cannot be taken for granted that the urban population is always better off than the rural population.

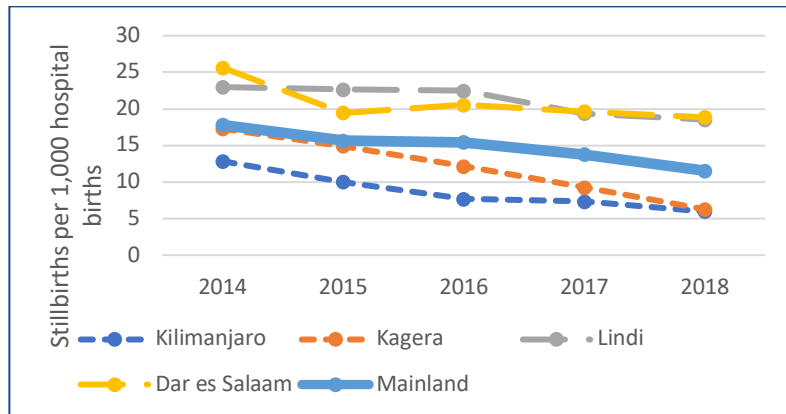


Figure 13 Stillbirths per 1,000 health facility births, mainland overall, top 2 and bottom 2 regions, DHIS

Targeting disease burden

In the BRN programme the regions Simiyu, Kigoma, Geita, Kagera Katavi, Mara, Shinyanga, and Mwanza were regions where extra resources were made available to address RMNCAH issues, as these regions were poor performers at that time. The figure below shows that on average the BRN regions have been able to reduce the gap in performance (from 12 in 2015 to 6 in 2018).

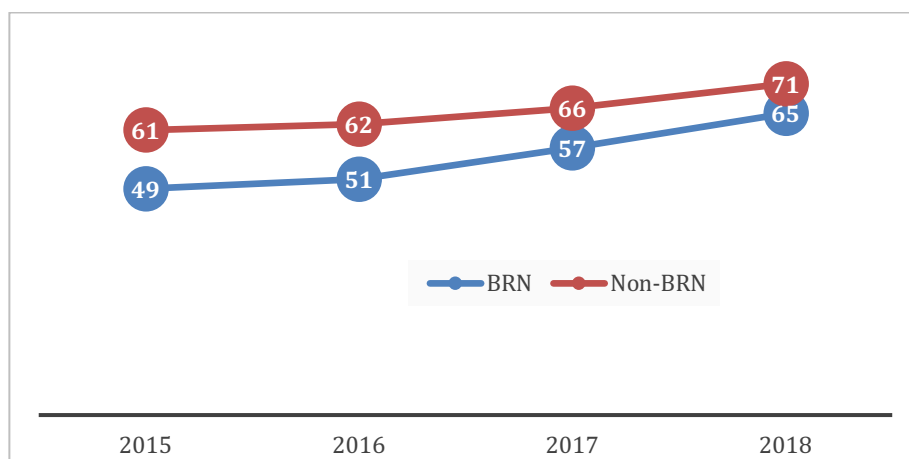


Figure 14 Average RMNCAH coverage index for BRN regions and for the other 18 regions, DHIS data

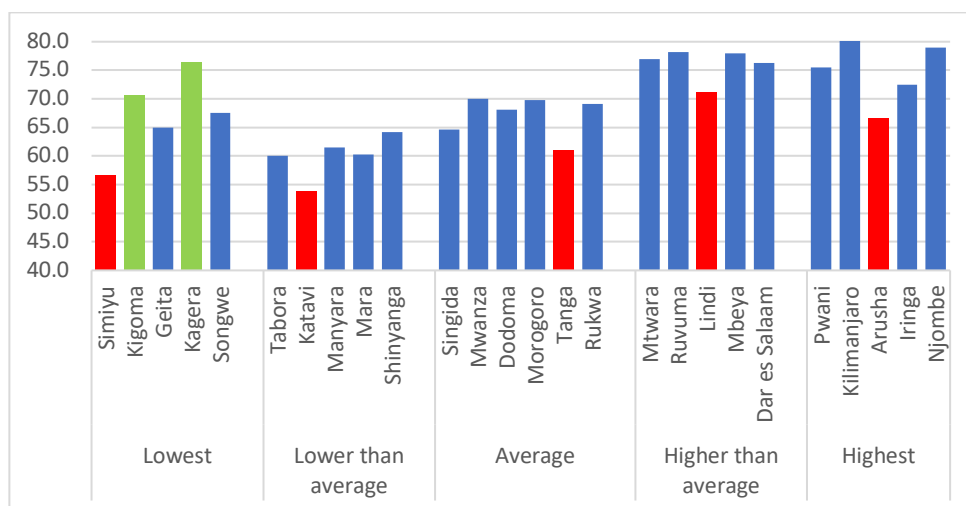


Figure 15 RMNCAH performance and categories of resources inputs (HRH, infrastructure)

The figure 17 above is a modification of figure 12 and shows that the BRN regions are still below average as regards inputs of human resources and infrastructure (except for Mwanza). Nevertheless, two regions (Kagera and Kigoma) have managed to perform above average in RMNCAH. Simuyu and Katavi have the lowest performance scores in RMNCAH, despite BNR investments. There is no easy conclusion to be drawn from the analysis whether a targeted approach like BRN was the right decision to move equity forward.

