THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

MPANGO WA MAENDELEO WA AFYA YA MSINGI (MMAM) 2007 - 2017

PRIMARY HEALTH SERVICES DEVELOPMENT PROGRAMME (PHSDP) 2007 - 2017

May, 2007

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ACRONYMS

AIDS	Acquired Immuno – Deficiency Syndrome
ART	Anti Retroviral Therapy
BOD	Bearden of Disease
BOD	Burden of Disease
CCHP	Comprehensive Council Health Plans
CHF	Community Health Funds
CHMT	Council Health Management Teams
CHR	Child Mortality Rates
CHSB	Council Health Services Board
CMO	Chief Medical Officer
CPR	Contraceptive Prevalence Rate
DHIR	District Health Infrastructure Rehabilitation
DHS	Demographic and Health Surveys
DHS	Demographic Health Survey
DIFID	Department for International Development, UK
DOT	Direct Observed Treatment
DUHP	Dar es Salaam Urban Health Project
EHIP	Essential Health Interventions Package
EmOC	Emergency Obstetric Care
ENT	Ear, Nose and Throat
EPI	Extended Programme on Immunization
EPZ	Export Promotion Zone
ERP	Economic Recovery Programme
ESAF	Economic Structural Adjustment Facility
ESAP	Economic and Social Action Programme
FP	Family Planning
FPMS	Financial Planning and Management System
GDP	Gross Domestic Product
GNP	Gross National Product
GOT	Government of Tanzania
HBS	Household Budget Survey
HC	Health Center
HE	Health Education
HIS	Health Information System
HIV	Human Immuno deficiency Virus
HMIS	Health Management Information System
HRD	Human Resources Development
HSR	Health Sector Reforms
ICB	International Competitive Bidding
IDA	International Development Agency (World Bank)
IEC	Information Education and Communication
ILO	International Labour Organization
IMR	Infant Mortality Rates
IPPF	International Planned Parenthood Federation

IRP	Integrated Roads Programme
IRTAP	Industrial Restructuring and Trade Adjustment Programme
JAS	Joint Assistance Strategy
JRF	Joint Rehabilitation Fund
LC	Local Competition
LGA	Local Government Authority
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aides
MDG	Millennium Development Goals
MIS	Management Information System
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (NSGRP)
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (PHSDP)
MNH	Muhimbili National Hospital
MNR	Maternal Mortality Rates
MOF	Ministry of Finance
MOH & SW	Ministry of Health and Social Welfare
MoH&SW	Ministry of Health and Social Welfare
MPDE	Methodology for Project Design and Evaluation
MRTH	Muhimbili Research and Teaching Hospital
MUCHS	Muhimbili University College of Health Sciences
NACP	National AIDS Control Programme
NDP	National Drug Policy
NGO	Non Government Organization
NIMR	National Institute of Medical Research
NORAD	Norwegian Aid Agency
NSGRP	National Programme for Economic Growth and Poverty Reduction (MKUKUTA)
NTF	Nigeria Trust Fund
OBYS	Obstetric and Gynaecology
OPD	Out patients Department
PCR	Project Completion Report
PER	Public Expenditure Review
PFP	Policy Framework Paper
PHC	Primary Health Care
PHN	Public Health Nurse
PHSDP	Primary Health Services Development Programme
PIU	Project Implementation Unit
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PMTC	Prevention of Material to Child Transmission of HIV Virus
POA	Programme of Work
PPB	Patients Per Bed
RHMT	Regional Health Management Teams
RMAs	Rural Medical Aides
RPFB	Rolling Plan and Forward Budget

RS	Regional Secretariat
STI	Sexual Transmitted Infections
TA	Technical Assistance
TACAIDS	Tanzania Commission on AIDS
TAF	Technical Assistance Fund
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TRCHS	Tanzania Reproductive and Child Health Survey
TRHS	Three Region Health Study
TSH	Tanzanian Shillings

EXECUTIVE SUMMARY

PRIMARY HEALTH SERVICE DEVELOPMENT PROGRAM 2007 – 2012

1.0 BACKGROUND

Tanzania Mainland has a population of about 38,710,723. The population growth rate is 2.9. The total geographical area is 945,000 square kilometers. The national population density stands at 38 people per square kilometer, with 10,342 villages, 2,555 wards, 113 districts and 21 regions.

2.0 SITUATION ANALYSIS

The Health Sector is understaffed operating at less than the international standards

The current available primary health facilities include 4,679 dispensaries, 481 health centers and 95 district hospitals. The new Health policy directs establishment of dispensary in every village, a health center in every ward and a district hospital in each district. In view of this, the shortfall is 5,162 dispensaries, 2,074 health centers and 8 district hospitals.

The Maternal Mortality Ratio and Child Mortality rate are quite high at 578 per 100,000 live births and 68 per 1,000 live births respectively (DHS 2005).

The country has a high burden of diseases of which the major cause is malaria, HIV and AIDS, TB and Leprosy, malnutrition & micro-nutrient deficiencies, child illnesses, accidents and non communicable diseases.

3.0 INSTITUTIONAL ARRANGEMENT

The implementation of PHSDP which is expected to cost Tshs. 11.8 trillion in the period of ten years will be under the Ministry of Health and Social Welfare in close collaboration with Prime Minister's Office – Regional Administration and Local Government and, Local Government Authorities (LGAs)

The Ministry will establish a Steering Committee, which will be responsible for overall overseeing of the programme. The members of the Committee will be drawn from the MoH&SW, PMO – RALG, MoF, MPEE, CSOs and Private Sector. The Committee will be chaired by the Permanent Secretary MoHSW and Permanent Secretary from PMO-RALG will be the co-chair. The Steering Committee will have a technical committee which will be responsible for planning, coordination and monitoring of the Programme

Authorities at district level will therefore play a key role in the implementation of this programme.

4.0 PROBLEM STATEMENT

Despite the good network of primary health facilities, accessibility to health care is still inadequate due to many reasons. In some areas the accessibility to health facilities is more than 10 kilometers and where accessibility is less than 5 kilometers to health facilities the availability of health care is inequitable, with human resource operating at 32% of the required skilled workforce, insufficient medical equipment, and shortage of medicines, supplies and laboratory reagents.

The existing health care system requires major rehabilitation, maintenance, and expansion up to the village level. The referral system is compromised by lack of transport, ambulance, outreach and mobile services. The problem is further compounded by lack of communication system such as radio calls, telephone and fiber optics. Most of these rural facilities lack reliable sources of energy. The facilities depend on kerosene, charcoal and rarely on solar energy or liquid paraffin gas for service operations.

Available skills for service provision are low or lacking. As a result this translates to high mortalities to children and women in reproductive age groups who fail to access care at the time of need.

The community is unable to maximize the utilization of the available services due to lack of knowledge, customs, behaviour, cultural beliefs and inadequate capacity of the health system

The health sector is under funded, under managed with poor MIS and low level of technology.

5.0 PRIMARY HEALTH SERVICE DEVELOPMENT PROGRAMME (MMAM)

5.1 Overall Objective

The objective of the programme is to accelerate the provision of primary health care services for all by 2012.

The main areas of focus will be on strengthening the health systems, rehabilitation, human resource development, the referral system, increase health sector financing and improve the provision of medicines, equipment and supplies.

5.2 Programme Approach

This programme will be implemented by the Ministry of Health and Social Welfare in collaboration with other sectors by the existing Government

administrative set-up including PMO-RALG, RSs, LGAs and Village Committees.

5.3 Components of the Programme in Priority Order

- *Human Resource*

  Situation Analysis:

  The human resource for health in Tanzania has remained at crisis level for a long time for a number of reasons. The production of human resource against population, the available human resources has remained at 25% of the requirement until 2005 where the efforts to address new recruitment including production has made it to improve at the level of 32% requirement. However, higher attrition rate is a threat and compounded by HIV and AIDS epidemic

  Strategies

  Right sizing the workforce by increasing output for the key health providers according to the establishment levels.

  Increasing the throughput in the existing training institutions by 100%, upgrading 4 schools for enrolled nurses, production of more health tutors and upgrading the skills of existing staff by provision IT skills and acquiring new medical technology.

- *Health Systems*

  Situation Analysis:

  The health system is generally weak and is unable to handle effectively the disease burden against high population growth, the HIV and AIDS epidemic which is exerting more demand on already over stretched system. The human resource for health is at crisis proportion, the infrastructure is old and dilapidated. Technology for service delivery is old and need updating. New equipment is required to deal with changing technologies. It is against this background, where the current PHSP with strengthen this system to improve access and equity in health services.

  Generally, the quality of health services in Tanzania is still unsatisfactory despite remarkable improvements over the years since the advent of health sector reforms in the early 1990s. Majority of the Tanzanians population lives in the rural areas and 97 out of 121 Local Government Authorities of Mainland Tanzania and is classified as rural.

  Strategies

  Strengthening the health systems by rehabilitation of existing health facilities and construction of new ones and the outreach services. This includes 8,107 primary health facilities, 62 district hospitals, 128

training institutions by year 2012. Strengthening the Referral System by improving information communication system and transport.

The Programme will address the new Health Policy and the health related Millennium Development Goals by

- *Maternal Health*
  Situation Analysis:
  Maternal mortality ratio is high.

  Strategies
  Reducing Maternal Mortality ratio from 578 to 220 per 100,000 live births through provision of basic and comprehensive Obstetric Care including emergency care; provision of ambulances, motor cycles to targeted health facilities to facilitate outreach services.

- *Malaria*
  Situation Analysis:
  The number of clinical malaria cases per year is estimated to be 17 – 20 million resulting in approximately 100,000 deaths.

  Strategies
  Rolling-back Malaria by scaling up effective interventions which include environmental management to reduce mosquito breeding sites, provision of insecticides treated nets to at least 80% of the households, correct diagnosis and treatment of malaria infection by using Artemisinin Combined Therapy and introduction of indoor residual spraying with DDT.

- *HIV and AIDS*
  Situation Analysis:
  Since the outbreak of the first case of HIV and AIDS the prevalence rate has been fluctuating above 12% in 1990s. With interventions the prevalence rate has decreased in all age groups in less than 7% to date

  Scaling up of HIV and AIDS prevention, care and treatment interventions to reduce prevalence by 50% from the current rate of 7%, and provide 600,000 AIDS patients on ART.

- *TB and Leprosy*
  Situation Analysis:
  Tuberculosis continues to be among the major public health problems in the country accounting for 7% of the burden of disease in the country up from 5% in 1999. Majority of TB cases are

young adults aged 15-45 years, the same age group affected by HIV/AIDS.

Strategies

To reduce by 50% prevalence and deaths associated with tuberculosis using DOTS approach; enhance correct diagnosis and treatment including resistant TB. Expand appropriate treatment of leprosy based on multi drug therapy.

Health Education and Health Promotion

Health Education and Promotion is a means of increasing individual and community participation in health action. Its implementation involves Health communication/Education, Advocacy, Social or community mobilization, Information, Education and communication, mediation & Lobbying. The primary focus is on development of knowledge and skills leading to community empowerment for health improvement

5.4 Outputs

Health facilities fully manned by qualified and skilled health personnel equipped with medicines and medical supplies.

Equity and access of quality health services at all levels this will include availability of services including medicines and other supplies in the rehabilitated, upgraded and in the constructed new facilities at the village level.

Eighty percent (80%) of the deliveries taking place at health facilities assisted by at least a skilled attendant. Emergency Obstetric Care (EmOC) provided to all women who are at risk during delivery.

The health related Millennium Development Goals on child health, maternal health and HIV and AIDS, Tuberculosis and Malaria (ATM) and other Communicable Diseases will be met.

5.5 Outcomes

Equitable and accessible health services available in every village at all the time.

Health systems responsive to basic needs in line with the MDGs and more lives of women and children will be saved.

A healthy population that contributes to high productivity and improved national economy.

5.6 Time Frame

This program spans a ten-year (2007 – 2012) implementation framework.

Each year the components are subdivided into specific objectives and targets to deliver at the expected output.

The initial investment especially on the health facilities and the human resource is high with maximum expenditure on the fourth year and tapering in the fifth year. On the specific programs to address the MDGs their expenditure are constant because they are recurrent in nature except HIV and AIDS.

The HIV and AIDS costs escalate annually reaching approximately 200% of the first year expenditure during the fifth year. This is mainly due to access of ARV treatment to AIDS patients which is a life long undertaking. The unit cost per patients on ARVs daily is US$ 1.

1.0 BACKGROUND INFORMATION

1.1 Introduction

Since independence in 1961, the Government has consistently focused its development strategies on combating ignorance, diseases, and poverty. The investment in primary health services is recognised as a potential tool in fighting diseases at the same time improving the quality of lives of the majority of people. Before outlining the challenges facing the primary health services perhaps it is important to understand the general information in which primary health services are placed. The information is on country's geographical features, administrative structures, current population characteristics, socioeconomic situation, health status, organization and management of health services, and the present status of primary health care services.

1.2 Geographical Features

The United Republic of Tanzania is a union between Tanganyika and Zanzibar, which was formed in April 1964. It lies between the latitudes 1^{o}S and 12^{0}S and longitudes 30^{0} East and 40^{0} East. It is the largest country in East Africa, occupying and area of about 945,087 sq. km, and has common boarder with 8 neighboring countries: Kenya and Uganda to the North: Rwanda, Burundi and Democratic Republic of Congo to the west, Zambia, Malawi and Mozambique to the South. There are two seasons of rainfall – long rains from March to May and short rains from November to January. The vast geographical spread of the country poses great challenges to physical accessibility of health facilities, at the same time the rain seasons influences the pattern of diseases.

1.3 Administrative Structure

Tanzania Mainland is divided into 21 administrative regions and 113 districts with 135 Councils. Each district is divided into 4 – 5 divisions, which in turn are composed of 3 – 4 wards. Every 5 – 7 villages form a ward. There are a total of about 10,342 villages. Management of government activities within districts are through Local Government Authorities (LGAs). The Council is the most important administrative and implementation authority for public services. For this reason, the Ministry of Health and Social Welfare is currently working with the Prime Minister's Office Regional Administration and Local Government to strengthen the LGAs to deliver quality health services in line with established national and international standards. Local Government Authorities at district level will therefore play a key role in the implementation of this programme.

1.4 Population characteristics

The total population of Mainland Tanzania is projected to be 38,710,723 for the year 2007. The population is growing at the rate of 2.9. Total Fertility Rate (TFR) stands at 6.3 per woman indicating a slight decline as compared to 1988(6.5) population Census. However, the rate of population growth differs across the 21 regions of Mainland Tanzania. Population composition is 48.9 percent for males and 51.1 percent for females. The national population density stands at 38 people per square kilometre; however, this varies considerably from region to region. The increasing population exerts a massive pressure to primary health services since they are not stocked and equipped adequately to meet the demands of the increasing population.

1.5 Socio economic information

GPD per capita is at 360. The real GDP is estimated to grow at 5.8 per annum. The slowdown in real GDP growth rate during 2006 was attributed to acute drought, energy shortages, and hiked oil prices towards the end of 2005. Low level of GDP has direct effect to development and operations of the health services development.

Health was identified as one of the priority sectors within the first Poverty Reduction Strategy (PRS) and was expected to benefit from increases in both the absolute level of government funding, and in its share of the budget. The share was highest in the 2001/02 when it reached 11 percent. There was a drop in the health sector's share during the financial year 2002/03 and 2003/04 such that by 2003/04 the share had dropped to 9.7 percent.

However, there seems to be an increase to 10.1 percent in the FY 2004/05. This is encouraging, although it should be noted that it still falls short of the share achieved in the earlier years of the PRS. It also falls short of the 15 percent of Abuja commitment. More important, the allocation is not adequate to meet the increasing demands of primary health care functional accessibility. The programme therefore proposes to phase implementation of different activities in the context of resource constraints. This is limiting to achieving increased coverage of health services functional and geographical accessibility.

1.6 Health Status

The Burden of Disease (BOD) is high. Malaria remains to be a major cause of morbidity and mortality both in rural and urban areas. It ranks number one in inpatient and outpatient statistics. It is also a major cause of death for children age below five years and inflicts a huge burden due to anaemia, especially in pregnant women. In recent years the pattern of malaria has dramatically changed expanding into areas previously known to be malaria free. Also there has been an increase in number of cases and deaths due to

HIV/AIDS and tuberculosis. The three diseases form a major threat to the health systems in Tanzania.

Health outcome indicator shows that Life expectancy at birth for Tanzanians is on average of 51 years (2002 census) compared with 50 years (1988 census), probably attributed to effects of the HIV/AIDS. Under Five Child mortality is on declining trend form 147 per 1000 in 1999 to 112 per 1000 in 2005 and Infant mortality rate has declined from 99 per 1000 to 68 respectively. Although promising the level is unacceptable if compared to developed countries. Maternal Mortality Rate has remained high. In 1996, maternal mortality was 529 while in 2005 was 578 per 100,000 live births.

With regard to children nutritional status has greatly improved since 1999 to 2005. Stunting has decreased from 44 percent to 38 percent while wasting from 5 percent to 3 percent and underweight from 29 percent to 22 percent. With increased efforts to strengthen primary health services presented in this proposal there is more room to make improvement.

1.7 Status of Primary Health Care Services

Primary health Care services form the basement of the pyramidal structure of health care services. It is made of a number of dispensaries, health centers and District hospital at the district level. Currently the health facilities for both public and private include 4,679 dispensaries, 481 health centers and 219 hospitals distributed throughout the country. The dispensaries and health centres that are at a centre of primary health care facilities were planned to serve an average population of 10,000 and 50,000 respectively.