7.3 Gender

Strategic Objective 2: The health and social welfare sector will improve **equitable access** to services in the country by focusing on geographic areas with higher disease burdens and by focusing on vulnerable groups in the population with higher risks.

In this MTR a special study was done into gender and health, especially activities proposed in the HSSP IV. A desk study and field study was performed. The full report is part of set of documents of the MTR.

Gender policies

The GRAS assessment (Gender responsive assessment scale) of HSSP IV showed Gender Blind/Sensitive (score 2): the document mentions gender, but does not get concrete in proposed actions.

The strategy identifies gender equity, disadvantaged groups, women and children in promotion of sustainable health sector development; identifies equity and right to health for all Tanzanians; prioritises reproductive and maternal health, but does not elaborate gender norms, roles and relations affecting access. It does not have any gender indicators that can help guide and track progress made towards reduction of gender related bottlenecks to access and utilization of health services by women and girls.

In other policies and strategies in the health sector there are hardly guidelines and instructions available on mainstreaming gender. One Plan II is an exception, with concrete plans and indicators with regard to gender.

Gender knowledge and practices in health facilities

Knowledge on gender of most health workers is insufficient at all levels. The concept gender is sometimes used as equivalent for RMNCAH services. In some government MDAs there are Gender Focal Points. However they are not part of the establishment, and do this work next to other regular duties. They have little impact on changing knowledge levels.

In curricula in the health sector there is no knowledge transferred with regard to gender. So, newly trained staff does not have information in this area.

Most health services do not have user-friendly opening hours, which enable e.g. male participation in reproductive health. Gender needs not adequately responded to, e.g. HIV, adolescent health, GBV. The roles of males is not sufficiently addressed, esp. in reproductive health, which hampers reduction of maternal and neonatal mortality and morbidity. There are some positive examples like skipping the queue for antenatal control when men and women come together.

Gender is addressed in community development and in social protection, also part of the MOHCDGEC. There should be more collaboration between the branches of the ministry, as well with sectors of education, police, etc. to improve gender equity.

Gender knowledge and practices in communities

The MTR interview revealed that male dominance is still an issue in reproductive health. Men do not want to participate in reproductive health services, but still take decisions, e.g. with regard to family size, wives using ANC or delivery services, managing transport for referral, etc. Men leave parenting of children to their wives.

In some communities there are bylaws with regard to RMNCAH, e.g. forcing ANC attendance or delivery in health facilities. The effect of this kind of interventions is not known.

If the health sector wants to improve health, reduce maternal and neonatal mortality, the gender issues have to be addressed. A special area of concern is adolescent girls' health. Teenage pregnancies are not reducing, with impact on women's education, participation in economic activities and social life. Adolescent girls are most hit by HIV. Violence against adolescent girls is high. They need better protection and care. This requires more intersectoral collaboration initiated by the health sector.

Best practice *Health facilities have different strategies in reaching men in RMNCAH, like skipping queue in ANC when coming as couple, male waiting room near delivery room, education via community health committee*

Health Information Systems and gender

In HSSP IV few gender indicators were included, but more in One Plan II. Disaggregation of data is hardly done, even where it would be relevant, e.g. in nutrition. There are some gender specific data available concerning gender, but those are not analysed in the system.

7.4 Community Partnership

Strategic Objective 3: The health and social welfare sector will achieve active **community partnership** through intensified interactions with the population for improvement of health and social wellbeing

Community participation in management

Community partnership in management of health facilities is developing well. Health Facility Governing Committees are functioning in most facilities, though not always gender-balanced and not always with the capacities to take well-informed decisions. The HFGCs play a role in the bottom-up planning, control of medicines and budgets. The DHFF has contributed to meaningful work of HFGCs. The relations between HFGCs and LGA authorities is not always well-defined and HFGCs are more focusing on management of facilities than on health advocacy in the community. Roles of VHCs and WHCs and also that of the HFGCs are not clear. Council Health Management Boards, are mostly in place in Councils but most of these are not functional. Hospital Management Boards especially at Regional Hospital level are not all operational.

This achievement of community participation in management can be considered as a next step in D-by-D. Its success show that shifting more powers to grassroot level improves performance.

Community services and empowerment

The MTR noted improvement of community service delivery and health promotion. There is outreach in all places, and health education, e.g. in schools. In MTR interviews it was found that remote communities only mention vaccination outreach as activity. Community members interviewed explained that health knowledge and practices have not improved in most communities: traditional harmful beliefs and male dominance are still common. It raises questions how effective health promotion is. It is alarming to see use of treated bed nets is decreasing, despite much investments in promotion and education.

Implementation of community based health is still fragmented and highly depending on external partners. The development of CHWs as professionals has halted. There is still a debate whether it should be a professional or a volunteer. Where they are operational, they work as extension workers rather than change agents.

The health sector is more focused on curative approaches than addressing social determinants of health. The majority of health facilities is not seeking active collaboration with other sectors, not even with community development. The community health strategy is only at the beginning of implementation, and no impressive results can be seen.

The upcoming NCDs require paradigm shift: prevention is only possible with active community engagement, empowerment and participation. If no real community empowerment will take place, the country will not be able to stop the epidemic, and will have to spend huge budgets on treatment of chronic diseases.

7.5 Modern management and partnerships

Strategic Objective 4: The health and social welfare sector will achieve a higher rate of return on investment by applying **modern management methods and innovative partnerships**

In HSSP IV two areas are addressed under this strategic objective: governance (decentralisation, collaboration, PPP) and finance (SNHI and resource mobilisation).

Governance

As explained in the section on governance, D-by-D is progressing well, with well-established systems and procedures. The next move to further decentralisation to facility level is yielding results, with better involvement of communities in health facility management, and better performance in most areas (e.g. improvement in star rating). Automated systems assist in planning, reporting and (financial) accountability.

Despite huge shortages in human resources, productivity has increased, with more services, often of better quality. This can be attributed also to better leadership at Council and Regional level.

Collaboration between MOHCDGEC and PO-RALG is improving; there is more clarity on roles and responsibilities, and personal relations between top management have improved. However, there is still too much fragmentation. Operating in silos at national level is inefficient, affecting the operational level, with too many parallel systems in quality improvement, logistics, reporting. There is no clear leadership for implementation of HSSP IV, giving room to separate – more or less autonomous – implementation of specific strategies. Development Partners fuel this approach through uncoordinated funding modalities.

The ambitious ideas at the time of formulating HSSP IV with regard to partnerships are not really taking off. SWAp has more or less become a routine, with little innovative thinking, and no longer aligned to the government policies of D-by-D and performance management. Public Private Partnerships do not show sparking new ideas, with regard to franchising, contracting in or contracting out, as suggested in HSSP IV. Only in pharmaceutical area new initiatives are seen, like the Prime Vendor system, contract lab equipment maintenance, and the local production of medical supplies. The momentum that was present at the start of HSSP IV somehow got lost. This is dangerous: D-by-D is progressing, and soon facilities will take own initiatives, leaving the central level behind; ICT development will go so quickly that new (international) networks will come to life, that play a role in service provision, human resources development. Accreditation of health facilities, and level playing field for public and private providers, assisted by new financing mechanisms, put private providers in a completely different role than they have at present.

The new health policy could give a new impetus to future-oriented strategies if indeed it captures developments of the 21st century, and is not a consolidation of present, often outdated, approaches. The health policy must guide the new initiatives for improvement of health services, not just list existing initiatives.

Health financing

At the time of formulation of HSSP IV there were huge ambitions in strengthening resource mobilisation, through a health financing strategy and through establishing the single national health insurance. Four years later, most of these ambitions have been shelved. The SNHI is still in an embryonic stage. There is a draft bill, that still needs a long way to go. Some increase in membership of health insurance schemes can be observed, and improved CHF is indeed an innovation. The ambition to have a national insurance scheme up and running by 2020 will not be achieved.

The Health Financing Strategy is ever further away than in 2015. Ideas like generating income from special taxes, from trust funds, and local charity and social investors have not been worked out.

On the side of the Development Partners there have not been moves to further coordination, integration or transparency. Apart from DHFF, no other successful new approaches have been realised. RBF has not developed as intended. Off-plan off-budget funding is still a common feature in the health sector.

The total resource envelope may be increasing in nominal terms, but not in constants value terms. Per capita spending still remains far below the minimum as set by WHO. With the quick expansion of NCDs, which require huge investments in prevention, and require long-term financing for treatment of chronic diseases, the country will face a public outcry if no appropriate response can be given.

7.6 Social determinants

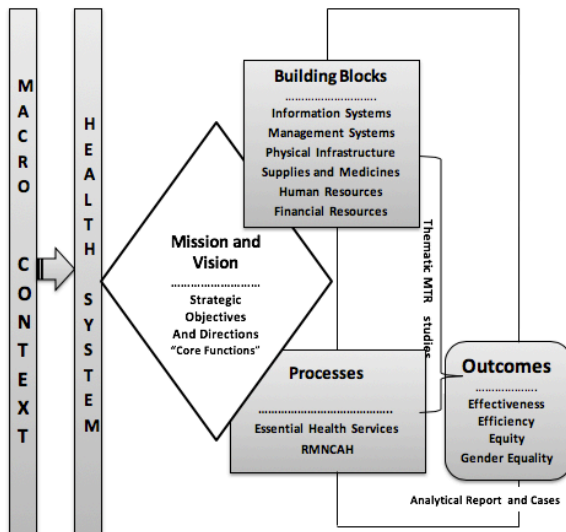
Strategic Objective 5: For improving **social determinants of health and welfare**, the health and social welfare sector will achieve close collaboration with other sectors, and advocate for inclusion of health promoting and health protecting measures in other sectors' policies and strategies.