However, with increasing population and slow pace/stagnation of construction primary health facilities, the average population served by each dispensary and health centres is more than the planned population, overstretching the effective functioning of the current primary health care facilities. The problem is compounded with shortage of staff, inadequate medical equipment and other supplies.

The geographical accessibility of the current primary health facilities is reported to be at about 90% of people living with five kilometres. Nevertheless, there is great variation among districts. Besides, land terrain and lack of reliable transport poses a great danger to expecting mothers and very sick patients to access health services when they need them. These factors influence accessibility of primary health services.

2.0 POLICY CONTEXT

The government has developed a number of enabling policies and environment as an effort to strengthen the health services in the country.

Enabling policies are both national and international commitments like National Vision 2025, National Strategy for Growth and Reduction of Poverty (NSGRP), Millennium Development Goals and National Health Policy, Health Sector Strategic Plan, and Policy Paper on Local Government Reform.

2.1 Vision 2025

In the Tanzania Development Vision 2025 the main objective is achievement of high quality livelihood for all Tanzanians. This is expected to be attained through strategies, which will ensure realization of the following health services goals: -

(i) Access to quality primary health care for all;
(ii) Access to quality reproductive health service for all individuals of appropriate ages;
(iii) Reduction in infant and maternal mortality rates by three quarters of current levels;
(iv) Universal access to clean and safe water;
(v) Life expectancy comparable to the level attained by typical middle-income countries;
(vi) Food self sufficiency and food security;
(vii) Gender equality and empowerment of women in all health parameters;
(viii) Encourage the participation of community in the delivery of health services.

In line with Government Development Vision 2025 goals, the Ministry of Health and Social Welfare is expected to contribute towards the improvement of health status and life expectancy of the people of Tanzania. This can partly be achieved through public health interventions and primary health services.

2.2 National Strategy for Growth and Reduction of Poverty

Under the National vision 2025, the health sector has been given higher status through cluster two of the National Strategy for Growth and Poverty Reduction as a key factor in economic development; the ultimate goal being improved quality of life and social well being.

2.3 Millennium Development Goals

Comment [MSOffice1]: Put MDG detailed goals

The fact that the government has its own commitments, also it has international commitments like Millennium Development Goals. Under these commitments the government is required to reduce child mortality by two-thirds, and improve maternal health by reducing MMR by three-quarters from 1990 to 2015. Also, to combat HIV/AIDS, Malaria and other diseases by controlling them by 2015 and began to reverse the spread of HIV/AIDS.

2.4 National Health Policy

The National Health Policy aims at implementing national and international commitments. These are summarized through policy vision, mission, objectives and strategies. The Health Policy vision is to have a healthy community, which will contribute effectively to an individual development and country as a whole. The mission is to facilitate the provision of basic health services, which are proportional, equitable, quality, affordable, sustainable and gender sensitive.

2.4.1 The National Strategy for Growth and Reduction of Poverty

The health sector is challenged to meet the health related Millennium Development Goals. NSGRP places these goals within cluster II which addresses improvement of the quality of life and social well being. The Ministry of Health and Social Welfare will use a greater proportion of the health budget to target cost effective interventions such as immunization of children under 3 years of age, Reproductive and Child Health including Family Planning and control of Malaria, HIV & AIDS, TB and leprosy. These interventions are largely covered by PHSDP.

The majority of the poor and specifically the rural poor suffer from the above and other preventable conditions. The Ministry will continue to advocate for an increase in resource allocation to address cost effective interventions, while at the same time join hands with other stakeholders, the communities and development partners to reorient the services to be more responsive to the needs of the population, and specifically targeting the indigent and vulnerable groups.

2.5 Health Sector Strategic Plan

The Strategic Plan of 2007 – 2010 aims at enabling the MoHSW to critically examine and identify areas those are core to MoHSW as stipulated by its mandate, and strategically allocate the meager available resources to priority areas where most impact is realized in line with MKUKUTA and other national policy frameworks. The plan therefore is congruent to the proposal in strengthening primary health services.

2.6 The Public Service Reform

The programme aims at transforming the public service into a service that has the capacity, systems and culture for continuous improvements of services. The main issues on which the programme focuses are: Weak capacity of the public services and poor delivery of public services. In order to implement aims of the public reform, each sector is executing sectoral reforms in line with public reform. This including provision of adequate staff in government health facilities.

2.7 Health Sector Reforms

Health sector reform aims at improving the health sector in provision of quality health services for communities. Health sector reforms is a sustainable process of fundamental change in national health policy and institutional arrangement that are evidenced based. The reform has nine strategies as follows: -

- District health services;
- Secondary and tertiary level referral hospital services;
- Role of the central MOHSW;
- Human resource development;
- Central support systems;
- Health care financing;
- Public and private mix;
- Donor coordination;
- HIV/AIDS.

However, the above nine strategies have been grouped into three components; namely District health services, Secondary and tertiary health services and central support to central ministries and regions.

2.8 Local Government Reform Policy Paper

The local government reform denotes devolution of powers and establishment of a holistic local government system, to achieve a democratic and autonomous institution. Within this context primary health services are also managed and administered by Local Government authorities.

2.9 CCM Election Manifesto 2005

The Health Sector Development Program is also developed in the context of the ruling Party, the CCM Election Manifesto 2005 as follows;

- Reduction of Infant Mortality Rate from 95 to 50 per 1000 newborns by year 2010.
- Reduction of under-fives deaths from 154 to 79 per 1000 by year 2010.
- Reduction of Maternal Mortality Rate from 529 to 265 per 100,000 live births by year 2010.
- Increase coverage of births attended by skilled attendants from 50% to 80% by year 2010.
- Strengthen the HIV/AIDS prevention and control initiatives.
- Ensure all health facilities are well equipped.

3.0 THE PRIMARY HEALTH SERVICE DEVELOPMENT PROGRAMME (PHSDP)

3.1 The Programme concept and rationale

The aim of policy and government commitments is the delivery of health services to ensure fair, equitable and quality services to the community. Furthermore, the policy aims at empowering communities and involving them in health services provision. Unfortunately fair, equitable and quality services remain to be desired. This is because the burden of diseases is still very high due to communicable and non-communicable diseases. As a result, communities are still faced with many cases of mortality and morbidity.

The biggest problem is inadequate coverage of the health system to deal with the health service needs of all people in the country. This state of affair mainly is due to uneven distribution of health services to different communities. The outcome of this, in some areas people need to travel long distance or many hours before reaching the point of health services delivery. This problem is due to poor infrastructure especially in rural areas. Uneven distribution of heath services also contributes to poor quality of services as some of communities are left out of health services participation.

Since independence, the government main focus was to ensure that health services reach all the Tanzanians especially those living in rural areas. However, due to various constraints this has taken more time to accomplish. In order to ensure that health services reach all the people the government is planning to speed up the process and the focus will be on the district health services where people can easily access services. The overall objective will be to provide accessible quality health services to all Tanzanians by 2012.

3.2 Objectives of the programme

Overall objective

To accelerate provision of quality primary health care services to all by 2012.

Specific Objectives

3.2.1 Infrastructure

- To rehabilitate, upgrading and establishment of facilities at primary level to ensure equity and access of quality health care to all Tanzanians

3.2.2 Human Resource for Health

- To upgrade and establish more training institutions to ensure adequate availability of skilled Human resources for Health.
- To fast track capacity building and upgrading of allied health workers to meet the needs of the primary health facilities. This will include on the job skills development
- To ensure quality of training.
- To strengthen and maintain human resource database

3.2.3 Equipment, Pharmaceuticals & Medical Supplies

- To provide standardized medical equipment, instruments, pharmaceuticals and sundries to all primary health facilities to ensure optimal performance

3.2.4 Referral system

- To ensure the referral system is operational, and where necessary to establish teams of consultants to conduct mobile clinics and outreach to support health facilities quality health care and minimize unnecessary referrals.

3.2.5 Financial Resources allocation

- To increase financial allocation to the sector with a view to attain the Abuja Call of 15% of the annual budget.

3.3 Programme Components.

The following seven programme components will make a contribution towards the realization of the above objectives:-

- District Primary Health Care Systems
- Human Resources for Health
- Maternal Health
- HIV/AIDS
- Malaria
- Tuberculosis
- Institutional Arrangements
- Health Promotion and Education

4.0 DEVELOPMENT COMPONENTS

4.1 District Health Services

4.1.1 Situation Analysis

Generally, the quality of health services in Tanzania, despite remarkable improvements over the years since the advent of health sector reforms in the early 1990s, is still unsatisfactory. For a long time, the performance of the health sector has been negatively affected by limited resources which have led to an unsatisfactory quality of health care provision at all levels.

The reforms are aimed at enhancing the effectiveness and efficiency in the provision of health services in line with the health sector policy of ensuring accessibility to health care services by all Tanzanians.

The total population of Tanzania has almost tripled during 35 years period between 1967 and 2002, when the most recent population census was conducted. Of the total 33,461,849 Tanzanians on Mainland Tanzania, 77 percent were in rural Tanzania while 23 percent were living in urban areas. However, like in any other developing country, there is rapid urbanization with figures showing that the proportion of the population in urban areas increased from 6 percent in 1967 to 23 percent in 2002.

Most of the population Tanzanians is rural and the majority of Local Government Authorities or Councils on Mainland Tanzania (97 out of 121) is classified as rural Councils. Health services in urban Councils have tended to be relatively better to those in rural settings. This is attributed to many reasons including historical ones whereby urban areas were favoured to those in rural areas during resource allocations.

Under funding of the health sector has undermined the health infrastructure across the country. The inputs to the sector in terms of equipment supplies, transport and communication remain insufficient.

Local Councils, especially rural ones, have benefited from a redistribution of health allocations through a more equitable pro poor Resource Allocation Formula in recurrent funding for health care. Also the set up of capital investment and health infrastructure development funds are steps in the right direction, though certainly not enough to cover deficits. This is most noticeable at primary care and district hospital level, and especially in all aspects of obstetric and surgical care.

This special focus on district health services is of particular importance to Tanzania in the context of the government's policy of decentralization by devolution and the commitment to reaching the goals under *MKUKUTA* and MDGs within the overall Government Vision 2025.

4.1.2 Access to health services

Tanzania Service Provision Assessment Survey of 2006 indicated that "basic services" were available in over 75 percent of facilities. Basic services include curative care for sick children, child immunization and growth monitoring, STI, family planning and ante natal care services. Curative care for sick children and STI services are, on average, available in all facilities, whereas other services are available in approximately 8 in 10 facilities.

In terms of access to health services, there are a number of factors that affect the patients'/clients' either positively or negatively.

4.1.3 Distances to health facilities and long queues

Clients at health facilities often experience long distances and queues. The problem is largely attributed to the shortage of staff. On the other hand some facilities serve a very large population, facilities being far from settlements, limited equipment, shortage of drugs and other supplies.

In some areas there are physical barriers to an existing facility though it may be within 5 kilometers of a population center. Geographical barriers include rivers, lakes, bad roads, valleys and mountains. There are many examples of non-functioning facilities scattered in the districts this is also a barrier to access.

4.1.4 Irregular availability of drugs

The "out of stock" phenomenon of essential drugs and supplies is a main factor that discourages access" of services at health facilities.

Considerably, challenges in provision of access to health services including long distances to health facilities, inadequate and unaffordable transport systems and continuous limited quality of care

In the light of the above critical parameters that amply justify this intervention programme, the ultimate goal is inevitably the strengthening of district health services so as to make them more effective and sustainable.

Given our natural barriers, communication systems, roads and the poverty line, there is a need of putting a health care facility in each village disregarding the concept of 5,000 people to qualify for a dispensary. The services should ultimately be accessible to the whole Tanzanian population with a focus on rural areas and particularly those most at risk.

4.1.5 Essential drugs and medical supplies

Availability of medicines, medical supplies and equipment is necessary for the provision of health services. The items have a special importance because they save lives, improve health of patients, promote trust of patients to the health delivery system and enhance participation and ownership of the services. Most of deaths and causes of sufferings and disabilities can be prevented, treated or alleviated with essential medicines, medical supplies and equipment.

Provision of health services in Tanzania faces a number of challenges, most notably the inadequacy of equity in access to essential medicines and related supplies, with a consequent impact on quality of care. Availability of medicines, medical supplies and equipment in health facilities is one of

the factors that make patients to visit them for services. Some health facilities are preferred to others because of availability of medicines, medical supplies and equipment. Therefore, it is important to maintain uninterrupted supply of these items in the health facilities at all times.

Expenditure on medicines, medical supplies and equipment in Tanzania is second only to personal emolument. The expenditure represents more than a third of the health budget. Since the budget is generally limited, the country has experienced a disproportion between the needs and allocated budget for the purchase of medicines and medical supplies.

Since 1984, dispensaries and health centers have been supplied with medicines and related supplies through a push system (drug kits). Although the system is easy to operate, it is unable to address needs of health facilities due to the difference in morbidity pattern resulting into wastages and shortages of medicines and related supplies in health facilities. In order to ensure a reliable supply of medicines, equipment and medical supplies in these facilities, the MoH&SW has developed systems that would ensure provision of the items according to needs taking into consideration of budget allocation. It is envisaged that the system will be operational in all public health facilities by 2010.

The provision of health services is costly. In this regard, the Government has been adapting different ways and mechanisms of financing the health sector. These mechanisms include, among others, cost sharing schemes such as Capitalization of Hospital Pharmacies, Community Health Fund (CHF) and National Health Insurance Fund (NHIF). The Ministry of Health and Social Welfare decided to introduce cost sharing schemes as alternative financing mechanism to raise funds for complimenting government budget for provision of health services in addition, to sensitize community sense of ownership.

Household surveys conducted in different parts of the world have shown that cost of medicines and related supplies represents the major out-of-pocket of health expenditures incurred by households. Price survey of medicines conducted in Tanzania in 2004 in the public, private, and non-governmental organizations (NGO) health facilities revealed that there were significant inter-sectoral price variations whereby the prices in the NGO and private facilities were higher than those in the public sector. Valuable information was also documented on the various mark-ups and add-ons by NGO and private health facilities to the wholesalers/manufacturer's price. It was noted in this report that majority of Tanzanians are not be able to afford to pay for essential medicines and related supplies and therefore depend on services provided by public health facilities.

4.1.6 Nutrition

District and Community levels response and action for nutrition has remained weak. The weakness is a result of non- availability of accountable staff for nutrition at these levels. There are no designated nutrition focal personnel to coordinate nutrition actions at these levels. There is therefore, a need to build capacity for nutrition at district levels by recruiting or deploying health staff at these levels. The staff will provide technical support and ensure coordination among health programmes in relation to nutrition as well as to ensure linkage with other sectors.

4.1.7 Transportation

It is the Government's policy to provide district and regional transport and vehicle replacement. In the early useful life of the vehicle 5 years, the maintenance costs are very low due to light repairs. The cost escalations start from the fourth year and hence become uneconomical to operate and also a burden to the users and in most cases the users put a plan for replacement when it is at this state.

Assessing the current situation of the Primary Health Care transport fleet composition and status in the councils is that:

- A total of 132 vehicles representing 57.4% of the vehicle fleet is over the age of 5 years. These are prone to draining funds in terms of huge vehicle repair costs. Ideally according to the vehicle replacement policy, they are overdue for replacement but due to insufficient funds they have continued to be used in the system.
- The remaining 98 vehicles representing 42.6% are within the age of 5 years as recommended in the Ministry of Health and Social Welfare transport policy and therefore are in good running condition.
- Vehicles under vehicle off road (VoR) condition are 6 representing 2.6%.
- While 49 vehicles representing 21.3% of the vehicle fleet are under repairable condition but are being repaired at an exorbitant cost.
- Vehicles serviceable, which are in varying degrees of running condition, are 175 representing 76.1% of the total fleet.
- The **132 vehicles which are over the age of 5 years** need to be replaced immediately if saving on uncalled for repair costs is to be realised as well as improvement of the operational status of vehicles in the councils.
- Basically, there is one funding mechanism option used for the replacement of vehicles in the councils but also with their shortcomings

4.1.8 Vehicle Replacement Using Block Grants and Government Subventions

At present vehicle depreciation is not taken into account when calculating a vehicle's operating cost. As such no provision is being made at council level to replace a vehicle once it has passed its economic life other than making provision within the capital vote of the annual budget.

Through the MTEF, funds for vehicle replacement have usually been set aside centrally for the procurement of vehicles. The trend of allocation of vehicle replacement over the years has been as follows

S/NO	FINANCIAL YEAR	EXPENDITURE
1	2001/2002	276,000,000
2	2002/2003	1,100,000,000
3	2003/2004	1,300,000,000
4	2004/2005	1,250,000,000

As can be seen above, if funding provided annually remains at last year's figure of Tshs. 1,250,000,000, it will take 6 years to replace the current fleet of 132 vehicles that need to be replaced now! By the end of 6 years, the current 42.6% of vehicles that are less than 5 years will be waiting in the queue to be replaced as well.

Vehicle replacement is therefore rather an add-hoc process, being dependent on the approval of others and the receipt of sufficient funds in any given financial year. Original plan was to procure 45 vehicles annually for the fleet to be fit for the purpose health delivery services.