There is improvement of intersectoral collaboration at national and regional level. Health in All Policies is becoming a more familiar term. There are committees functional at those levels, and discussions take place on how to address jointly determinants of health. However, it has not yet resulted in practical achievements. There are no Health Impact Assessments of government policies in other sectors. For example the impact of quick urbanisation and industrialisation on health is not studied, and no policies are developed to mitigate effects of pollution, traffic, etc.

At Council level there is collaboration with other sectors through the LGA system, and also with other partners in several programmes. Therefore, it is striking that the MTR found that 60% of interviewed facilities indicated not to work actively with other sectors. Apparently, the strategy that the health sector should work on social determinants of health has not trickled down to the operational level, that continues focusing on curative services. If there is no win-win situation at grassroot level for all sectors working with communities, intersectoral collaboration remains a domain of committees and conferences.

8 Conclusions in the context of Reference Frameworks

Input-process-outcome framework



Measuring HSSP IV against the input – processes – outcome framework, a positive picture emerges. Starting with the **outcomes**: quite a number of indicators that could be measured in recent years, show improvement, but not all health areas in the same way, and not all regions in the same way. This asks for more decentralised, smart targeting of interventions. With regard to equity and gender, still considerable steps have to be made to achieve the HSSP IV goals set.

Processes are running better, especially at facility and Council level. Procedures are well-established and automation can

help smoothing planning, reporting and accounting. Harmonisation of ICT systems is badly needed. Quality systems are slowly becoming integrated in work processes and start changing the culture. Community health is improving, but needs a boost empowering communities to engage in their own health issues.

With regard to the **building blocks** a mixed picture can be seen. While in infrastructure, equipment, medicines and supplies, major achievements have been noted, concerns with regard to human resources have increased in the last years. Not only numbers of health workers are insufficient, but also competencies are inadequate to cope with all (quickly changing) demands of the services. Financial resources remain insufficient, and innovative alternatives for government funding and donor funding have not yet been sufficiently developed. A SNHI has to highest priority, replacing an inadequate waiver and exemption system.

Mission and vision are clear but the strategic objectives as defined in HSSP IV, are not commonly shared among stakeholders. There are too many autonomous strategies. There is not yet a culture of achieving a common goal, and harmonisation is an urgent challenge. Here a big task remains for leadership of the involved MDAs. SWAp requires revitalisation and adaptation to developments in Tanzania.

The **socio-economic developments** in Tanzania are favourable for the health sector, with reduction of absolute poverty, improvement of infrastructure, etc. Also the policy environment of D-by-D, performance management, PPP and investment, help in strengthening service delivery. Urbanisation, industrialisation, environmental threats and global warming, on the other hand, need to be taken better into account.

Integrated people-centred health services

The WHO's *Framework on integrated people-centred health services* is a call for a fundamental shift in the way health services are funded, managed and delivered. It was adopted by the World Health Assembly in 2016. It supports countries progress towards universal health coverage by shifting away from health systems designed around *diseases* and *health institutions* towards health systems designed for *people*. This framework offers the MTR to assess developments against the background of achieving UHC in Tanzania.

The five interdependent strategies are: (1) empowering and engaging people and communities; (2) strengthening governance and accountability; (3) reorienting the model of care; (4) coordinating services within and across sectors; and (5) creating an enabling environment. Attainment of these five strategies cumulatively will help to build more effective health services; lack of progress in one area will potentially undermine progress in other areas.

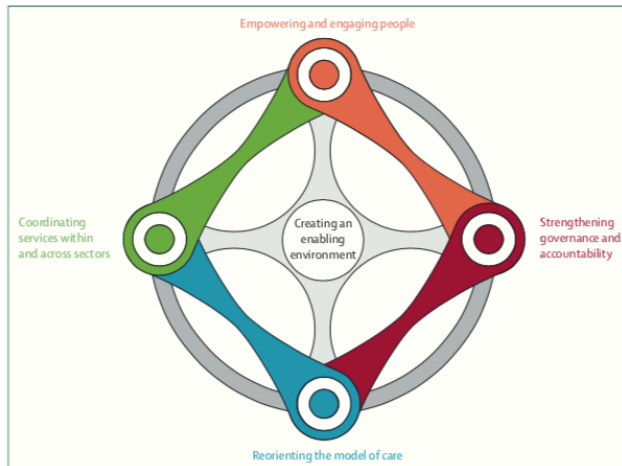


Figure 9: WHO's integrated people-centred health services framework
Data used by permission from WHO.¹⁹³

1. Community strategies aim at **empower individuals** to make effective decisions about their own health and to enable communities to become actively engaged in co-producing healthy environments. As mentioned above, in Tanzania the strategy is there, but it needs strengthening in implementation, especially with regard to empowering communities.

2. **Strengthening governance** requires a participatory approach to policy formulation, decision-making and performance evaluation at all

levels of the health system, from policy-making to the clinical intervention level. This MTR found that the necessary policies (D-by-D, performance management) are in place. There are improvements in practice, especially at lower levels, but there is a need for more harmonisation at higher levels. The SWAp approach needs an innovation bringing it up to date with developments in government.

3. **Reorienting healthcare** requires a shift from inpatient to outpatient and ambulatory care and from curative to preventive care. It requires investment in holistic and comprehensive care, including health promotion and ill-health prevention strategies that support people's health and well-being. It also respects gender and cultural preferences in the design and operation of health services. The MTR found improvement in some areas, but also noted many areas where improvement is still possible, which are needed especially in the light of upcoming NCD epidemic. The division between curative care and preventions should be removed to yield success.

4. **Coordination** across sectors encompasses intersectoral action at the community level in order to address the social determinants of health and optimize use of scarce resources, including, at times, through partnerships with the private sector. As discussed above, the MTR found more intersectoral collaboration in the health sector, with good intentions at MDA level, but especially at the grassroots level there are areas for improvement. It requires a more outward-looking culture among health workers

5. **Creating an enabling environment** entails the necessary changes in leadership and management, information systems, methods to improve quality, reorientation of the workforce, legislative frameworks, financial arrangements, and incentives. In these areas steps are being made in for example governance, ICT, TQIF. Weak areas remain human resources and financing.

9 Recommendations

The strategic directions, listed in HSSP IV in each of the sections, are still valid and worth revisiting, when looking for the way forward in implementation of HSSP IV. For many the areas, the recommendations can simply be: continue doing as planned in HSSP IV. The recommendations below show some of the priorities identified by MTR consultants. Because of the late execution of this MTR, most recommendations can only be implemented in the period of the next strategic plan from 2020 to 2025.

These recommendations are a very short summary of recommendations made by the consultants in the thematic reports. Please refer to those reports for details.

9.1 Recommendations for HSSP IV Going Forward

Governance

D-by-D

Governance at local level is developing well. Capacity building of local HFGCs and CHMBs is important to take D-by-D one step further and really empower the beneficiaries of health services. Moving to some type of community ownership (management contract) of health facilities, like in other countries, can stimulate local investments and contributions, including employment of staff.

The Terms of Reference for HFGCs, VHCs and WDCs have to be clarified and collaboration has to be strengthened to play a role in community empowerment.

National coordination

For governance at national level more integration is required, breaking silos between programmes, departments and MDAs, for better support to relevant health priorities. There should be one health sector strategic plan, accompanied by an implementation plan at national level. All specific strategic plans (especially of programmes) have to follow that national plan in timing and in priorities. The DPP should guide planning processes, and give direction to harmonisation of implementation.

MOHCGGEC needs more a matrix structure than a fork structure, and more integration between curative and preventive services, as most national programmes work across the whole spectrum of promotion, prevention, curative, and even palliative activities. More leadership is needed to focus disease control programmes on achieving goals, especially in prevention and screening where they are lagging behind.

Health in all policies

Intersectoral collaboration to address the social determinants of health should continue, but more as effort to create win-win for all sectors, than demanding that other sectors should be working for health. Focus on social determinants of health should reach the grassroot level, and change working culture in peripheral health facilities, to become more outward looking. Health impact assessments should be stimulated for investment projects.

Performance management

Performance management is in principle a powerful tool both at facility level as at individual level. It can be very instrumental in improving productivity and quality. However, it has to be accompanied by rewards and career development.

PPP

PPP is an important strategy, especially for innovative approaches in health service delivery. Increasing urbanisation requires better arrangements with private providers for access to quality services for the poor. Service Level Agreements with FBO institutions require a quality improvement to increase transparency, and guarantee financial support of services provided.

SWAp

The MTR recommends to revitalise the SWAp and make it relevant again as mechanism for joint action to strengthen the health sector. The focus at national level should be more on monitoring strategic directions than on control of implementation (e.g. reduce 99 action points in the policy commitment matrix 2019/2020).