In order to have sufficient funds for vehicle replacement the Councils will require setting up depreciation/retention accounts and for councils to be disciplined in ensuring that the equivalent annual depreciation cost of running a vehicle is deposited into these accounts

The large sums involved in setting up of such accounts will also focus a council's awareness on the need to only operate sufficient vehicles to meet the operational demands of the individual departments. Adapting good transport management systems will enable councils to identify those vehicles that are superfluous to requirements which can be disposed of and the financial savings, both capital and operational, redirected into other development programmes.

4.1.9 Communication System

In order to strengthen the referral system from the dispensary to the health centre, there is a need of placing an ambulance and a mortar cycle in each health centre and, radio call system in each district.

Currently some districts have received funds to support their communication system, which is one of the inputs to strengthen the referral system.

There is inadequate transportation at health facilities and in communities in general specifically there are insufficient vehicles to provide administrative, supervisory or logistical support for the Districts. ***The situation is even worse when the transportation of the sick and injured is considered. Vehicles designated as ambulances are typically used for administrative and logistical functions.***

Key activities need to be implemented which include procurement and installation of appropriate communication equipment (radio call system) and emergency transportation means to facilities and community interventions such as outreach service, educational campaigns , establishing community emergency preparedness mechanism.

4.1.10 Health infrastructure network and medical equipment

The infrastructure part of the primary health care services network encompasses dispensaries, health centers and district hospitals. The Health Services Delivery System in Tanzania consists of a network of facilities, which assumes a pyramidal Structure starting from a Dispensary, Health Center through the District and the Regional Hospitals to the Referral Hospitals.

In principle the referral system is designed for the dispensary to refer patients to health centers and for the health centers in turn to refer patients into hospitals. Unfortunately this system is not functioning as intended. A number of factors contribute to this situation, among others, under funding, weak management arrangements, inadequate staff and difficulties in transport and communication.

The 2006 Health Policy recognize the importance of accessible and sustainable Primary Health Care services for all citizens through provision of dispensary in every village, a health center in every ward and, a hospital in every district. However, with the given country size, population and, the geographical barriers, the health services are not easily accessible to all.

The private sector is contributing approximately 40 percent in the provision of health service delivery. The distribution of health facilities on Mainland Tanzania by ownership shows that the government owns 64.2 percent of all facilities, voluntary agencies 17.7 percent, parastatal, and private institutions has 3.0 percent and 15.0 percent, of the facilities respectively.

The distribution by ownership shows how different stakeholders supplement government efforts in providing quality health services in the country. The proportion of government health facilities in good state of repair can also be used as proxy indicator for good quality services.

Most of the Tanzania population 90% now lives within 5 kms. Only 10% are 10 kms from a health facility (MOHSW 2006; HSA). However, due to geographical barriers and difficulties for the sick and pregnant women to cover such a distance when services are needed, more facilities are still required.

Table 1: Distribution of Hospitals and Health Centers by Regions and ownership in year 2004/2005

Region	Hospitals					Health Centers				
	Gvt	**Vol**	**par**	**Pvt**	**Total**	**Gvt.**	**Vol**	**Par**	**Pvt**	**Total**
Dodoma	5	2	0	0	**7**	18	2	0	1	**21**
Manyara	4	2	0	0	**6**	4	7	0	0	**11**
Arusha	3	7	1	1	**12**	16	5	2	6	**29**
Kilimanjaro	5	9	1	3	**18**	21	4	1	6	**32**
Tanga	5	4	0	3	**12**	18	7	0	0	**25**
Morogoro	5	4	1	2	**12**	21	5	3	2	**31**
Coast	5	1	1	0	**7**	15	1	0	1	**17**
Dar es Salaam	4	2	2	19	**27**	5	7	2	9	**23**
Lindi	5	3	1	0	**9**	13	1	0	1	**15**
Mtwara	4	1	0	0	**5**	12	2	0	0	**14**
Ruvuma	3	5	0	0	**8**	8	3	0	0	**11**
Iringa	5	6	0	4	**15**	19	14	1	0	**34**
Singida	3	6	0	0	**9**	11	2	0	1	**14**
Mbeya	6	8	0	2	**16**	20	7	0	1	**28**
Tabora	4	3	0	0	**7**	12	2	0	1	**15**
Rukwa	2	1	0	0	**3**	20	8	0	0	**28**
Kigoma	3	2	0	0	**5**	13	4	1	0	**18**
Shinyanga	5	1	1	1	**8**	23	2	0	1	**26**
Kagera	2	10	0	1	**13**	17	11	0	2	**30**
Mwanza	6	6	0	1	**13**	32	3	0	4	**39**
Mara	3	4	0	0	**7**	13	4	0	3	**20**
Total	**87**	**87**	**8**	**37**	**219**	**331**	**101**	**10**	**39**	**481**

Source: Health Statistical Abstract, April 2006

Gvt.= Government, Vol= Voluntary Agencies, Par = Parastatal, Pvt = Private Health Facilities

Table 2; Distribution of dispensaries and total health facilities by region and ownership year 2004/05

Region	**Dispensaries**					**All Health Facilities**				
	Gvt	**Vol**	**Par**	**Pvt**	**Total**	**Gvt.**	**Vol**	**Par**	**Pvt**	**Tota**
Dodoma	185	28	12	15	**240**	208	32	12	16	**268**
Manyara	75	36	1	11	**123**	83	45	1	11	**140**
Arusha	89	60	7	40	**196**	108	72	10	47	**237**
Kilimanjaro	149	63	7	113	**332**	175	76	9	122	**382**
Tanga	186	23	0	22	**231**	209	34	0	25	**268**
Morogoro	159	49	13	28	**249**	185	58	17	32	**292**
Coast	128	28	10	16	**182**	148	30	11	17	**206**
Dar es Salaam	71	28	11	230	**340**	80	38	15	258	**390**
Lindi	135	6	7	6	**154**	153	10	8	7	**178**
Mtwara	128	12	1	11	**152**	144	15	1	11	**170**
Ruvuma	127	31	3	13	**174**	138	39	3	13	**193**
Iringa	190	70	5	17	**282**	214	90	6	21	**331**
Singida	89	38	0	8	**135**	103	46	0	9	**158**
Mbeya	227	40	7	33	**307**	253	55	7	36	**351**
Tabora	156	22	2	27	**207**	172	27	2	28	**229**
Rukwa	156	11	0	17	**184**	178	20	0	17	**215**
Kigoma	164	17	7	8	**196**	180	23	8	8	**219**
Shinyanga	108	52	23	33	**216**	136	55	24	35	**250**
Kagera	142	99	4	10	**255**	161	120	4	13	**298**
Mwanza	243	25	16	52	**336**	281	34	16	57	**388**
Mara	131	25	9	23	**188**	147	33	9	26	**215**
Total	**3,038**	**763**	**145**	**733**	**4,679**	**3,456**	**952**	**163**	**809**	**5379**

Source: Health Statistical Abstract, April 2006
Gvt.= Government, Vol= Voluntary Agencies, Par = Parastatal, Pvt = Private Health Facilities

The physical condition of the health facility buildings (infrastructure) is poor. More than as over 50% of them require urgent major rehabilitation or complete reconstruction. There is also lack of adequate space for service provision as more than 60% of the health facilities do not have the required number of rooms in accordance with the standards defined by the Ministry of Health and Social Welfare. Most of the health care facilities have a working or service delivery space that is less than 50% of the requirement, the maternal and child health being the most constrained than other services areas.

The aim of the Government is to improve the access, quality and efficiency of district based health services by strengthening the planning and management capacity of decentralized district health and administrative system, through construction, rehabilitation, extension and provision of equipment and furniture

for the health facilities rendering the primary health service. This programme aims to help in achieving this goal and guide future health facility development.

A well-designed and constructed health facility shall consist of the following basic components:

- Buildings,
- Roads and drainage
- Walkways, parking and landscaping
- Security fences and lighting
- Water supply
- Sewerage system
- Solid waste management/incinerator
- Power supply

Water Supply

Reliable water supply is essential for improved hygiene and provision of health services. The principle sources of water supply are surface and ground or sub-soil water. Most of the dispensaries and health center do not have reliable water supply and in most cases where water exist the system has deteriorated beyond repair. Most of the district hospitals are connected to piped supply of the urban water and sewerage systems. However it is prudent to supplement the piped water supply with sub-surface water from shallow wells and/or boreholes. Rainwater harvesting with water reservoirs is highly recommended in places where the other sources are not available.

In the context of this programme it is assumed that all dispensaries and health centers situated in rural settings do not have reliable water supply. It is suggested that all these facilities be provided with this essential amenity. The introduction of safe water supply in these facilities will eventually benefit both facility and the communities.

Dispensaries

A standard dispensary consists of out-patient-department, maternal and child health services, toilets and a minimum of two staff quarters. The current situation with dispensaries is as follows:

Total number of villages 10,342
Total number of existing dispensaries; 4,679
Total number of health centers; 481
Total number of villages without dispensaries; 5,162

Note: A village with a health center does not need a dispensary

It has been established that more than 50%[1] of the dispensaries are in bad state of repair. PMO RALG in Tanzania, with assistance from the Development Partners is currently rehabilitating 25% PHC facilities in Tanzania with the remaining 25% of the existing health facilities in poor state, which need to be rehabilitated under this programme is 1170 dispensaries.

Most of the existing dispensaries are operating without a space for maternal and child health services. Approximately 70%[2] of the dispensaries lack this necessary element of the facility.

Staff houses form an integral part of the dispensary, however in most cases these have been neglected during the construction of these units and where they exist are in a very bad state of repair. It is assumed that 80%[3] of the dispensaries lack modest staff houses the provision of which will give impetus to the health service delivery.

Health Centers

A standard health center consists of out-patient-department, maternal and child health services, 24 beds medical ward for female and male, obstetrics theatre, diagnostic services, mortuary, surf-burner (improvised incinerator), kitchen, store, and a minimum of 10 staff quarters 2 out of them being grade 'A staff quarters'. The current situation with Health Centers is as follows:

- Total number of wards; 2555
- Total number of existing health centers; 481
- Total number of health facilities required; 2074

The MoHSW, PMORALG with support of Development Partners have put in place a District Health Infrastructure Rehabilitation Component (DHIRC) and a special Rehabilitation Fund (JRF) was established to finance this rehabilitation. 25% of the primary health infrastructure will be rehabilitated under this arrangement. 25% more will be rehabilitated by using Local Government Capital Development Grant and Tanzania Social Action Funds. The rest 50% of the PHC- infrastructure is still in poor state of repair. About 120 Health centres will be addressed under this programme.

Most of the existing health centres are operating without adequate space for maternal and child health services. It is held that 40% of the health centres lack this necessary element of the facility. Furthermore obstetric theatres will be constructed in each health centre to improve health service delivery.

[1] The percentage has been arrived at in the Rehabilitation Needs Assessment Study by PMO-RALG

[2] From the Three Regions Health Study

[3] From the Situation Analysis Report for preparation of Standard Guidelines and Drawings by PMO-RALG

Staff houses form an integral part of the Health Centre, however in some cases these have not been given the required credence during the construction of these units and where they exist are in a very bad state of repair. It is assumed that 30% of the health centres lack adequate and suitable staff houses and 60% of the existing staff houses are in bad state of repair. The provision of staff houses is a fundamental necessity and will give the required impetus to the health service delivery.

District Hospitals

Also known as Level-1 Hospital care, it is provided in:

- District and Designated District Hospitals (DDH) serving the 121 Local Authorities in the country;
- A number of other hospitals in districts owned and run by voluntary agencies or private institutions.

District hospitals are an integral part of the PHC system forming the apex of a system of dispensaries and health centres. District and other level I hospitals are either owned by the government or voluntary institutions. A few private hospitals now exist but mostly in urban areas. Government district hospitals are the responsibility of Local Authorities, funded through the Prime Minister's Office Regional Administration and Local Government.

In districts where there is no government hospital, a voluntary agency hospital is contracted by the Ministry of Health & Social Welfare to serve as a Designated District Hospital (DDH). It is worthwhile to realize that certain voluntary agency hospitals are providing or have the capacity to provide some level II hospital care (for example St. Francis Hospital in Kilombero District, Morogoro Region or Ndanda Hospital in Masasi District, Mtwara Region). The current situation with District Hospitals is as follows:

- Total number of districts; 113
- Total number of district and designated district hospitals 95
- Total number of district hospitals required; 8

The existing district hospital infrastructure is not adequate and mostly not suitable to support provision of quality basic curative and preventive services to the population they serve.

Lack of privacy in the inpatient wards, consultation and counseling rooms together with overcrowding in diagnostic and inpatient wards, long waiting queues in diagnostic areas and lack of functioning equipment; all have shown to deter the delivery of quality health services.

The state of hospitals' infrastructure is generally in poor condition and the electrical and mechanical installations such as incinerator equipment and mortuary body cabinets need urgent repair and replacements. A recent study by

Mekon Arch Consult under PMO-RALG revealed that more than two thirds of all buildings require urgent repair, renovation or reconstruction.

4.1.11 Public Private Partnership

The growing demand for health care services posed by evolution of emerging and re-emerging diseases has put more pressure on the health care delivery system in terms of increased need for extra resources and expertise. The continuing resource shortage for health necessitated the government to reintroduce private health practice for profit in 1991, which had in the past been restricted since 1977. This is aimed at assuring that the private sector services complemented health care services provided by the government in efforts to narrow down the existing gap that cannot be filled by the government on its own.

Private sector health facilities account for some 40 percent of the total facilities in the country. Of this total, 35 percent are Faith Based Organizations owned of which most are located in disadvantaged areas of the country. Some of them are funded by government through grants; basket funds and other forms of support e.g. medicines, equipment, staff secondment and training.

On the other hand, almost 90 percent of private for profit health facilities are situated in urban areas, a ratio that is inconsistent with the population distribution in the country whereby about 80 percent live in rural areas while only 20 percent in urban areas.

This Programme will take into account the already existing initiatives geared towards promoting and sustaining Public Private Partnerships in health service provision. Strengthening the health infrastructure network through constructing new ones, repair and rehabilitation works and provision of non core services is to be done by the private sector. Through PHSDP/MMAM, the government will put increased focus on district health services and further consolidate involvement of the various stakeholders at that level while continuing to maintain its fundamental role of ensuring provision of quality health services to all citizens.

4.1.12 Referral System

In the context of the Tanzania health system, the planned referral system is basically non-functional due to a number of reasons:

- Critical shortage of the core health human resources from the dispensaries upward to health centres to district hospitals to deliver core services at those levels to reduce unnecessary referrals due to lack of the required skills;

- Inadequate or inability to complete diagnostic check up at dispensaries and district hospitals;

- Lack of transportation and communication facilities to operationalize organized referrals and feedback processes from the lower levels to the district hospitals and higher up the referral chain;

- Irregular supply of essential drugs necessary at levels of the health delivery system to minimize unnecessary referrals.

- Lack of communication, between various health service providers within districts and regions to maximize utilization of existing skills and facilities, particularly in private facilities, towards promoting horizontal referral of patients

This situation leads to self-referrals and by pass of the referral system by patients, unnecessary referrals by unskilled staff at the various levels of the health care delivery system. This undermines the users' trust and credibility of the sector.

For the purposes of the PHSDP, innovative and at times unconventional mechanisms will be required to ensure timely and a smooth referral system while maximizing on locally available facilities and skills within districts and regions in order to ensure continuity of care. This will ensure organized and timely access to specialized referral services for populations within all districts across Tanzania.

4.2.1 District Health Services:

Specific Objectives

(i) Access to health services

Specific Objectives:

- Increase availability of basic health services(curative, preventive, promotive and rehabilitative) from 75% health facilities to 100 % public health facilities by 2012

Strategies

- Deployment and recruitment of appropriate skilled personnel
- Ensure availability of drugs, supplies, equipment
- Rehabilitate existing health facilities to be able to provide additional services having additional rooms to ensure privacy

(ii) Distances to health facilities and long queues.

Specific Objectives:

- To have a health facility in every village by the year 2012

Strategies

- Construct new health facilities with necessary skilled health providers
- Provide mobile clinics for outreach services

(iii) Drugs and Medical Supplies

Specific Objectives

- To ensure availability of essential medicines, medical supplies and equipment in public primary health facilities at affordable cost.

- To promote efficient and effective management of medicines, medical supplies and equipment in public primary health facilities

Strategies

- Ensure adequate allocation of budget for medicines and medical supplies in public primary health facilities to ensure constant availability of essential medicines, supplies and equipment at affordable cost.
- Improve delivery system for provision of medicines, supplies and equipment in public primary health facilities.
- Improve management of medicines, supplies and equipment at primary health facilities.
- Ensure availability of guidelines in primary health facilities to promote rational use of medicines, medical supplies and equipment
- Establish planning system and standardized stock-control systems which would include pricing information for budgeting purposes, as well as procedures for drug financing and accounting in all health facilities will be established.

(iv) Nutrition

Specific Objectives

- To build capacity for Nutrition at district and community levels

Strategies

- Development and recruitment of nutrition focal personnel

(v) Transport

Specific Objectives

- To acquire132 vehicles and ambulanced to all H/Cs and D/Hs during the five years programme period,
- To maintain and keep in good running condition all acquired vehicles during the five years programme period

Strategies

- The Government will procure and maintain vehicles and ambulances to all district hospitals and health centres based on the standard guidelines of the Ministry of Health and Social Welfare by year 2012.