It is important to see how SWAp can catch up with the decentralisation of government, and be a more relevant instrument for bottom-up planning and management. First of all, good Terms of Reference are needed for such decentralised structures, including the relations between regional and national level, and PO-RALG and MOHCDGEC. The action planning based on a regular analysis of performance, could be a task for regional level. Mapping of partners at regional and council levels is helping to decide who should becoming partners in decentralised SWAp. Participating partners should commit to full transparency of their own activities in the regional and council level

The Technical Working Groups need to get a new role, less compartmentalised, and more integrated in the SWAp processes, i.e. be part (preparation and follow-up) of joint planning and evaluation. The TWGs should monitor strategic directions, rather than operations.

Government should develop a health investment plan, for DPs to join in, instead of bilateral negotiations where donor preferences set the agenda. The Digital Health Investment Plan is a good example.

Health financing

Health Insurance

The MTR sees it as an absolute priority to take the SNHI forward, and follow the necessary legal procedures of adoption of the legislation. It may be wise to involve stakeholders (like private providers) in an early stage of formulation. SNHI will improve access and equity, will improve the income position of health facilities, and will make it possible to remove the inequitable exemption systems.

In the meantime, it is important to strengthen improved CHF, expand it to more regions and improve acceptability by the community. Payment of matching funds is important as incentive for health workers on promotion.

Formulation of the Basic Health Package or the national essential package of health services can start now, as innovations and new health services need to find their place in the system. It has a direct link with the list of essential medicines for health levels.

Health Financing Strategy

The Health Financing Strategy should be put back on the agenda, and innovative types of funding for health services need to be elaborated and implemented. It is highly unlikely that government will be able to increase budgets to levels needed to advance healthcare to a global standard. So new methods of financing need to be put in place, to achieve universal health coverage. The role of DP funding should find a place in the health financing strategy, whereby issues of sustainability and transaction costs should become part of the negotiations.

Financial management

Present financial management procedures should be continued and where needed, strengthened. Timely disbursement of government funding, health basket funding, result-based financing, insurance reimbursements is absolutely necessary to optimise health service delivery.

DHFF has been a major success and could be extended to other funding mechanisms, beside HBF. FBO facilities should be brought back into the financing mechanism. Part of the Other Costs budget could follow this modality.

Service delivery and RMNCAH

Quality

Government should continue strengthening QI systems, and focus on reaching the grassroot level, where adherence to standards makes the difference. Quality Improvement Teams can play a role in this. Further development of star rating system and certification for accreditation is very important as incentive for maintaining a quality focus (and needed for a viable and reliable insurance system). Self-assessment and automation of some processes may be instrumental in monitoring. It is absolutely necessary that parallel systems are brought under one umbrella and integrated.

Patient rights

The Patient Charter should be applied everywhere and should serve as basis for dialogue with the community about perceptions of quality of services.

Equity

Equity is not solved by resources allocation alone, as shown in the analysis of the MTR. It goes without saying that taking health services to remote and under-served areas is important. But even within well-served Councils there are under-served areas. Even within Dar-es-Salaam there are vulnerable groups that need special attention. A system of frequent analysis of poor performing health facilities and vulnerable populations, can help Councils to quickly address needs, where they are identified. And, as the analysis showed, health problems shift from region to region; dynamic responses are needed, led by the RHMTs.

Gender

Gender issues need an approach that affects all levels of the system, from policies and strategies, to training, equipment, organisation of services. For the next HSSP a gender implementation plan should accompany the strategic plan.

RMNCAH

RMNCAH needs a fully functioning health system, with good infrastructure, equipment, capable workforce, etc. Specific area of attention is cancer screening, both cervical cancer and breast cancer, which should reach more women than now. RMNCAH suffers most from harmful traditional beliefs and male dominance, and therefore community sensitisation is extremely important. Gender based violence needs more attention, both in capacity building of staff as in equipment and procedures. Similarly, adolescent health needs more support, especially in providing required services without shame or blame.

Community health

Health education and health promotion should be strengthened and health literacy improved. Capacity building in communities to enhance problem solving powers is important, as intersectoral endeavour to address social determinants of health. Therefore the health sector

has to work closely with the community development branch and others. Emphasis on prevention in PHC facilities is needed to address upcoming NCDs. This should also become part of training.

Emergency and Outbreak Preparedness

Present initiatives need to continue, but it is important to ensure that the systems reach grassroot level, through capacity building and through provision of resources (information materials, consumables). Strengthening the notifiable disease surveillance system is important to maintain a complete picture of possible outbreaks.

Commodities and medical supplies

Quantification and procurement requires further harmonisation of systems, to increase efficiency. Parallel systems need to be brought under one umbrella.

The present strengthening of MSD should continue, including the financing needed to expand services. Medicines needed for primary health care should be available fully, not just the tracer medicines. New diseases trends should be recognised especially upcoming NCDs.

Integration of logistics supply management systems is absolutely necessary to avoid wastage and additional workload for the operational levels.

Equipment

Standardisation of all types of equipment is the way forward for better functioning of diagnostic services as well as surgical and dental services. Maintenance contracts are helping to do preventive maintenance and keep services running.

Infrastructure and transport

Government is committed to continue expansion programme, but this should be in a smart way, using better analysis of supply and demand of health services, of existing infrastructures and road networks. Information systems now facilitate such analysis. A strategic location makes more impact than just increasing buildings in every ward.

One of the priorities is to complete projects that have started, especially CEmONC in health centres. The present percentage of 30% health centres with functioning CEmONC should increase quickly. Blood banks and theatres have to be put in place.

Concentrating on infrastructure alone makes little impact. While building, the full package of equipment, human resources, allocation for purchasing medicines, HBF, etc. should be put in place as well. Empty building do not improve health of the population.

For emergencies, road traffic accidents and CEmONC a functional referral system with ambulances is important.

Human Resources

The whole human resources system in health needs a complete overhaul. Nearly all constraints found in this MTR can be brought back to quantity and quality of human resources. HRH is the priority for the coming time.

Human resources planning

Human resources planning should become smart, needs-based, evidence-based. Figures on performance show that a differentiated approach is required to achieve optimal effects of the placement of health work force. Here also bottom-up planning should replace a static

establishment. Information systems have to be improved, to make the planning system responsive to needs.

Human resources management

The present system does not serve efficiency and effectiveness. There is no flexibility, no incentives, no rewards for performance (and no repercussion for lack of performance). New types of employment should be introduced, with different types of contracts. This requires a discussion across government institutions.

Further increase of productivity will be possible with smart personnel management. Performance management has to be strengthened, and payment of dues, career development belong to this approach as well.

Human resources development

The present training system in the health sector needs a complete overhaul. Training institutions should address the needs of tomorrow, delivering health workers with competencies that are needed in the coming decades. The training programmes need scientific support, better guidance and more qualified teachers. Infrastructure should be adequate for training. Competency focused education needs more practice, and special health facilities should offer this.

Continuing professional development should become quality assured, accredited and part of reregistration of professionals. Mentoring and on-the-job training need to be institutionalised, and be part of CPD as well.

M&E and ICT

HMIS

Interoperability and rationalisation of information systems should be put high on the agenda. The workload for health workers in peripheral health facilities should be reduced. DHIS2 has to be strengthened, be the core of information systems, and automation should be taken to grassroot level. The HMIS should become the basis for evidence-based planning and management from the lowest level to the top level in the health sector. Score cards, dashboards, etc. should help to bring a culture change. Regional differentiation of priorities based on information systems should be part of the data-for-decision-making approach, whereby data are frequently analysed and summarised for management.

Other systems

Surveillance, sentinel site monitoring, surveys etc. are important for in-depth analysis in health issues. These systems require investments, and better use of the information that can be obtained from it. Again, also in this area integration and harmonisation is important.

ICT

The issues of fragmentation and non-alignment of 180 apps in the Tanzanian health system are well-known. A clear strategy has been formulated to move integration, harmonisation and interoperability forward. This strategy should get full support from the leadership, and from DPs.

ICT should not be technology-driven, but content driven, and therefore needs more inputs from end-users. Simple systems, that respond to needs of health workers and clients are needed. GoTHoMIS could be a viable system for electronic medical records, but cannot replace management information systems and reporting and accounting systems. Apps to be used in the health sector should be licenced to ensure interoperability and user-friendliness.

Capacity building is very important, both in using the systems, as in using the data generated for management. Adequate ICT staffing at all levels is required to keep systems going.

9.2 Recommendations to Inform HSSP V

9.2.1 Timeframe for Preparation of HSSP V

The timeframe for producing HSSP V is tight; however it is feasible to produce a plan by October 2019, in time to prepare for budgets for the coming fiscal year. Preparation in a short time is possible revitalised TWGs can do a large part of the preparatory work.

- Preparation should start with the JAHSTRM meeting of October 2019. It is proposed to institute a Preparatory Committee during the meeting, which will oversee and guide the process (like the approach of the MTR). TOR and the composition of the committee should be agreed during the meeting.
- In October–November 2019 the committee should define the priority themes of HSSP IV, which reflect the strategic areas to be covered. The selected themes will be presented for approval of senior management.
- In December 2019–February 2020 TWGs and other forums will formulate detailed strategies for the priority themes of HSSP V, with the MTR and analytical report as status report in the background.
- In March 2020 a working group will formulate a realistic resources envelope for the health sector, including financial resources (based on reliable predictions) and human resources (based on available budgets)
- In April 2020 the committee will formulate indicators and M&E for HSSP V and will present the draft to stakeholders. Extensive consultations will take place at that time
- The strategic plan will be approved by government in May 2020

9.2.2 Themes for HSSP V

The themes for HSSP V are strongly related to changing context and identified opportunities and challenges in the MTR of HSP IV