(vi) Communication System

Specific Objectives

- To ensure procurement of radio call systems in all 113 districts

Strategies

- The Government will provide equipment, furniture and plants to selected health centres by year 2012

(vii) Health Infrastructure Network and Medical Equipment

Specific Objectives

- To rehabilitate, construct and upgrade 8107 primary health care facilities, 62 district hospitals and 128 training institutions, including construction of new training institution
- To strengthen 2,555 health centers by constructing theatres and providing them with necessary medical equipment and furniture
- To equip and furnish 8,189 health facilities

Strategies

- The Government will construct, expand, and rehabilitate dispensaries in various sites based on the standard guidelines of the Ministry of health and Social Welfare by year 2012.
- The Government will provide equipment, furniture and plants to selected dispensaries by year 2012

(viii) Public private partnership

Specific Objectives

- To further strengthen working relations at the district level with private sector participation in the programme for the purpose of increased access and choice to health service users.

- To facilitate recognition, organization and representation of private service providers within the district as partners to the public service providers and managers.
- To ensure participation, by private sector representatives in the implementation, of PHSDP/MMAM programme.
- To strengthen private sector involvement and participation in the provision of non core services
- Develop more effective and sustainable mechanisms for partnership based interventions and implementations through joint planning, trainings and capacity building.
- The government will promote and facilitate the establishment and functioning of interfaith forums at district level to ensure working partnerships among health service providers of all faiths and denominations in matters of communications, dialogue and negotiation with the government;
- The government will, jointly with both public and private providers, ensure effective working of Service Agreements clauses towards increased accountability and transparency for allocated health resources to ensure provision of quality and accessible health services.
- The government will facilitate processes towards self regulation by members of locally established associations of private service providers, of various categories, to ensure quality, public safety and adherence to agreed norms and standards

Strategies

- The government will regularly review monitoring systems and jointly develop, with private providers, guidelines for monitoring of private health services.

- The government will promote and facilitate regular partnership meetings to strengthen and sustain public-private partnership initiatives as part of the implementation arrangements

(ix) Referral system

Specific Objectives

- To ensure a continuity in the referral chain from the lowest to higher levels of the health system through the provision of the required essential elements for the system to function effectively
- To facilitate maximization in the utilization of locally available facilities and skills to minimize patient referrals, and its related inconveniences to the patients, to outside of the districts and regions
- To facilitate increased access to specialized outreach services from tertiary level hospitals to district and regional hospitals.

Strategies

- Provision of resources to facilitate specialized outreach services conducted by using consultants from specialized referral hospitals to regional and district hospitals
- Strengthening of skilled health human resources in numbers, distribution and skills mix, for effective clinical management of patients at all levels of the health system.
- Strengthening transport and communication systems at all levels, particularly at health centre level, to promote timely and effective communication and referrals and feedback from rural facilities.
- Strengthen modalities for horizontal communications and referrals and feedback within districts and regions through maximization of available facilities and skills including private sector capacities.
- Application of ICT (Tele Medicine) to strengthen referral system through increased access to specialized care from the tertiary level hospitals.

4.2.2 District Health Services annual activities targets

Annual activity targets are found under the matrix annex 1.

4.2.3 Budget

The total budget for this component to meet the targets up to the year 2012, including infrastructure, equipment, drugs and medical supplies is attached.

4.3 Human Resources for Health

Situational Analysis

Human resources situation has shown a decline of skilled human resources from 67,000 in 1994 to 49,000 in 2001/02. The MoHSW staffing levels versus existing staff shows an enormous HRH shortage across all main cadres. It is worse among Clinicians, Nurses, Pharmaceutical Technicians, Laboratory Technicians, Radiographers, Therapists, Health Officers and Health Administration cadres. According to the MoHSW staffing level (1999) 46,868 qualified health professionals in the public health facilities are required while the available technical staffs are 15,060 which is equal to 32.1% of the requirement, this reveal a shortage of 31,808 equal to 67.9%. This analysis reflects the whole system from the lower level up to the higher level of the national hospital.

Other sectors, which complement the Ministry in the provision of health services, are facing the same problem. The situation in the Faith Based Organizations and private sector is becoming worse currently due to the staff movement trends to the public facilities. The Social Welfare services are also affected whereby, the number of technical staff required is 816 while the actual strength is 269 and the deficit is 547, which indicate 67% of the requirement.

The Ministry of Health and Social Welfare is dedicated to ensure equitable, quality and accessible health services, this calls for deliberate effort to formulate new health policies and subsequent plans to facilitate achievement of the desired health services. As a response the Ministry is in the process of developing a Primary Health Services Development Programme (PHSDP), which is focusing on catalyzing improvement in access of health services at all, levels.

Among the strategic issues critical to the success of this programme is to have in place the right number of qualified and skill mix staff in the right place at the right time, cost and motivation to provide quality and accessible services to meet the health need of Tanzanians.

The need to do the situational analysis of the major strategic issues that affects access of health services is therefore inevitable so as to address existing challenges. These issues are workforce training and development, management that includes recruitment, deployment and retention.

Training and development

Among the most serious HRH challenge facing the health sector is the existing low HRH production capacity both quantitative and qualitative at the same time there is limited skills, knowledge and competence gap among health workers to cope with fast technological advancement in health.

The training and supply of health workers has not kept pace with health sector needs, both quantitatively and qualitatively. The country has 126 training institutions of which government owns 62 and 64 are owned by the private sector and faith based organizations. There are also 6 medical universities 5 of which are privately owned. For the past nine years the output from medical schools is 23,536 including all cadres in health from certificate to postgraduate studies.

In-service training (IST) and continuing professional development (CPD) is essential for updating and maintaining health workers skills and knowledge and for assuring quality service provision. IST/CPD systems and practices need to base on the factors such as changing disease patterns and health services demand.

Unfortunately, the capacity of the current IST/CPD system to address these issues is limited. In-service training interventions need to be well coordinated. In service training programmes are often done outside the working environment contributing to staff absences and increased workloads for those remaining on site.

The MoHSW has established 8 Zonal Training Centers (ZTC) to facilitate the update of health workforce skills particularly at the district level. Given the changing and expanding roles of health workers it is also important to ensure that IST/CPD interventions focus on professional and personal as well as medical training and development.

The justification to train and develop workers is due to:

- The increasing burden of disease as a result of HIV/AIDS and expanding health worker roles and new forms of service provision.
- Political commitment to establish health facility in every village which translate to additional skilled health workers
- Presence of tremendous community enthusiasm and expectations for health improvement
- Realization and commitment to address critical HRH shortage in the Health sector
- Increase and maintain the supply and production of human resources,
- The need to maintain standards and quality

Workforce management

There are multiple players in the management of the health workforce. It is a shared responsibility undertaken by MoHSW, PO-PSM as an employer, MoF as a financier and Local Government Authorities and the private sector as employers. The MoHSW is the technical Ministry responsible for developing policy and guidelines as well as ensuring standards in health care delivery at all levels. Having multiple players in the management of human resource for health has contributed to inefficiency in some practices including development, recruitment, deployment and retention processes. The government has identified HRH as a priority area and is fully committed for its improvement. A number of initiatives are currently being undertaken by the MoHSW to address the HRH crisis. This plan seeks to address the following human resources' areas;

Recruitment and Deployment

The health sector has also suffered from under investment in health infrastructures including staff housing, provision of water, basic communication, transport and working tools and materials. The hardships in the most remote areas and hard to reach is a great challenge to retain qualified staff in adequate numbers.

MoHSW acknowledges the obligation of ensuring the availability of competent and adequate staff with appropriate skill mix. In assuming this responsibility various initiatives are implemented, these include special three year recruitment permit from February 2006 to February 2009, substantial increment of HRH wages as per Civil service Circular number 1 of 2006, the emergency hiring initiatives and ongoing efforts to develop

HRH strategic plan of 2007 which presents a long term strategy to address the HRH crisis in the country.

In addition, the Benjamin William Mkapa Foundation is complementing the Government effort in the recruitment of health workers in remote and hard to reach areas. The Foundation works by providing a three years contract with a special incentive package.

Retention

The HRH crisis in the health sector is attributed to various related causes, lack of retention strategies being one of them. Socio-economic disparities and other work environment challenges have been factors that put off professionals and thereby affecting their retention, particularly in the rural areas. Improving Human Resource Management (HRM) has the purpose of ensuring that staffs know what they are supposed to do, get timely feedback, feel valued and respected, and have opportunities to learn and grow on the job. An incentive package and retention strategy need to be developed that will take into account the need to improve performance and management.

The PHSDP plan seeks to encourage improved retention of health staff particularly in hard to reach districts using innovative retention strategy. Efforts to encourage health workers to accept postings to very remote areas would be explored. The use of attractive differential incentive packages including preferential career development would be advocated.

4.3.1 Objectives

Human Resources for Health

- Expand training intake for increased output
- Train and acquire adequate tutors
- Recruitment and deployment of adequate skilled health workers
- Improve health workers competence
- Promote incentive initiatives/package for health workers with emphasis to those working in the difficult areas
- Establish new training program for most needed cadres

4.3.2 Strategies

- **To cover the shortage of 68% of human resource for health, an additional workforce will be required through the following strategies to be implemented in 5 years:**
    - Introduce an incentive package that will attract health workers to work in difficult and remote areas
    - Device workplace programs that will retain health workers.
    - Reduce attrition of health workforce
    - Technical Assistance by using consultants in specialized fields

- Provide adequate essential medicines, medical supplies, reagents.

Infrastructure

- 11 Multipurpose training centres established and operational by 2012
- 64 Allied Health and Nursing Schools expanded and equipped by 2012
- 64 Allied Health and Nursing Schools rehabilitated by 2012
- Acquisition of staff to facilitate training at regional health facilities

Personnel Emoluments and incentive package Incentive package for all health workers established by 2008:-

- Incentive for hardship areas introduced by 2008
- Enough supplies, houses, equipments and transport provided to health workers by 2012
- Criteria for ranking hardship areas established by 2008
- Occupational health safety promoted by 2008
- Workers motivation programs designed and implemented by 2012
- Health workers job satisfaction survey conducted by 2009
- Credit facilities guideline developed by 2008.

4.3.4 Budget

The total budget for this component to meet the targets up to the year 2017, including equipment, supplies is Tshs 368,701,000,000 in the first year Tshs. 24,380,000,000 will be adequate to have an additional workforce in year 2009/2010 but due lack of adequate financial resource the in the coming financial the Ministry has set aside Tshs 11.5 billions. However, the problem of Medical Doctors will only be resolved in the year 2015, three years after the end of the programme.

4.4 Maternal Health

4.4.1 Situation Analysis

Maternal and newborn health care is one of the key components of National Package of Essential Reproductive and Child Health Interventions focusing on improving quality of life of women, adolescents and children. The major elements of the package include antenatal care, care during childbirth, Emergency Obstetric Care (EmOC), Newborn care, postpartum care, and Childcare.

It is estimated that over 80% of the Tanzanian population live within 5km from the health facility, in spite of the good coverage of health facilities, not all components of the services are provided to scale, hence, maternal, newborn and child mortalities remain a major public health challenge in Tanzania. Maternal mortality ratio is 578 deaths per 100,000 lives births TDHS 2004. Over 80% of the maternal deaths are due to direct causes that

includes obstetric, hemorrhages, obstructed labour, pregnancy induced hypertension, sepsis and abortion complications. The majority of maternal deaths can be prevented if pregnant women can be assured of access to skilled attendance4 at childbirth and emergency obstetric care when pregnancy related complications arise.

According to *TDHS 2004*, 94% of pregnant women attend antenatal care at least once. However, the quality of antenatal care provided is inadequate. About 65% of the women have their blood pressure measured and 54% have blood sample taken for haemoglobin estimation and syphilis screening. About 41% have urine analysis done and only 47% are informed of the danger signs in pregnancy and childbirth. Regardless of high ANC attendance, only 47% of births occur at health facilities. Of all deliveries occurring in health facilities, only 46% are attended by skilled attendants.

Major barriers perceived by women to access delivery health services include lack of money (40%), long distance to a health facility (38%), lack of transport (37%), and unfriendly services (14%). The high rates of home deliveries are also attributed by poor geographical access to health facility, lack of functioning referral system, inadequate capacity at health facilities in terms of space, skilled attendants, commodities and other socio-cultural aspects surrounding the pregnant women. Additional factors include gender inequalities in decision-making and access to resources at household level.

Emergency obstetric care services are crucial in addressing complicated pregnancies. However, lack of functioning blood banks at most hospital and health centres in Tanzania is correlated with the low rate of caesarean section[5], whereby only 3% of babies born are delivered by caesarean section (*TDHS2004*). 64.5% of hospitals provide comprehensive emergency obstetric care (EmOC), whereas only 5.5% of health centres are providing Basic Emergency Obstetric Care[6]. Furthermore, the referral system has serious challenges including limited number of ambulances; unreliable logistics and communication system; and low community based facilitated referral system.

Adolescent friendly Reproductive Health services need to be addressed as young people under the age of 24 make up nearly two-thirds of the Tanzanian population. Young people have special concerns that must be addressed in regards to Maternal and Neonatal health. According to some recent studies have shown that: Infant mortality is highest in countries

[4] - Making Pregnancy Safer: The Critical Role of the Skilled Attendant, A Joint Statement by WHO, ICM & FIGO, 2004

[5] International recommendation is caesarean section between 5-15%

[6] 2005 Unpublished Public Facility EmOC Survey

with the largest proportion of births to adolescents[7]; Children born to adolescents are much more likely to die than those born to women ages 20 to 29[8] and Maternal mortality is as twice as high for young women, ages 15-19, than it is for women, ages 20-34[9]In order to effectively reduce maternal and child morbidity and mortality the needs of young people must be addressed. In Tanzania[10], more than half of young women under the age of 19 are pregnant or already mothers; the perinatal mortality rate (per 1,000 pregnancies) is significantly higher for young women under the age of 20 (56), that it is for women aged 20-20 (39), and older women aged 30-39 (32).

Weakness in the health system has direct impact on the delivery of maternal and newborn services i.e. shortage of skilled providers in most of health units, lack or inadequate supplies equipments, poor infrastructures, inadequate and poor referral system. To be able to reach the MDG 4 & MDG5 targets by 2012 substantive efforts has to be made in strengthening the existing system and expand and decentralize further services, this implies a comprehensive approach is required to improve coverage within all districts.

Hence proposed actions are aimed at ensuring provision of adequate services and care during adolescence, pregnancy, ante-natal, delivery and prompt emergency care to prevent morbidity and death from obstetric complications including prevention of unwanted pregnancies.

4.4.2 Objectives

- To reduce maternal mortality from 578 to 220per 100,000 live births by 2012.
- To increase coverage of births attended by skilled attendants from 46% in 2004 to 80% by 2012

4.4.3 Strategies

- Capacity building for Maternal and Neonatal interventions for service providers and pre service tutors
- Recruitment and deployment of skilled providers to the existing and new health facilities.
- Increase intake of students in allied health institutions (Nurse Mid wives, AMOs, CO, Anaesthetists, Laboratory technicians)
- Strengthening health system

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[7] : Zwicker C et al. Commitments: Youth Reproductive Health, the World Bank and the Millennium Development Goals. Washington D.C.: Global Health Council 2004

[8] Zwicker

[9] Mathur S et al. *Too Young to Wed.* Washington D.C.: International Center for Research on Women, 2003

[10]. 2005 *Tanzania Demographic and Health Survey 2004-05.* Dar es Salaam, Tanzania: National Bureau of Statistics, Tanzania, and ORC Marco

- Procurement of Essential Equipment, supplies for maternal and newborn health implementation.
- Renovation and building operating theatres , labour wards, RCH Clinics, including staff houses
- Procurement and distribution of radio calls and ambulances to be station in selected health facilities(hospitals , health centres) in each districts
- Behavioural change communication
- Advocacy for maternal, newborn and child health at all levels
- Community mobilization and empowerment

4.4.4 Budget

The total budget for this component to meet the targets up to the year 2012 is attached.

4.5 The National Aids Control Programme

4.5.1 Situation Analysis

The National AIDS Control Programme (NACP) of the Ministry of Health and Social Welfare (MOHSW) plans to expand and strengthen the care, treatment and support services to rural communities and make the services accessible to all in need by 2012. Based on the targets that were set in the previous Health Sector Strategy for HIV/AIDS (2003 – 2006), the NACP is currently providing care and treatment services in 200 facilities across the country. The facilities include; referral, regional, district hospitals and also non-Governmental organization and faith based owned hospitals. From year 2007, the services will expand to rural communities by including 500 primary health care facilities of health centres and dispensaries. The number of patients to be initiated with anti-retroviral drugs (ARVs) is expected to increase from the targeted 440,000 in the year 2008 to 600,000 in 2012.

The increased number of patients accessing care, treatment and support services including ARVs will increase substantially the demand for HIV test kits, laboratory equipment and supplies for screening and monitoring of patients on Care and Treatment. Currently, the Haematology Analyzers are available in only 141 health facilities. Chemistry analyzers are available in 148 health facilities. The FACS count machines for determining the levels of CD4 have been distributed in 4 Referral hospitals, 18 Regional hospitals, 19 District hospitals, 1 NGO hospital and 1 military hospital. To expand these service to the community, the NACP plans to distribute CD4 count machines to all remaining district hospitals and other hospitals owned by Faith based organizations. Patients' blood samples for CD4, chemistry and haematology analyses from remote health and HIV testing sites will be transported to the nearest care and treatment facilities that are equipped with respective equipment. HIV infant diagnosis has also been established in referral hospitals. Patients' blood

samples will be transported from the health facilities around the zonal catchments areas. With such extensive laboratory support, it is expected that more than 600,000 patients will access these services countrywide in 2012.