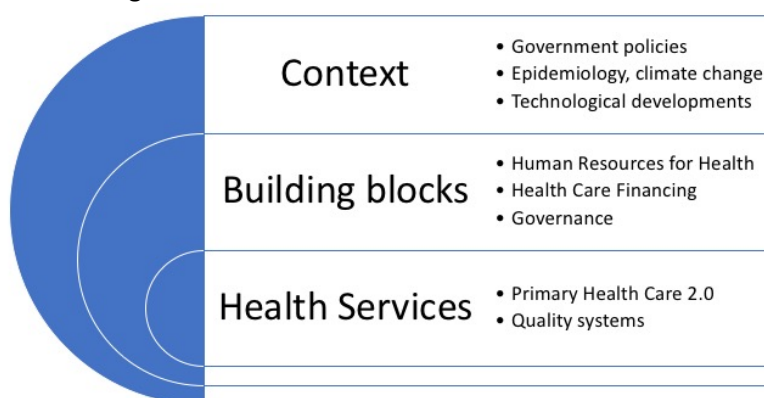


Figure 16 HSSP V themes

Context for the HSSP V

The HSSP V will be guided by policy developments in government; Vision 2025, the new National Five Years' Development Plan. Possibly a new draft Health Policy will guide the process of formulating HSSP V.

Internationally the Sustainable Development Goals and Universal Health Coverage are leading themes. The WHO framework for integrated people-centred health services is a good tool to continue working with.

Technological developments change the world, and will continue to make major impact on societies, also in Tanzania. The health sector is already seeing the change, but future developments will drastically change the day-to-day practice of health workers, managers and policy makers.

On the side of epidemiological developments, it is now high time to shift the focus to prevention of non-communicable diseases, and stop the epidemic before it explodes. This requires a paradigm shift in thinking at all levels. At the same time international health security remains an important issue, addressing new epidemics that go over the globe, and in addition antimicrobial (including antimalarial) resistance as threat.

Climate change, global warming with possibly more draught or more flooding or hurricanes due to unpredictable weather conditions require more preparedness.

Finally, urbanisation and industrialisation in Tanzania will bring major changes in living conditions of many people, both in positive and in negative terms.

Building blocks

1. Governance

D-by-D is entering in a new phase, where health facilities become the centre of planning, management and monitoring. Community ownership and engagement are the driving force to manage health services. At the same time, local analysis of performance, analysis of needs for health services, should guide evidence-based planning.

Flexibility and response to emerging problems, NCD or infectious diseases, climate change, environmental threats, should be guiding to meet emerging needs of communities. New Health Technologies (NHT) should assist in this.

The national level should be facilitating and enabling bottom-up planning and management, and harmonise support from national level through changing to a matrix structure of operation. SWAp reorientation and decentralisation is to be implemented

2. Innovative financing

Dependency on government or donor funding will reduce. New types of financing, like insurance schemes, trust funds, social investment plans, etc. will emerge to facilitate universal health coverage. Costing of the basic package of services can guide target setting for resource mobilisation.

3. Human Resources for Health

The main bottleneck in health services, i.e. quantity and quality of HRH needs to be solved in the coming five years. All elements in HRH, planning, HRH management, HRH development (pre-service and in-service) need to be addressed in a comprehensive way.

Service delivery

4. Primary Health Care 2.0

Technology will dominate the future in healthcare. Information systems, planning systems, accounting systems, are already in place. Telemedicine, interprofessional consultations,

remote imaging, decision support systems, social media utilisation and other developments have to be incorporated in the new health system (primary healthcare 2.0).

5. Integrated quality system

As demonstrated above, quality is key to increasing utilisation of health services and is a cross-cutting theme for service provision (community, PHC and hospital care) areas and support services (HRH, infrastructure, pharmaceutical supplies, M&E). The comprehensive approach towards quality is linked to accreditation systems at the facility level and the individual professional level (re-registration) and to performance management systems. Accountability is a crucial element.

Quality is closely linked to initiating health insurance schemes, as clients should have confidence in the health system to become members and pay in advance for services.

6. Existing and new priorities

Focus on continuity of care from health promotion to prevention, curative and palliative care, looking both at “unfinished business in RMNCAH” and at new emerging needs, e.g. in non-communicable diseases

Annexes

Annex 1 Reports

Reports as part of the MTR

1. Data analysis
 - Analytical report to inform the Tanzania Health Sector Strategic Plan IV 2015 – 2020
2. Thematic analysis
 - Governance
 - Health financing
 - Service delivery and infrastructure
 - RMNCAH and One Plan II full report
 - RMNCAH and One Plan II qualitative analysis
 - Community Health
 - Gender
 - Equity
 - Human Resources for Health
 - Health commodities
 - Monitoring, Evaluation and Information and Communication Technology
3. Reports of Regional Visits
 - Dar es Salaam
 - Dodoma
 - Geita
 - Katavi
 - Kigoma
 - Lindi
 - Mbeya
 - Tanga
 - Quantitative summary of 8 regions
4. Other report
 - Inception report
 - Consultations of stakeholders

Annex 2 References used

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