Testing and Counseling is an entry point for care, treatment and support for people living with HIV/AIDS (PLHA). Services have been established in 1,027 sites (3 VCT sites in each district). Though Voluntary Counseling and Testing (VCT) has been the main recruiting ground for patients accessing care, treatment and support services, this avenue is insufficient and inadequate to meet the target set for Care and Treatment enrolment. It is planned therefore, to introduce Provider Initiated Testing and Counseling (PITC) in the clinical setting so that all patients coming in-touch with the health system will be offered Counseling and Testing. It is expected that the majority of 20 million of the population attending out-patients and in-patients department will accept to undertake the test and identify the eligible persons for care, treatment and support services. By 2012, the NACP plans to scale up quality HIV Testing and Counseling services in the country from 15% to 35% of the population aged 15- 49 years.

Community Home Based Care (CHBC) acts as a health facility and community linkage system for providing basic nursing and medical care at home including counseling, care and support. It is therefore an important link for monitoring of patients. CHBC services have been established in more than 70 districts. A total of 1,400 HBC providers have been trained at the health centres and dispensaries and more than 200 HBC providers have been trained at the community level. The plan by 2012 is to implement home based care in all districts and to have at least 5 to 10 facilities implementing these services in each district.

Sexually Transmitted Infections (STI) control programme focuses on strengthening STI treatment practices in health facilities using STI syndromic case management approach. STI services have now been established in all 21 regions of Tanzania Mainland, covering all public hospitals, health centers, 60% of dispensaries and some private owned facilities. The plan by 2012 is to further expand STI services to all remaining public and private facilities, to ensure the continuous availability of essential STI drugs to all health facilities offering STI services and ensure syphilis screening is offered to all pregnant mothers on their first ANC visit.

Prevention of Mother to Child services have been expanded to all regional hospitals and other 145 hospitals including district and faith based owned hospitals, 182 health centres and 332 dispensaries. Already 255,913 pregnant women have been reached with PMTCT services. Guidelines

have been developed and 2,758 providers have been trained. The plan is to reach 1,400,000 pregnant women by strengthening PMTCT programme management and coordination by 2012. The NACP plans to increase facility coverage through integration of PMTCT services into routine RCH services in hospitals, health centers and dispensaries and to provide anti-retroviral (ARVs) prophylaxis to 75% of all HIV+ pregnant women who are not eligible for anti-retroviral therapy (ART).

In promoting health and behavioral change, the NACP has been using various approaches to reach specific groups of people as well as the general population. These approaches include production of Information, Education and Communication (IEC) print materials such as posters, leaflets, wall calendars, newsletters, brochures as well as electronic media (TV and Radio Programmes). The plan is to further promote positive behavioral change towards HIV/AIDS/STI through health promotion by producing more print materials and distribute them to the community especially in the villages. Also to produce more educative radio and television programmes and air on various channels especially those, which reach the rural areas. In addition, the NACP library continues to maintain a variety of informative resource materials in form of reports, guidelines, training manuals, books on HIV/AIDS/STI, CD-ROMS which can be utilized by researchers, academicians, students and the general public free of charge. Since 2006, the Programme made an attempt to move towards digital distribution of its HIV/AIDS information through the global network infrastructure by establishing a website (www.nacptz.org). The plan is to increase access to HIV/AIDS/STI information to clients.

Goal

Reduce HIV/AIDS prevalence rate by 50% by 2012 from the current 7%.

4.5.2 Objectives

- To provide highest attainable standard of management of HIV/AIDS by 2012
- To develop and implement comprehensive care strategies in public and community based settings by 2012
- To strengthen diagnostic services to support prevention, care and other interventions
- Increase access to quality VCT services and initiate Provider Initiated Testing and Counseling in all health facilities by 2012
- Increase access to services for the prevention of mother to child transmission of HIV in all health facilities providing reproductive and child health services by 2012
- Strengthen the provision of blood which is free from HIV and other common blood transmissible infections
- Reduce the rate of sexual transmission of HIV

- Establish programme to prevent and reduce stigma, denial and discrimination related to HIV/AIDS by 2012
- Implement universal precautions in health care settings to prevent nosocomial transmission of HIV
- Improve capacity and working conditions of health care personnel by 2012
- Strengthen and expand surveillance activities to monitor te dynamics of the epidemic and impacts of interventions
- Strengthen the programme management function

4.5.3 Strategies

- To scale up access to ART stepwise from tertiary, secondary centers to potentially include district health facilities, Health centers and dispensaries in the context of training, establishing and strengthening these services and drug availability by end of 2012.
- To evaluate the progress of the training and scaling up of ART services.
- To scale up down to the district level, involving communities through home-based care using lessons learned in the first years of implementation of care and treatment in the country.

4.5.4. Target

By the end of 2012 all districts should have HIV/AIDS care and treatment clinics that would provide comprehensive package of care, treatment and support. These would have the potential to scale up to provide care and treatment services to at least all the hospitals, health centers, and dispensaries in all the districts. The districts must have good plans to ensure availability of sustainable resources in order to accomplish their service provision.

4.5.5 Budget

The total budget for this component to meet the targets up to the year 2012 is attached.

4.6 Malaria

4.6.1 Situation Analysis

Introduction

Malaria currently kills up to 3 million people per year worldwide, most of them being children below five years of age and pregnant women. About 90 % of all malaria deaths in the world today occur in Africa south of the Sahara. This is because the majority of infections in Africa are caused by Plasmodium falciparum, the most dangerous of the four human malaria parasites. It is also because the most effective malaria vector – the mosquito Anopheles gambiae sensu lato – is the most widespread in Africa and the most difficult to control (WHO, 2003). The impact of malaria on the poor is

exacerbated by hunger, malnutrition, anemia coupled with other diseases associated with poverty.

The number of clinical malaria cases per year is estimated to be 17 – 20 million resulting in approximately 100,000 deaths. The population groups most vulnerable to malaria are children under five years and pregnant women, due to their particular immunity status. The current estimated infant mortality and under five year mortality rates are 68 and 112 per 1,000 live births respectively (2004-05 TDHS). Maternal mortality is estimated at 578 deaths per 100,000 live births. Life expectancy at birth is 45 years. It has been estimated that malaria contributes to about 36% of all deaths in children under five years of age (IHRDC-DSS, 2005).

As part of the review of the Malaria strategic plan 2002-7 conducted in late 2006 and early 2007 as a process of developing a New NMMSP 2008-12, it was revealed the following are the weakness and threats within the malaria control strategies.

Major weakness have been identified to include; Low percentage of malaria confirmed cases and malaria over diagnosis; on the other hand more than 95% of all febrile patients receive an anti-malarial treatment, which means that the wastage of drugs is equivalent to the magnitude as the over-diagnosis. Unclear stipulated malaria quality system from the diagnostic unit in the MOHSW were observed; Absence of strategic actions to address Integrated Malaria Vector Control issues has resulted to the increase of burden of disease in the country; Weak infrastructures and Inadequate knowledge and skills within the community to manage environmental management reduced participation at grass root level; Lack of enforceable legislations (Mosquitoes Extermination Ordinance of 1935 is out-dated) has resulted into scattered breeding sited.

The vision of the new strategy is that: Tanzania becomes a society where malaria is no longer a threat to the health of its citizens regardless of gender, religious or socio-economic status.
The Mission is to ensure that - Tanzanians have universal access to malaria interventions through effective and sustainable collaborative efforts with partners at all levels.

For this strategic plan the Goal is - To reduce the burden of Malaria by 80% by the end of 2012 from current levels.

Vision
The vision of the new strategy is that: Tanzania becomes a society where malaria is no longer a threat to the health of its citizens regardless of gender, religious or socio-economic status.

Mission

The Mission is to ensure that - Tanzanians have universal access to malaria interventions through effective and sustainable collaborative efforts with partners at all levels**.**

4.6.2 Objectives;

To reduce the burden of Malaria by 80% by the end of 2012 from current levels.

4.6.3 Strategies

- Case Management and Malaria in Pregnancy
- Integrated Malaria Vector Control
  - Re introduction of Indoor Residual Spray
  - Environmental Management
  - Laviciding
  - ITNs
- Malaria epidemics
- Information Education and Communication/ Behavioural Change Communication
- Operational Research.
- Monitoring and Evaluation
- Program Management and Coordination

These strategies aim to rapidly scale up the levels of coverage for in the main intervention areas, by adopting cost effective sustainable channels. This is provided as a comprehensive array of activities that will guide the combat of malaria activities in Tanzania.

4.6.4 Budget

The total budget for this component to meet the targets up to the year 2012 is attached.

4.7 Tuberculosis and Leprosy

4.7.1 Situation Analysis

Tuberculosis

Tuberculosis continues to be among the major public health problems in the country accounting for 7% of the burden of disease in the country up from 5% in 1999. The number of tuberculosis cases notified in country has steadily increased from 11,753 in 1983 to over 64,000 in 2004, which is almost six-fold increase. Data from AMMP shows that TB is the third cause of deaths among adults after malaria and HIV/AIDS.

Majority of TB cases are young adults aged 15-45 years, the same age group affected by HIV/AIDS. Nearly two thirds of all TB cases notified are

males. Various studies conducted in the country show that the rapid increase of tuberculosis is mainly attributed to the HIV epidemic, but other contributing factors include population growth and overcrowding especially in urban settings. TB is one of the earlier indicators of HIV infection and it is estimated that 40-50% of all HIV infected individuals in Tanzania may develop tuberculosis during their life time. Similarly TB is the leading cause of death among AIDS patients accounting for about 30% of all AIDS-related deaths. Other consequences include stigmatisation of the TB diagnosis, which is automatically associated with HIV/AIDS by health workers and the community at large.

The distribution of TB in the country is not equal. Almost two thirds of all cases are reported by 7 regions alone - Dar es Salaam, Arusha, Tanga, Morogoro, Iringa, Mbeya and Mwanza). Dar es Salaam alone notifies about 25% of all forms of TB cases notified in the country annually.

Another dangerous aspect of tuberculosis is the spread of multi-drug resistant TB (MDR-TB), which threatens to reverse achievements so far gained in TB control in the country. Available NTLP routine surveillance data indicates that the problem is still low around 1%. Despite the low prevalence, there are a substantial number of MDR-TB cases that are documented in different hospitals and among health care workers. Referral centers like Kibong'oto attend to a number of patients who have failed TB treatment regimens in other settings. The absence of a policy on follow-up of these cases or treatment regimen could easily increase transmission to the general population

Leprosy

The number of registered leprosy cases notified annually has decreased from over 35,000 cases in 1983 to about 4,500 in the year 2004. About 8% of the annual notified cases are children under 15 years of age and 10% have permanent disability according to WHO classification. The number of newly notified cases has not significantly changed in the last one decade despite intensification of leprosy elimination campaigns. The number of registered leprosy in Tanzania in the year 2004 was 1.4 per 10,000 populations which is still above the World Health Organisation (WHO) target of 1 case per 10,000 populations.

The disease still continues to have a very negative social image in the

community, frequently responsible for discrimination and stigmatisation. Patients also face serious psychological problems including loss of marriage prospects. The stigma and cultural association of leprosy with evil spirits causes many victims to seek assistance from traditional healers before reporting to health services. Additionally many general health workers are not able differentiate leprosy from other skin diseases when it is presented to them at an early stage without nerve damage and deformities

Justification of TB and Leprosy

Tanzania has adopted WHO strategies for TB and leprosy. DOTS strategy is one of the most cost-effective strategies in the control of TB and similarly, MDT strategy for leprosy control has led to a drastic reduction of leprosy cases notified annually. NTLP gives priority to early case finding and treatment of both TB and leprosy thereby saving a large number of lives, preventing many disabilities and reducing innumerable human sufferings.

The Ministry of Health and Social Welfare plans to intensify its efforts further in the control of TB and leprosy thus contributing to the country's wider efforts to meet vision 2025, the Poverty Eradication Strategy goals and the Millennium Development Goals, which have clear targets. More specifically, the Ministry will endeavour to achieve the WHO targets set for TB of detecting 70% infectious cases and 85% treatment success by 2005 based on the Stop TB strategy. Currently, only 50% of the estimated infectious cases are notified in the country and of these, 82% are successfully being treated.

In the case of leprosy, Ministry will increase efforts to eliminate leprosy as a public health problem – achieving the WHO target of less than 1/10,000 population. Special activities such as leprosy elimination campaigns (LEC) and integration into the existing health care services will help to accelerate reduction of the number of registered leprosy cases in the country.

The Ministry also intends to intensify scaling up of collaborative TB/HIV activities in collaboration with other stakeholders in the country. These activities will be complimentary to and in synergy with the established core activities of tuberculosis and HIV/AIDS prevention and control in the country.

A successful DOTS program is the best way of preventing the development of drug-resistant strains of TB. However, since there are already a few cases of MDR-TB in the country, there is a need to establish

a system to treat them to interrupt transmission of infection to others including health workers using WHO DOTS-Plus strategy complimented by a good infection control in health facilities.

4.7.2 Objectives

- To reduce prevalence and death rates associated by Tuberculosis by 50% by 2012
- To create awareness of community members on various tuberculosis and leprosy control measures from 30% to 80% by 2012
- To establish national capacity to treat 100 patients with drug resistant TB according to WHO guidelines by 2012
- To strengthen laboratory capacity to conduct surveillance and detect drug resistant tuberculosis by 2012
- To provide anti-TB and anti-leprosy drugs in all eligible health facilities by 2012
- To expand screening of patients co-infected with tuberculosis and HIV/ in all districts by 2012
- To eliminate leprosy as a public health problem in the country from 1.2 to below 1 case per 10,000 population by 2012
- To strengthen the quality of TB and leprosy information system in all districts by 2012
- To monitor and evaluate TB and leprosy control activities in all districts by 2012

4.7.3 Strategies

Political commitment with long-term planning, adequate human resources, expanded and sustainable financing

This strategy aims at increasing Government budget to control TB and leprosy in the country in collaboration with interested donors, other partners, communities, private sectors and other stakeholders. The purpose is to bring free services closer to the community by strengthening existing health facilities and involving others hitherto not providing these services. It will also help intensify and streamline TB and leprosy control in prison services and refugees' camps in the country including agreeing on treatment regimens and training of service providers in these institutions. Special emphasis of TB control will be on major cities which notify most of the TB cases. The Ministry will provide the necessary support – training, equipment and supplies to ensure that they provide free quality services. The entry point will be the Association of the Private Hospitals in Tanzania (APHTA).

Improve the scope and quality of DOTS

In order to achieve and sustain performance beyond the targets of 70% case detection 85% successful treatment, continued efforts are needed to

improve the quality of DOTS, through improvement of programme management, supervision, and laboratory services for sputum smear microscopy, and strengthening of human resources. This will ensure that all TB patients get early access to quality care and thus reducing transmission of the infection and deaths.

Furthermore, the Ministry will conduct a survey to determine the prevalence of TB in the general population. The findings of the survey will help to determine baseline and guide the process of reaching the MDG goals. This strategy will be implemented in collaboration with partners and other stakeholders including research institutions

Raise awareness among community members on TB and leprosy diseases

Correct knowledge of symptoms and signs of tuberculosis and leprosy will help patients and the community at large to prevent them from being infected and where necessary come early to health facilities for investigations and appropriate treatment. During this period, the major focus will be to increase the general knowledge of community members on TB, TB/HIV co-infection and leprosy through various means of communication and in collaboration with other stakeholders at different levels based on research. Similarly the Ministry will participate in international commemorations such as World TB Day and World Leprosy day.

TB management through quality-assured diagnosis (microscopy, culture and drug sensitivity testing) and standardized treatment

The programme will provide guidelines and manuals to help health workers to provide quality assured diagnosis and standardised treatment to TB and leprosy patients in all districts. Recognising the shortage of qualified staff at health facility level the Ministry will provide in-service training to health workers to improve their knowledge and skills in the management of these diseases. They will also be trained on infection control in hospital settings and clinics including improved ventilation, cough hygiene and personal protection.

An effective and regular drug supply with improved management capacity

Availability of high quality drugs and reagents for both TB and leprosy treatment all the time at health facilities will ensure that patients are correctly diagnosed, treated and cured. In the course of next 5 years, the Ministry will introduce 4-FDC and 2-FDC drug formulations in blister packets as provided by the Global Drug Facility (GDF). Similarly, the Ministry will continue monitoring the quality of anti-TB drugs imported into the country through MSD in with TFDA.

Scaling up screening of TB and HIV/AIDS co-infected patients and coordination

A steering committee will be established to coordinate these activities supported by technical committees at national, regional and district levels. TB/HIV coordinators will be recruited at the national and district levels to accelerate implementation of activities.

All AIDS patients on ARVs will be screened for tuberculosis with purpose of early diagnosis and treatment. VCT sites and CTCs will be the point of entry point for screening TB. All suspects will be referred to diagnostic centres for TB diagnosis and treatment. PLWHA without active TB will be given self-administered isoniazid prophylactic treatment for 9 months.

Likewise all TB patients will be offered diagnostic HIV testing with an "opt out" option. TB clinics will provide co-trimoxazole prophylaxis and antiretroviral therapy (ARVs) among eligible patients. The referral system will be strengthened to ensure that all TB patients with HIV co-infection have direct access to HIV care and support after completing their TB treatment.

Establish services for the management of drug-resistant tuberculosis

Until now, there is no treatment of MDR-TB in the country despite having TB patients who are not responding to the first line of anti-TB drugs. The Ministry is a DOTS-plus component within the regular DOTS program at Kibong'oto TB hospital. All patients with proven MDR-TB will be treated with a standardised second-line treatment regimen based on drug sensitivity testing (DST) surveillance results. Kibong'oto hospital is being rehabilitated to accommodate the new role by building a new TB ward at together with an attached laboratory and training personnel in the management of MDR-TB. A technical committee will be established to monitor management of MDR-TB in the country.

Equitable access to TB and leprosy services for all people, especially the poor and marginalized

This strategy aims to bring TB and leprosy services closer to communities that have difficulties accessing services due to geographical positioning or socio-economical barriers such as the poor, nomadic communities and those living in overcrowded small houses in squatter areas in urban areas.

Strengthen leprosy elimination campaigns and PoD activities in the country

The Ministry will conduct leprosy elimination campaigns in all districts with prevalence of more than 1 per 10,000 populations including areas with poor access to health services. Communities will be sensitised to come for screening during the campaigns and health workers will be orientated to clearly identify the signs of leprosy and its management.

Patients will be diagnosed will be initiated treatment immediately and followed up until completion of treatment and removal from registers. Those with disabilities will be trained on self-care and wherever necessary referred to higher levels for surgical care and rehabilitation. They will also be provided with protective footwear. The Ministry encourages participation of NGOs, CBOs, FBO and community members.

Improve TB and leprosy management information system to accommodate TB/HIV surveillance and gender disaggregating

The routine recording of TB cases and treatment outcome at district level will been computerised (electronic TB register) throughout the country to improve the quality of data captured, efficient cohort analysis and information management. Confidentiality of TB/HIV information will be given highest priority in line with standards for the security of HIV/AIDS data. Health workers including DOT nurses, laboratory staff, DTLCs and RTLCs will be trained and supervised to generate quality data which will be channelled to HMIS for routine planning and management at the district level. Finally efforts will be taken to adopt and scale up leprosy electronic register in the country.

Data collected will be analysed and disseminated quarterly at district, regional and national levels. Districts will be encouraged to give feedback to the respective health facilities – through annual reports, fact sheets etc.

An efficient monitoring system for programme supervision and evaluation including impact measurement

All health facilities providing TB and leprosy control activities will be supervised at least once every month to check on staff competence, provide on-the job training and check on the availability of necessary reagents and medicines for the treatment of patients. The supervisors will also check on completeness and quality of the registers and cards kept by the facility. Wherever possible, patients will be interviewed on the quality of services provided to them.

4.7.4 Annual Activities Targets

Overall targets

Control of Tuberculosis and leprosy aims at achieving the following overall targets. These Targets are annualized.

- Reduce prevalence associated by Tuberculosis by 50% by 2012
- Establish capacity to treat at least 20 patients with drug resistant TB (MDR – TB) according to WHO guidelines by 2012
- Endure that all eligible health facilities have an uninterrupted supply of anti-TB and anti-leprosy drugs and reagents by 2012
- 100% of TB patients and HIV/AIDS screened for co-infection in all districts by 2012

- Leprosy prevalence in the country from below 1 case per 10,000 population by 2012

4.7.5 Budget

The total budget for this component to meet the targets up to the year 2012, including tuberculosis and leprosy is attached.

4.8 Health Promotion and Education

Preamble

Health Education and Promotion is a means of increasing individual and community participation in health action. Its implementation involves Health communication/Education, Advocacy, Social or community mobilization, Information, Education and communication, mediation & Lobbying. The primary focus is on development of knowledge and skills leading to community empowerment for health improvement.

4.8.1 Situation Analysis

Health Education & Health Promotion in Primary Health care services

The coverage of Primary Health Care services is still unacceptably low. The target was to provide PHC services for all by the year 2000. Health and health related problems are unlimited as reflected by high BOD for both communicable and non-communicable diseases while resources are limited. Health seeking behaviour is poor, thus leading to high morbidity and mortality of diseases.

The health sector is striving to improve accessibility and quality care for the public. One of the strategies is to implement PHSDP. Social mobilisation and public awareness is a critical step in the success of the programme. Health Education and Health Promotion will enhance delivery of Primary health services to the community focusing on essential health interventions such as RCH, HIV & AIDS, TB and Malaria.

In order to facilitate smooth and sustainable implementation of the program (PHSDP), health education and promotion will:
Strengthen prevention of communicable and non-communicable diseases
Increase community awareness and health seeking behaviour
Increase community involvement, social mobilisation and participation in health services

4.8.2 Objectives

- To build capacity for communities and individuals to engage to the Health Education and health Promotion activities
- To adapt health practices and make health choices from available health services.

4.8.3 Strategies

Support all program components to enhance behaviour change for informed health choices and action

Promote advocacy for primary health care services and mobilize resources for the program

Build capacity on Health promotion & education/communication to all stakeholders.

Promote community involvement and participation in health activities

4.8.4 Annual Activities Targets

See Annex

4.8.5 Budget

The total budget for this component to meet the targets up to the year 2012 is attached.

4.9 Institutional Arrangements

National Level

Ministry of Health & Social Wealfare

At the National level, the Ministry of Health and Social Welfare will be responsible for:-

i) Overseeing the implementation of the Programme in collaboration with PMO – RALG.

ii) Formulating policy guidelines and strategies for implementation of the Programme

iii) Resource mobilisation for implementation of the programme.

iv) To support RS to build capacity of LGAs in the implementation of the Programme

v) Monitoring, reviewing and evaluation of the programme

vi) Overall coordination of the programme activities

vii) Quality assurance and regulation

PMO – RALG

The role of PMO – RALG is to oversee the proper functioning of the regional and district hospitals, health centres, dispensaries and community level health services. Under PHSDP, PMO – RALG – will be responsible for:-

i) Supervision of the implementation of the programme at LGAs level.

ii) Resource allocation to RS and LGAs

iii) Ensuring that LGAs prepare plans and budget of the programme

iv) Collaborating with the MoH&SW in the implementation of the Programme

REGIONAL LEVEL

The Regional Secretariat (RS) will interpret the policy guidelines; provide technical and advisory support to the LGAs in order to ensure proper implementation of the Programme. The Regional Secretariat will be responsible for:-

i) Supervising Programme Implementation

ii) Providing technical support to LGAs for the programme implementation

iii) Ensuring that the programme is incorporated in the Comprehensive Council Health Plans and Budget.

LOCAL GOVERNMENT AUTHORITIES (LGAs)

The overall objective of the health Policy in Tanzania is to improve the health and well-being of all Tanzanians, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. This policy objective is translated into this Programme whose focus will be at the LGA level in order to further extend and strengthen accessibility, provision and utilization of quality health services. The LGAs level will be responsible for:-

i) Management and delivery of Primary Health Care Services in the Council

ii) Incorporating the Programme in the Comprehensive Council Health Plan

iii) Implementation of the programme activities.

iv) Providing technical support to health centres and dispensaries.

v) Building capacity to health facility personnel on the Programme.

vi) Further strengthen participation of the community and other stakeholders in the Programme management.

vii) Preparation and submission of quarterly technical and financial report.

viii) Maintaining data bank for the programme activities.

ix) Enhance awareness of the community on health seeking behaviour and to use health services.

x) Reporting progress of implementation of the Programme to PMO-RALG and MoHSW through RS.

COMMUNITY INVOLVEMENT AND PARTICIPATION

The Programme will enhance and strengthen community involvement and participation in planning and implementation of programme. To ensure sustainability and create sense of ownership of the investment, the community will participate in the management of health facilities at the Council level through Council Health Services Boards, Hospital Governing Committees and Health Facility Committees of the Health Centres and Dispensaries.

COUNCIL HEALTH SERVICES BOARD

Through an instrument for establishing Council Health Services Board, the community will continue to be involved in the management of District Hospital and overseeing implementation of health development plans in the Council

The Council Health Services Boards will oversee implementation of Council Health Services by Council Health Management Teams (CHMTs).

HOSPITAL GOVERNING COMMITTEES

The Hospital Governing Committees will be responsible for:-

i) Management of resources of the hospital plans and budget before forwarding to Council Health Service Board;
ii) Receiving and deliberating reports prepared by Hospital Management Team;

iii) Identifying sources of funds for the running of the hospital;

iv) Collaborating with other health facilities committees and faith based organization in order to ensure better provision of health services;
v) Providing feed back to the community on the management, running of the hospital and development plans.

HEALTH CENTRE COMMITTEES

Responsibilities and duties:

i) Receive and approve implementation reports from Health centres management teams.

ii) Identify and avail resources and funding for the centres' operations.

iii) Collaborate with the Board and other stakeholders in the delivery and improvement of health services.
iv) Strengthening infrastructure for sustained medical supplies and health services provision.

v) Consult and advise the Board on matters relating to recruitment, training, staff development and fringe benefits.

vi) Assist the Health centre management teams in planning and supervision of community health programmes.

vii) Supervise and ensure the availability of essential medicines, medical supplies, reagents and equipment.

DISPENSARY COMMITTEE

i) Enhance and strengthen involvement and participation
ii) Ensure availability of quality and affordable health services

iii) Receive, determine and approve plans for the dispensary

iv) Identify and avail resources and funding for dispensaries operations

v) Collaborate with other health committees and stakeholders in the delivery of health services

vi) Consult and advise the Board on matters relating to recruitment, training, staff development and fringe benefits

vii) Assist dispensary management team in planning and supervision of community health programmes.

viii) Submit quarterly, bi annual and annual plan to the Board.

ix) Undertake any other responsibility as directed by Ward Development Committee.

Capacity Building

Providing equipment, tools and training for the management of the programme at different levels.
Provide support, technical backup, at different levels.

Sustainability of the programme

The implementation of this programme will follow the Government structures and the involvement of the community is a key element of the sustainability of the

programme. The implementation of the Programme will be part of the Comprehensive Council Health Plans

Availability of human resources at different levels and timely financial resources is a prerequisite to the sustainability of the programme.

4.9.1 Situation Analysis

The MoHSW is responsible for delivery of the health services in the country with a focus on the provision of health services by devolving powers to LGAs. The MoHSW supports the Regional Secretariats and LGAs on technical issues. In addition the Ministry of Health and Social Welfare advises the PMO-RALG on technical performance of the LGAs. Health service delivery in the country has shortfalls in quality of services provided and accessibility. Current demands in health services provision is to ensure that all Tanzanians are reached with quality health services

In order to address these demands, the Ministry is embarking on developing and implementation of a PHSD programme. The implementation of PHSDP will be under the Ministry of Health and Social Welfare in close collaboration with Prime Minister's Office – Regional Administration and Local Government and Local Government Authorities (LGAs)

The overall oversight of the programme will be lead by the Ministry of Health and Social Welfare. The Ministry will establish a Steering Committee which will be responsible for overall overseeing of the programme. The members of the Committee will be drawn from the MoH&SW, PMO – RALG, MoF, MPEE, NGOs and Private Sector. The Committee will be chaired by the Permanent Secretary MoHSW and Permanent Secretary from PMO-RALG will be the co-chair. The Steering Committee will have a technical committee which will be responsible for planning, coordination and monitoring of the Programme

4.9.2 Objective

The overall objective of the institutional arrangement is coordination and management

4.9.3 Strategies

i) The national Steering Committee (SC) and the Programme Implementation Unit (PIU) will be appointed by MOH&SW in collaboration with the PMO-RALG.

ii) The ToRs and number of staff for the PIU will be developed at a later stage but the specialists needed for the PIU include Project Manager with construction and rehabilitation experience, Health Facility

Architect, Quantity Surveyor, Structural Engineer, Services Engineer, Public Health Specialist, Sociologist, Administrator, Accountant, and supporting staff

i) The PIU will act as the sub-technical committee, will coordinate the Consultants and support the relevant committees. They will be responsible for quality assurance of the outputs and technical reports.

ii) The PIU during the implementation will develop a procurement plan and procurement cycle. In addition, will monitor the procurement process in line with the programme Gantt chart.

iii) The RS will inspect their respective districts to ensure compliance to the specifications and timely implementation of the programme activities.

iv) The Works Department under the LGAs will be responsible for the day-to-day supervision (Clerk of Works) of the Health Centres and Dispensaries. In addition, to oversee the construction and rehabilitation of district hospitals.

v) It is also proposed to appoint the Main Consultant and, Sub Consultants to provide consultancy services for works' supervision / inspection to the constructions of the health facilities.

vi) Contractors will implement all constructions, extensions and rehabilitations through competitions in line with the Public Procurement Acts 2004 and Regulations 2005

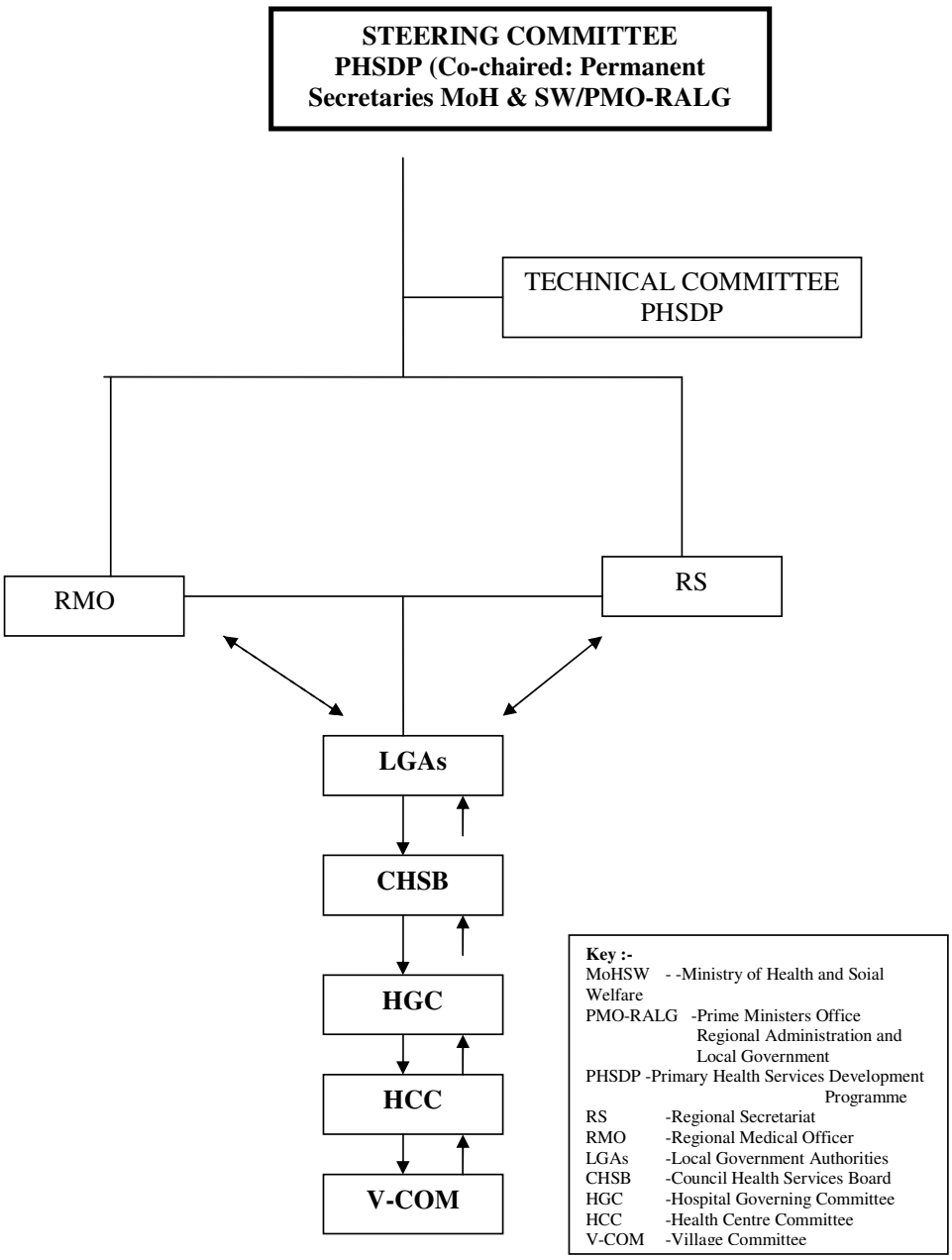
4.9.4 Annual Activities Targets

The Steering Committee and Programme Implementation Unit (PIU) appointed, and Regional Secretariat Teams and Local Authority Teams all together operationalized during the implementation period

4.9.5 Budget

The total budget for this component to meet the targets up to the year 2012 is attached.

INSTITUTIONAL FRAMEWORK FOR PHSDP IMPLEMENTATION



4.10 Other Communicable and Non Communicable Diseases

4.10.1 Situational Analysis

Neglected Tropical Diseases

Introduction

Though the country faces a number of challenges in combating non communicable and communicable diseases, there is also good reason for optimism that the following diseases can be controlled and eliminated as public health problems through integrated mass drug administration capitalizing on existing drug donation programs. Among these facilitating factors are: a) a strong commitment by the Ministry of Health[11] to address these diseases on a large scale; b) the geographic overlap of many of these diseases; c) the existence of on-going national control programs for all five NTDs; d) a number of platforms from which integrated disease control could be launched including school health, and the national vitamin A supplementation program, and; e) the commitment of governmental and non-governmental organizations to work as a consortium.

Onchocerciasis

Onchocerciasis is present in 7 areas of the country, putting approximately two million people at risk[12]. In most areas, control efforts started in 1999 and will need to be sustained for 15-20 years at a 65% therapeutic coverage rate. Onchocerciasis is controlled through Community-Directed Treatment of Ivermectin (CDTI), a program that has successfully integrated other interventions, such as lymphatic filariasis and bed nets, and upon which other distribution programs (e.g. for trachoma) have been modeled. The onchocerciasis control program is managed by the National Eye Care Program. It is supported by NGDO partners HKI, IMA, SSI and Rotary International

Lymphatic Filariaisis

Rapid mapping for lymphatic filariasis (LF) indicates that the whole country is endemic. The coastal region is suspected to bear the highest burden of disease, with prevalence rates of up to 45%, as found on Mafia Island. Onchocerciasis and LF overlap in all the onchocerciasis-endemic regions, and there has been some success in integrating the respective

[11] Ministry of Health issued a statement in September 2006 which stated that "The importance of addressing the Neglected Tropical Diseases at the moment needs to be underscored if we want to raise the economies of scale. This is central to economic development of our countries if we want to meet our goals in the Strategy for Growth and Poverty Reduction by 2010"

[12] National Onchocerciasis Control program, National Strategic Plan Draft Document 2006-2010, MOHSW

interventions, particularly in the Tanga region in the northeastern part of the country. The LF program is managed by the National LF Program.

Soil Transmitted Helminthes
The predicted prevalence of soil transmitted helminthes (STH) is between 20-49% in most of the country, with some areas predicted to be over 50%. The main intestinal parasites includeThe problem of STHs overlaps with all the other diseases. School age children are targeted for control efforts due to the high prevalence of STHs among that group. A national de-worming program for children under 5 has been integrated into the current Vitamin A supplementation program implemented through twice a year child health days since 2004. Tanzania has maintained a VAS and de worming coverage of approximately 90% since the start of the Child Health Days. (TFNC survey 2004)

Schistosomiasis
Schistosomiasis has a predicted prevalence of over 50% in over half the country, particularly in the six regions around Lake Victoria and Taganyika, the four coastal regions including Dar es Salaam, and Zanzibar and Pemba. Schistosomiasis overlaps in regions endemic with all of the other diseases. As with STHs, the greatest disease burden is among school children. The National Schistosomiasis Control Programme (NSCP) is based under the Reproductive and Child Health division within the Ministry of Health and collaborate with the Ministry of Education and Vocational Training. Drug treatment with Praziquantel and Albendazole was administered to 11 endemic regions in the country in 2005 by the MOH, in partnership with the Schistosomiasis Control Initiative (SCI).

Trachoma
Active trachoma is endemic in 43 districts (prevalence >10%) in Tanzania, with prevalence rates as high as 64% in some districts. Control efforts follow the WHO-endorsed SAFE strategy (**S**urgery for in-turned eyelids, **A**ntibiotics for active disease, **F**acewashing to prevent infection, and **E**nvironmental change as another preventive measure). As onchocerciasis, trachoma is overseen by the National Eye Care Program. Zithromax is managed by the International Trachoma Initiative (ITI) with the actual distribution

4.10.2 Objectives

To reduce the budern of neglected tropical diseases by 80% by 2012

4.10.3 Strategies

The government and private entities (e.g. NGOs and donors) are currently involved in combating these diseases through vertical disease control

programs. The outcome tailored to the needs of communities aimed at integrated into council health plans for implementation at district level. These plans will reduce duplication of effort; maximize effective use of resources and sustainability.

The control of these diseases are developed, coordinated and implemented via the Ministries of Health& Social Welfare and Education to reduce the disease burden to a level that they will no longer be of public health problem in the respective communities. Implementations of the programs occur at district level by ensuring that annual treatment for the appropriate neglected tropical diseases is carried out.

i) The National Trachoma Control Program (NTCP) under the **National Eye care Program (NECP)** deliver the SAFE strategy to control and treat active trachoma—which has improved the capacity of public health systems in PPP with ITI Since 1998, ITI in collaboration with MoHSW has managed the implementation of the SAFE strategy, endorsed by the World Health Organization (WHO) and comprising four elements:
ii) Surgery to correct advanced stages of the disease;
iii) Antibiotics to treat active infection and interrupt the cycle of infection;
iv) Face washing to reduce disease transmission; and,
v) Environmental change to increase access to clean water and improved sanitation.

The A component is achieved by the Pfizer donated Xithromax where **MDA** is done in communities where trachoma is more than 10%.

i) The control of **Schistosomiasis** is undertaken through the **School Health Program (SH P).** Praziquantel is the drug of choice. The delivery is by MDA or distribution through schools. At the moment Praziquantel is provided by the Schistosomiasis Control Initiative **(SCI)**. Albendazole and/or mebendazole are the drugs of choice for

treatment of hookworm, Ascaris and Trichuris. An annual treatment is done while distributing drugs for Schistosomiasis.

ii) Lymphatic Filariasis **(LF)** is controlled through the **Lymphatic Filariasis Control Program** (LFCP) Albendazole and Ivermectin are delivered annually for 5-8 years to every individual (except pregnant women and children under 5) in an endemic area it is expected that LF will be brought down to the specified levels for elimination by the WHO (to achieve local interruption of LF transmission, as targeted by the Global Agency of Elimination of LF, (GAELF). Ivermectin (Mectizan®) is donated by Merck and Albendazole is donated by GSK.

iii) **Onchocerciasis** is controlled through the National Onchocerciasis Control Program .Treatment with Merck & Co donated Ivermectin (Mectizan®) is offered to populations in endemic areas annually to prevent the symptoms and transmission of Onchocerciasis by killing of microfilariae.

All these programs have different mechanisms for chemotherapy distributions which is coupled by **Vector elimination efforts** through the **Vector Control unit**. LF distributes to children under 5 and adults, trachoma to children 6 months and older (tetracycline can be given to infants, but azithromycin only to children over 6 months and adults). STH and Schistosomiasis program is school-based, while LF, Onchocerciasis and trachoma are community-based.

5.0 LOGICAL FRAMEWORK

5.1 Annual Activity Targets

The attached Annex 1, physical implementation summary shows the outputs.

5.2 Financial Outlays

The attached Annex 2, financial outlays shows the resource requirements.

Annex 1

ANNUAL ACTIVITY TARGETS

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
District Health System	Rehabilitation, construction and upgrading of 8107 primary health care facilities, 62 district hospitals and 128 training institutions, including construction of new training institution by year 2012.	2,432 Primary Health Care Facilities, 19 district hospitals, 38 training institutions constructed, rehabilitated and upgraded.	1,621 Primary Health Care Facilities, 12 district hospitals, 26 training institutions constructed, rehabilitated and upgraded	1,621 Primary Health Care Facilities, 12 district hospitals, 26 training institutions constructed, rehabilitated and upgraded	3,242 Primary Health Care Facilities, 24 district hospitals, 52 training institutions constructed, rehabilitated and upgraded	810 Primary Health Care Facilities, 6 district hospitals, 13 training institutions constructed, rehabilitated and upgraded
	To strengthen 2,555 health centers by constructing theatres and providing them with necessary medical equipment and furniture by year 2012		767 Health Centres strengthened	511 Health Centres strengthened	1,022 Health Centres strengthened	255 Health Centres strengthened
	To equip and furnish 8,189 health facilities		2,457 Health Facilities equipped and furnished	1,638 Health Facilities equipped and furnished	3,276 Health Facilities equipped and furnished	18 Health Facilities equipped and furnished
	To strengthen outreach services by providing 2563 ambulances, 140 supervision	769 Ambulances, 42 Vehicles, 34 Mobile Clinics and 767 motor cycles procured and		513 Ambulances, 28 Vehicles, 23 Mobile Clinics and 511 mortar cycles procured	1026 Ambulances, 56 Vehicles, 46 Mobile Clinics and 1022 mortar	255 Ambulances, 14 Vehicles, 10 Mobile Clinics and 255 mortar cycles procured

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	vehicles, 113 mobile clinics and 2,555 motor cycles	distributed		and distributed	cycles procured and distributed	and distributed
HUMAN RESOURCE	Increase output for most needed cadres (Pharm. Tech, Radiology, Health off, Community Social Workers ,Lab. Tech. AMO. Enrolled Nurses (NM) , Clinical Officers (CO) and Registered Nurses	Feasibility study to construct and expand 11 multipurpose training centres (8 zonal training centres and Tanga, Tabora and (Sumbawanga)	5 Multipurpose training centres completed	4 Multipurpose training centres construction and expansion completed 5 Multipurpose training centres fully furnished and in use by students	2 Multipurpose training centres construction and expansion completed 4 Multipurpose training centres fully furnished and in use by students	2 Multipurpose training centres fully furnished completed and in use complex used at full capacity by students
	Expand training intake in the existing Training Institutions by 100%	Increase intake by 10%	Increase intake by 15%	Increase intake by 25%	Increase intake by 25%	Increase intake by 25%
	Re open 4 MCHA schools for Enrolled Nurses Midwife	Rehabilitate and Full Furnish 4 Institution (Tunduru and Kibondo Nachingwea and Nzega)	Admit first intake 160 students	Admit second intake 160 students	Admit third intake 160 students	Admit fourth intake 160 students
	Train and acquire 500 tutors	Train 100 tutors	Train 100 tutors	Train 100 tutors	Train 100 tutors	Train 100 tutors
	Obtain adequate clinical instructors	On site training conducted to districts and regional centres	On site training conducted to districts and regional centres	On site training conducted to 27 referral and regional centres	On site training conducted to 27 referral and regional centres	On site training conducted to 27 referral and regional centres
	Rehabilitate 20 Health Institutions	Rehabilitate 5 Institutions	Rehabilitate 5 Institutions	Rehabilitate 5 Institutions	Rehabilitate 5 Institutions	Rehabilitate 5 Institutions

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Capacity building for existing Health Workers on new technological advancement in health.	Comprehensive training needs conducted	Refresher course conducted to 1,000 staff	Refresher course conducted to 1000 staff	Refresher course conducted to 1000 staff	Refresher course conducted to 1000 staff
	Ensure increase of recruitment and deployment of staff Medical doctors, CO, Nurse Midwives, AMOs, Lab Tech.	Recruitment of 21,692	Recruitment of 21,877	Recruitment of 21877	Recruitment of 21877	Recruitment of 21707
	Institute differential incentive package to all Districts	Incentive package established /developed	Incentive package applied to 25% of all districts	Incentive package applied to 50% of all districts	Incentive package applied to 75% of all districts	Incentive package applied to 100% of all districts
	Improve working environment	Occupational Health safety promoted to 20% of all health facilities	Occupational Health safety promoted to 20% of all health facilities	Occupational Health safety promoted to 20% of all health facilities	Occupational Health safety promoted to 20% of all health facilities	Occupational Health safety promoted to 20% of all health facilities
	Devise work place motivational programme for all districts	Workplace motivational programme developed	Workplace motivational programme implemented by 50% to the hardship districts	Workplace motivational programme implemented by 50% to the hardship districts	Workplace motivational programme implemented by 50% to the non-hardship districts	Workplace motivational programme implemented by 50% to the non-hardship districts

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Improve establishment by 50% to reduce the current ratio of skilled staff to population by 2012	Review existing establishment and advocate its implementation	Reduce the ratio for skilled workforce to population by 15%	Reduce the ratio for skilled workforce to population by 30%	Reduce the ratio for skilled workforce to population by 40%	Reduce the ratio for skilled workforce to population by 50%
	Recall capable retired skilled health workers to provide services	Provide contract to capable retired skilled health workers to provide services	Provide contract to capable retired skilled health workers to provide services	Provide contract to capable retired skilled health workers to provide services	Provide contract to capable retired skilled health workers to provide services)	Provide contract to capable retired skilled health workers to provide services
MATERNAL HEALTH	**To reduce maternal mortality from 578 to 220 per 100,000 live births by 2012**	**2, 000** service providers trained in maternal and newborn care	**2, 200** service providers trained in maternal and newborn care	**1, 800** service providers trained in maternal and newborn care	**1,000** service providers trained in maternal and newborn care	**1,000** service providers trained in maternal and newborn care
		200 tutors trained from various schools and health institutions on maternal and newborn care	**200** tutors trained from various schools and health institutions on maternal and newborn care	**200** tutors trained from various schools and health institutions on maternal and newborn care	**200** tutors trained from various schools and health institutions on maternal and newborn care	Follow up of 50% of trained service providers in all regions

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
		Procurement of Essential Equipment, for maternal and newborn care and tools for health facility in **60** districts (hospitals, health centers & dispensary)	Procurement of Essential Equipment, for maternal and newborn care and tools for health facility in facility and community for **60** districts (hospitals, health centers & dispensary)	Procurement of Essential Equipment, for maternal and newborn care and tools for health facility in **60** districts(hospitals, health centers & dispensary)		
		Renovation and building operating theatres , labour wards, RCH Clinics, including staff houses for **40 Health centers**	Renovation and building operating theatres , labour wards, RCH Clinics, including staff houses for **40 Health centers**	Renovation and building operating theatres , labour wards, RCH Clinics, including staff houses for **40 Health**	Construction of operating theatres , labour wards, RCH Clinics, including staff houses for **New 52 Health centers**	
		Establishment of maternity waiting homes in **30 districts**	Establishment of maternity waiting homes in **20 districts**	Establishment of maternity waiting homes in **38 districts**	Establishment of maternity waiting homes in **10 districts**	Establishment of maternity waiting homes in **10 districts**
		Procurement and distribution of radio calls and ambulances to be station in selected health facilities(hospitals, health centers) in each districts				

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
		Provision of a pair of Kanga voucher to 1.4million pregnant to attract women to deliver in health facilities	Provision of a pair of Kanga voucher to **1.4million pregnant women**	Provision of a pair of Kanga voucher to **1,450,000** pregnant women	Provision of a pair of Kanga voucher to **1.500,000** pregnant women	Provision of a pair of Kanga voucher to **1,550,000** pregnant women
		Establish community health workers for Maternal and Newborn care in **800** villages	Establish community health workers for Maternal and Newborn care in **1000** villages	Establish community health workers for Maternal and Newborn care in **1200** villages	Establish community health workers for Maternal and Newborn care in **1400** villages	Establish community health workers for Maternal and Newborn care in **1600** villages
		Empowerment of TBAs through capacity building in **20 districts** (disadvantage/remote)	Empowerment of TBAs through capacity building **in 30 districts** (disadvantage/remote)	Empowerment of TBAs through capacity building in **30 districts** (disadvantage/remote)	Empowerment of TBAs through capacity building in **10 districts** (disadvantage/remote)	Follow-up of TBA and other community health workers in all regions
	To increase coverage of births attended by skilled attendants from 46% in 2006 to 80% by2012	Recruitment and deployment of; 10,000Nurse Midwives 100AMOs, 2,000CO, 100 Lab tech, 100Anesthetists, 200 Medical Doctors in to the existing and new health facilities.	Recruitment and deployment of; 7,000Nurse Midwives 100AMOs, 2,000CO, 100 Lab tech, 100 Anesthetists, 200 Medical Doctors in to the existing and new health facilities.	Recruitment and deployment of; 7,000 Nurse Midwives 100AMOs, 2,000CO, 100 Lab tech, 100Anesthetists, 200 Medical Doctors in to the existing and new health facilities.	Recruitment and deployment of; 7,000 Nurse Midwives 100AMOs, 2,000CO, 100 Lab tech, 100Anesthetists, 100 Medical Doctors in to the existing and new health facilities.	-

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
		Designing practical training exposure to clinical officers and AMOs on emergency obstetric care to minimize maternal mortality rate On site training conducted to 27 referral and regional centers.	On site training conducted to 27 referral and regional centers	On site training conducted to 27 referral and regional centers	On site training conducted to 27 referral and regional centers	On site training conducted to 27 referral and regional centers
HIV/AIDS	Reduce HIV prevalence by 50% from the current level of 7% by 2012	Increase access to Testing and counseling from 15% to 17% of the population 15 – 49 years	Increase access to Testing and counseling from 17% to 20% of the population 15 – 49 years	Increase access to Testing and counseling from 20% to 25% of the population 15 – 49 years	Increase access to Testing and counselling from 25& to 30% of the population 15 – 49 years	Increase access to Testing and counselling from 30% to 35% of the population 15 – 49 years
		Distribute 60,000,000 pcs condom through public sector	Distribute 80,000,000 pcs condom through public sector	Distribute 100,000,000 pcs condom through public sector	Distribute 150,000,000 pcs condom through public sector	Distribute 200,000,000 pcs condom through public sector
		Increase coverage of quality STI services from 70% to 75% (of existing health facilities)	Increase coverage of quality STI services from 75% to 80%	Increase coverage of quality STI services from 80% to 85%	Increase coverage of quality STI services from 85% to 90%	Increase coverage of quality STI services from 90% to 95%

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To strengthen HIV/AIDS Care and treatment services to cover 600,000 patients by 2012	Increase coverage of HBC in 5 to 10 facilities per district from the current 70 districts to 80 districts	Establish HBC services in 5 to 10 facilities in 10 new districts	Establish HBC services in 5 to 10 facilities in 15 new districts	Establish HBC services in 5 to 10 facilities in 15 new districts	Establish HBC services in 5 to 10 facilities in 17 new districts
		Increase coverage of PMTCT services from the current 12% to 20%	Increase coverage of PMTCT services from 20% to 30%	Increase coverage of PMTCT services from 30% to 40%	Increase coverage of PMTCT services from 40% to 50%	Increase coverage of PMTCT services from 50% to 60%
		Increase number of patients on ART from 70,000 to 150,000	Increase number of patients on ART from 150,000 to 200,000	Increase number of patients on ART from 200,000 to 300,000	Increase number of patients on ART from 300,000 to 450,000	Increase number of patients on ART from 450,000 to 600,000.
		Provide 3,500,000 HIV test Kits	Provide 3,600,000 HIV test Kits	Provide 3,700,000 HIV test Kits	Provide 3,900,000 HIV test Kits	Provide 4,000,000 HIV test Kits for all testing needs
		Procure 3,000 CD4 reagent kits for 123 CD4 count machines	Procure 5,000 CD4 reagent kits for 123 CD4 count machines	Procure 8,000 CD4 reagent kits for 123 CD4 count machines	Procure 10,000 CD4 reagent kits for 123 CD4 count machines	Procure 12,000 CD4 reagent kits for 123 CD4 count machines
		Procure 200,000 tests of Haematology for 123 Haematology machines	Procure 400,000 tests of Haematology for 123 Haematology machines	Procure 600,000 tests of Haematology for 123 Haematology machines	Procure 800,000 tests of Haematology for 123 Haematology machines	Procure 1,000,000 tests of Haematology for 123 Haematology machines
		Procure 200,000 tests of Chemistry	Procure 400,000 tests of Chemistry	Procure 600,000 tests of Chemistry	Procure 800,000 tests of Chemistry	Procure 1,000,000 tests of Chemistry

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
		Ensure service of laboratory equipments of 200 Health facilities	Ensure service of laboratory equipments of 200 Health facilities	Ensure service of laboratory equipments of 200 Health facilities	Ensure service of laboratory equipments of 200 Health facilities	Ensure service of laboratory equipments of 200 Health facilities
		Increase basic knowledge about HIV/AIDS from the current 78% to 80%	Increase basic knowledge about HIV/AIDS from 80% to 85%	Increase basic knowledge about HIV/AIDS from 85% to 90%	Increase basic knowledge about HIV/AIDS from 90% to 95%	Increase basic knowledge about HIV/AIDS from 95% to 98%
		Create awareness and knowledge on comprehensive HIV/AIDS package for prevention care and treatment by 10%	Create awareness and knowledge on comprehensive HIV/AIDS package for prevention care and treatment by 15%	Create awareness and knowledge on comprehensive HIV/AIDS package for prevention care and treatment by 20%	Create awareness and knowledge on comprehensive HIV/AIDS package for prevention care and treatment by 20%	Create awareness and knowledge on comprehensive HIV/AIDS package for prevention care and treatment by 20%
MALARIA	To raise community health seeking behaviour for fever treatment within 24hrs from 25% to 80% by 2012	25% of fever cases treated within 24hrs of onset of fever	35% fever cases treated within 24hrs of onset of fever	45%fever cases treated within 24hrs of onset of fever	65%fever cases treated within 24hrs of onset of fever	80%fever cases treated within 24hrs of onset of fever
	To raise Laboratory diagnosis for malaria from 20% to 80%	20% of malaria cases have laboratory confirmation	40% of malaria cases have laboratory confirmation	50% of malaria cases have laboratory confirmation	60% of malaria cases have laboratory confirmation	80% of malaria cases have laboratory confirmation

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To improve availability for antimalarial drugs and laboratory reagents to 90% by 2012	70% of health facilities have no stock out of drugs and reagents	75 of health facilities have no stock out of drugs and reagents	80% of health facilities have no stock out of drugs and reagents	85% of health facilities have no stock out of drugs and reagents	90% of health facilities have no stock out of drugs and reagents
	To raise the use of SP for Intermittent Preventive Treatment (IPT) in pregnancy from 44% to 80% by 2012	44% of pregnant women take 2 doses of SP	60% pregnant women take 2 doses of SP	65% pregnant women take 2 doses of SP	70% pregnant women take 2 doses of SP	80% pregnant women take 2 doses of SP
	To improve stock in of SP to 100% availability in primary health facilities.	80% of health facilities have SP available	100% health facilities have SP available	100% health facilities have SP available	100% health facilities have SP available	100% health facilities have SP available
	To raise community awareness on various malaria vector control measures to a knowledge level of 90% by 2012	50% of population aware of mosquito preventive measures	60% of population aware of mosquito preventive measures	70% of population aware of mosquito preventive measures	80% of population aware of mosquito preventive measures	90% of population aware of mosquito preventive measures
	To raise the use of ITNs by vulnerable groups (Pregnant women and Children) from 23% to 80% by 2012	23% of households have at least 1 Insecticide Treated Net	50% households have at least 1 Insecticide Treated Net	60% households have at least 1 Insecticide Treated Net	80% households have at least 1 Insecticide Treated Net	100% households have at least 1 Insecticide Treated Net

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To introduce indoor residual spraying (IRS) in all epidemic prone districts, and to 25% of the endemic districts in the country by 2012	2% of the districts implementing IRS	10% of the districts implementing IRS	20% of the districts implementing IRS	30% of the districts implementing IRS	40% of the districts implementing IRS
	To raise community awareness in epidemic prone districts on recognition and early reporting of malaria epidemics to a level of knowledge of 90% by 2012	20% of population in epidemic prone districts recognizes characteristics of malaria epidemics	40 population in epidemic prone districts recognizes characteristics of malaria epidemics	60 population in epidemic prone districts recognizes characteristics of malaria epidemics	70 population in epidemic prone districts recognizes characteristics of malaria epidemics	90 population in epidemic prone districts recognizes characteristics of malaria epidemics
	To maintain in 25 epidemic prone districts a system for early detection and early reporting of malaria epidemics by 2012	75% of epidemic prone districts have a system for early detection and reporting of malaria epidemics	80% of epidemic prone districts have a system for early detection and reporting of malaria epidemics	85% of epidemic prone districts have a system for early detection and reporting of malaria epidemics	90% of epidemic prone districts have a system for early detection and reporting of malaria epidemics	100% of epidemic prone districts have a system for early detection and reporting of malaria epidemics

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To have in 25 epidemic prone districts a contingency stock of equipment, supplies of drugs and insecticides for early containment of malaria epidemics by 2012	40% epidemic prone districts have a contingency stock of equipment, supplies of drugs and insecticides for early containment of malaria epidemics	50% epidemic prone districts have a contingency stock of equipment, supplies of drugs and insecticides for early containment of malaria epidemics	70% epidemic prone districts have a contingency stock of equipment, supplies of drugs and insecticides for early containment of malaria epidemics by	90% epidemic prone districts have a contingency stock of equipment, supplies of drugs and insecticides for early containment of malaria epidemics	100% epidemic prone districts have a contingency stock of equipment, supplies of drugs and insecticides for early containment of malaria epidemics
	.To raise community awareness on all malaria control intervention to achieve a an awareness level of 80% by 2012	30% of population knowledgeable on all malaria control interventions	40 % of population knowledgeable on all malaria control interventions	50% of population knowledgeable on all malaria control interventions	60% of population knowledgeable on all malaria control interventions	80% of population knowledgeable on all malaria control interventions
	To conduct monitoring and supervision at least once a year, every year up to 2012					

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
TUBERCULOSIS	To reduce prevalence and death rates associated by Tuberculosis by 50% by 2012	Conduct survey to establish magnitude and deaths due to tuberculosis	40% of all health centres and hospitals including private sector have capacity to provide quality diagnosis of TB and successfully treat 85% of patients	60% of all health centres and hospitals including private sector have capacity to provide quality diagnosis of TB and successfully treat 85% of patients	80% of all health centres and hospitals including private sector have capacity to provide quality diagnosis of TB and successfully treat 85% of patients	100% of all health centres and hospitals including private sector have capacity to provide quality diagnosis of TB and successfully treat 85% of patients
		Train 500 in-service health workers (nurses, clinical officers, doctors and laboratory technicians) in TB and leprosy control	Train 1,000 in-service health workers (nurses, clinical officers, doctors and laboratory technicians) in TB and leprosy control	Train 1,000 in-service health workers (nurses, clinical officers, doctors and laboratory technicians) in TB and leprosy control	Train 1,000 in-service health workers (nurses, clinical officers, doctors and laboratory technicians) in TB and leprosy control	Train 1,000 in-service health workers (nurses, clinical officers, doctors and laboratory technicians) in TB and leprosy control
	To establish national capacity to treat 100 patients with drug resistant TB according to WHO guidelines by 2012	Strengthen Kibong'oto hospital infrastructure to provide MDR-TB care	Maintain infrastructure of Kibong'oto strengthened to provide MDR-TB care	Maintain infrastructure of Kibong'oto strengthened to provide MDR-TB care	Maintain infrastructure of Kibong'oto strengthened to provide MDR-TB care	Maintain infrastructure of Kibong'oto strengthened to provide MDR-TB care
		At least 20 MDR-TB patients managed at Kibong'oto hospital	At least 20 MDR-TB patients managed at Kibong'oto hospital	At least 20 MDR-TB patients managed at Kibong'oto hospital	At least 20 MDR-TB patients managed at Kibong'oto hospital	At least 20 MDR-TB patients managed at Kibong'oto hospital

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To strengthen laboratory capacity to detect drug resistant tuberculosis and conduct surveillance by 2012	3 referral hospitals have capacity to detect drug resistant tuberculosis (MDR-TB)	All 4 referral hospitals have capacity to detect drug resistant tuberculosis	All 4 referral hospitals have capacity to detect drug resistant tuberculosis and conduct surveillance	Monitor drug resistant tuberculosis in the country	Monitor drug resistant tuberculosis in the country
	To provide anti-TB and anti-leprosy drugs in all eligible health facilities by 2012	Procure anti-TB drugs for 65,000 patients and anti-leprosy drugs for 5,000 patients	Procure anti-TB drugs for 65,000 patients and anti-leprosy drugs for 5,000 patients	Procure anti-TB drugs for 65,000 patients and anti-leprosy drugs for 5,000 patients	Procure anti-TB drugs for 65,000 patients and anti-leprosy drugs for 5,000 patients	Procure anti-TB drugs for 65,000 patients and anti-leprosy drugs for 5,000 patients
		90% of the eligible health facilities have no stock-out of anti-TB and anti-leprosy drugs for more than 3 months.	95% of the eligible health facilities have no stock-out of anti-TB and anti-leprosy drugs for more than 3 months	100% of the eligible health facilities have no stock-out of anti-TB and anti-leprosy drugs for more than 3 months	None of the eligible health facilities have stock-out of anti-TB and anti-leprosy drugs for more than one month	None of the eligible health facilities have stock-out of anti-TB and anti-leprosy drugs for more than one month
	To expand screening of patients co-infected with tuberculosis and HIV/ in all districts by 2012	Introduce screening of TB and HIV/AIDS in 25 districts	Introduce screening of TB and HIV/AIDS in 45 districts	Introduce screening of TB and HIV/AIDS in 80 districts	Introduce screening of TB and HIV/AIDS in 105 districts	Introduce screening of TB and HIV/AIDS in all districts

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To eliminate leprosy as a public health problem in the country from 1.2 to below 1 case per 10,000 population by 2012	Conduct leprosy elimination campaigns in 10 high burden districts	Conduct leprosy elimination campaigns in 10 high burden districts	Conduct leprosy elimination campaigns in 10 high burden districts	Conduct leprosy elimination campaigns in 10 high burden districts	Conduct leprosy elimination campaigns in 10 high burden districts
	To strengthen the quality of TB and leprosy information system in all districts by 2012	Introduce an updated and computerised TB/leprosy health information system in 40 districts	An updated and efficient NTLP management information system in place and functional in 60 districts	An updated and efficient NTLP management information system in place and functional in 80 districts	An updated and efficient NTLP management information system in place and functional in 100 districts	An updated and efficient NTLP management information system in place and functional in all districts
	To create awareness of community members on various tuberculosis and leprosy control measures from 30% to 80% by 2012	40% of community members knowledgeable of various TB and leprosy control measures	50% of community members knowledgeable of various TB and leprosy control measures	60% of community members knowledgeable of various TB and leprosy control measures	70% of community members knowledgeable of various TB and leprosy control measures	80% of community members knowledgeable of various TB and leprosy control measures
	To monitor and evaluate TB and leprosy control activities in all districts by 2012	Supervision and monitoring of TB and leprosy control activities done in at least 50% of all districts	Supervision and monitoring of TB and leprosy control activities done in at least 100% of all districts	Supervision and monitoring of TB and leprosy control activities done in at least 100% of all districts	Supervision and monitoring of TB and leprosy control activities done in at least 100% of all districts	Monitoring and evaluation of TB and leprosy control activities done in at least 50% of all districts.
Institutional arrangement	To build the capacity of MOHSW and PMO	PIU recruited	4 Steering Committee Meeting and 12 Programme	4 Steering Committee Meeting and 12	4 Steering Committee Meeting and 12	4 Steering Committee Meeting and 12

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	RALG in coordinating and managing PHSDP by recruiting PIU		Review Meetings conducted	Programme Review Meetings conducted	Programme Review Meetings conducted	Programme Review Meetings and End of the Programme Evaluation conducted
Health Promotion and Education	Support all program components to enhance behaviour change for informed health choices and action	Consultancy to map behaviors related to Program components conducted	Key messages and IEC materials for the program components Developed and disseminated	Develop key messages and IEC materials for the program components	Review key messages and IEC materials and technical assistance provided	Review key messages and IEC materials and technical assistance provided
	Promote advocacy for primary health care services and mobilize resources for the program	Capacity building to all zonal & all regional centres for human resources development for promoting advocacy and mobilization of resources conducted.	Advocacy for implementation of MMAM to all councils	Advocacy for implementation of MMAM to all councils	Advocacy for implementation of MMAM to all councils	Advocacy for implementation of MMAM to all councils
	Build capacity on Health promotion and education/communication to all stakeholders.	Retooling Health education section with audiovisual equipment and mobile communication unit to support MMAM implementation	Capacity building and technical assistance to the lower levels of MMAM implementation	Capacity building and technical assistance to the lower levels of MMAM implementation	Capacity building and technical assistance to the lower levels of MMAM implementation	Capacity building and technical assistance to the lower levels of MMAM implementation

Components	Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Promote community involvement and participation in health activities	Capacity building to all Zones and RS to support LGAs staff	Capacity building to all Zones and RS to support LGAs staff	Capacity building to all Zones and RS to support LGAs staff	Capacity building to all Zones and RS to support LGAs staff	Capacity building to all Zones and RS to support LGAs staff
Neglected Diseases	To reduce the burden of neglected tropical diseases by 80% by 2012	1. Mapping of all Neglected tropical diseases. 2. Training of health workers on integration approaches	Access to prevention, treatment and control of neglected tropical diseases (e. g Trachoma, Onchocerciasis, Lymphatic filariasis, schistosomiasis, plague, trypanosomiasis, helminthic infections etc.) increased by 70% from the current level of 65% by 2010	Access to prevention, treatment and control of neglected tropical diseases (e. g Trachoma, Onchocerciasis, Lymphatic filariasis, schistosomiasis, plague, trypanosomiasis, helminthic infections etc.) increased by 75% from the current level of 70% by 2010	Access to prevention, treatment and control of neglected tropical diseases (e. g Trachoma, Onchocerciasis, Lymphatic filariasis, schistosomiasis, plague, trypanosomiasis, helminthic infections etc.) increased by 80% from the current level of 75% by 2010	Access to prevention, treatment and control of neglected tropical diseases (e. g Trachoma, Onchocerciasis, Lymphatic filariasis, schistosomiasis, plague, trypanosomiasis, helminthic infections etc.) to a level that is not a public health problem

FINANCIAL OUTLAY TSHS.'000

Annex 2

COMPONENTS	YEAR 1-2('000)	YEAR 3-4('000)	YEAR 5-6('000)	YEAR 7-8('000)	YEAR 9-10('000)	TOTAL('000)
HUMAN RESOURCE FOR HEALTH	24,380,000	118,976,930	154,549,740	174,979,740	145,949,740	618,836,150
DISTRICT HEALTH SYSTEMS	93,870,500	1,923,572,700	1,360,136,810	2,563,618,158	879,660,360	6,820,858,528
MARTENAL HEALTH	462,250,000	465,800,000	421,145,000	646,300,000	389,990,000	2,385,485,000
TB & LEPROSY	14,240,000	16,180,000	15,820,000	17,680,000	17,580,000	81,500,000
HIV & AIDS	49,845,910	60,925,790	67,549,100	88,864,100	102,853,200	370,038,100
MALARIA	660,600,000	169,700,000	195,600,000	242,600,000	262,600,000	1,531,100,000
HEALTH PROMOTION & EDUCATION	2,600,000	1,800,000	1,500,000	1,000,000	800,000	7,700,000
ANNUAL TOTALS	**1,307,786,410**	**2,756,955,420**	**2,216,300,650**	**3,735,041,998**	**1,799,433,300**	**11,815,517,778**
Available	422,300,000	422,300,000	422,300,000	422,300,000	422,300,000	2,111,500,000
Resources Gap	**885,486,410**	**2,334,655,420**	**1,794,000,650**	**3,312,741,998**	**1,377,133,300**	**11,393,217,778**

The Programme will cost Tshs. 11.8 Trillions